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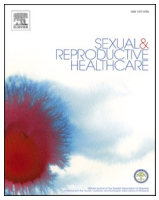

'Goodbye and good luck' Midwifery care to pregnant undocumented migrants in Norway: A qualitative study

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ABSTRACT

Objective: To explore community midwives' experiences caring for pregnant undocumented migrants seeking prenatal care in Norway.
Method: Due to the relatively limited previous research and number of pregnant undocumented migrants we used an explorative approach through qualitative method. Ten community midwives were interviewed after snowball sampling in Oslo, the capital of Norway. The main themes emerged through a qualitative analysis of the transcripts, and meaning units were extracted.
Results: Midwives with no prior experience with pregnant undocumented migrants expressed uncertainty regarding the women's rights. In contrast, those midwives who had had prior experience with this group, developed their own solutions and enacted certain strategies to help them without any guidelines from their employer. All the midwives found it challenging to provide follow-up care to the undocumented migrants during pregnancy and postpartum. They also expressed concerns regarding increasing challenges creating clinical trusting relationships and restrictions and practices at public hospitals.
Conclusions: To ensure adequate perinatal care, it is needed to reassure pregnant undocumented migrants free and safe care at all stages in the birth giving process. Community midwives need professional support in establishing trusting clinical relationships with pregnant undocumented migrants to reduce maternal stress and facilitate continuity in perinatal care.

Introduction

Undocumented migrants have been identified as being in a particularly vulnerable situation facing several health risks [1]. Within the European Union (EU), governments' stated commitments to sexual and reproductive health rights (SRHR) and universal health coverage for undocumented migrants show significant disparities between intentions and practices. Undocumented migrant women face several challenges that undermine their SRHR, including disproportionately high maternal and infant mortality; limited access to contraception and pregnancy termination; and heightened levels of discrimination and gender-based violence [2–4]. Although undocumented migrants have rights that are recognized and protected under international human rights treaties, these migrants are nevertheless reported to be systematically abused and neglected [5].

The term 'undocumented migrants' is generally agreed as referring to third-country nationals without a valid permit authorizing them to reside in EU member states. This includes those who have been unsuccessful in asylum procedures (rejected asylum-seekers), those who have violated the terms of their visas ('over-stayers'), as well as those who have entered the country illegally [6]. Current data on the number of undocumented migrants in the EU are characterized by inaccuracy and low reliability due to the migrants' legal status and incomplete data [7].

Despite the feminization of international migratory patterns, migration policy has remained male-biased, leaving women with considerably fewer opportunities for legal migration and thus increasing the number of undocumented migrant women [8]. Due to their residence status, this group lacks those elements that constitute a basic standard of living in Norway [9]. They are denied health care, face exploitation in the workplace, and are disproportionately vulnerable to

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gender-based discrimination. Living in low-income, high-risk situations, the precarious administrative status of undocumented women makes them highly susceptible to systematic abuse within both public and private domains [10]. Undocumented migrant women have been found to face several health problems. Studies suggest that undocumented migrant women have a higher risk of mental health problems, sexually transmitted infections, preterm birth and low birth weight of offspring [4,11–13]. Further, a Danish study found that undocumented migrant women have a higher prevalence of hepatitis B virus infection compared to documented migrants [14]. A study in the Netherlands showed that pregnant undocumented migrants have increased risk of preterm birth even when midwives followed referral guidelines [15].

In addition to urgent care and care that is totally necessary and cannot be deferred, pregnant undocumented migrants in Norway are entitled to public care before and after giving birth [16]. However, they must cover all costs themselves but the Ministry of Health and Care Services has declared that care for those unable to pay will be covered by the hospitals [17]. Health professionals in Denmark have previously reported challenges providing care for undocumented migrants [18,19]. Public health nurses' challenges have been described as encountering ethical and unmanageable dilemmas [20]. Community midwives caring for pregnant undocumented migrants at public Maternal and Child Health Centres (MCHC), must navigate between women's needs, practical challenges and ambiguous relation between rights to health care and coverage. To overcome barriers and facilitate universal health coverage, it is a need to investigate experiences giving undocumented migrants care [21]. We therefore wanted to explore community midwives' experiences caring for pregnant undocumented migrants seeking prenatal care in Norway.

Methods

Because of the exploratory nature of our study, and because of the relatively limited number of pregnant undocumented migrants in Norway, we deemed an inductive approach based on individual interviews as most suitable for shedding light on midwives' experiences with these women during and after pregnancy. Inductive content analysis is a useful method to describe and investigate a phenomenon with limited existing research [22].

Setting

In Norway, pregnant undocumented migrants do not have the right to a regular general practitioner but are to have access to seek perinatal care from midwives at public MCHC. Health care related to pregnancy and childbirth is free for all members of the Norwegian National Insurance Scheme but pregnant undocumented migrants cannot be a member and should by default pay for giving birth at hospitals [17]. However, it is stipulated that the costs will be covered by the hospital for those unable to pay and it is rendered illegal for institutions to ask for payment before urgent treatment is provided [17]. In 2021, a new model of midwifery care was implemented in Oslo, which includes a postpartum home visit shortly after the mother and baby return home after the birth [23].

An NGO clinic for undocumented migrants was established in Oslo in 2009 by the Red Cross and the Church City Mission in cooperation and is mainly staffed by volunteer health professionals. Around 3,000 consultations were performed in 2019 and about half of these were for women, mostly of childbearing age. Pregnant undocumented migrants are a heterogenous group with the majority coming from Africa. Those who come to the NGO clinic are mainly referred to MCHCs and midwifery care [4].

Sample

Community midwives were recruited via snowball sampling. As most midwives in Norway have limited experience caring for pregnant undocumented migrants, this method seemed the most suitable [24]. Recruitment began with volunteering midwives at the NGO clinic: many of these midwives also work at community driven MCHCs, where they invited their colleagues to participate. Ten midwives agreed to be interviewed. Nine of them had at least 10 years of experience as midwives, while one had only recently completed her midwifery examinations. The midwives referred to a range of encounters with pregnant undocumented migrants (Table 1).

Data collection

Interviews, all in Norwegian, were collected between June 2018 and February 2020. Interviews took place at the participants' workplace. The head of the MCHC/NGO clinic approved all the interviews. The interviews were semi-structured, with open-ended questions to allow the participants to freely interpret and respond to the questions. Principal investigator (NV) conducted and transcribed the interviews, which were audio recorded and then transcribed.

Data analysis

The transcripts were analysed by the first author. Each transcript was read separately several times, until the main themes were generated from the text. Next, inductive content analysis was conducted, following Graneheim and Lundman's recommendations [25], and meaning units relevant to the study's aim were identified. Secondly, condensed meaning units were labelled with a code. Subthemes were identified and sorted into themes. (Table 2) Finally, four main themes were identified. The themes, however, were not mutually exclusive [25].

The text involves multiple meanings, and the interpretation of the principal investigator is influenced by her long clinical experience working in the field of undocumented pregnant migrants.

Ethical considerations

Participation was voluntary. All the participants signed a written consent form at the start of the interview after having been given both verbal and written information about the study. They were also informed that they could withdraw from the study until analysis, without having to provide a reason. Interviews were recorded and stored on an encrypted memory stick and all material was kept in a locked location.

Results

Four main themes were generated from the analysis: finding strategies, discontinuity of care, lack of trust and strict hospitals. The community midwives in this study had different experiences providing care to pregnant undocumented migrants; these experiences appeared to correspond to how often they had encountered pregnant undocumented migrants in their practice in the past. Midwives with experience from the NGO clinic knew that women had the right to prenatal care and how to respond to questions about access to giving birth and payment. In contrast, the midwives who had limited experience with this population

Table 1
Places where midwives encountered pregnant undocumented migrants.

Participant number	Non-governmental clinic	Maternal and Child Health Centre	Hospital
1	X		X
2	X	X	X
3	X	X	X
4	X		X
5	X	X	
6	X		
7		X	
8		X	
9	X	X	
10		X	

Table 2
Example of the analytical process

Meaning unit	Condensed meaning unit	Sub theme	Theme
All the midwives felt responsible to care for the women in a vulnerable situation	Midwives worried about the women	Midwives felt responsible for the care	Discontinuity of care
Difficult to keep track of the women and their appointments	Some women just disappeared		
Midwives were not able to make appointments with the mothers to a postpartum home visit. The mothers did not want a home visit, or they did not have a permanent address		Difficult to make appointments with the women	
The women lacked Norwegian identification numbers	Difficult to follow up		

were uncertain as to how best to help them. Nevertheless, all the midwives shared a fundamental desire to provide the women with the best possible care – and all of them developed their own solutions and enacted certain strategies to help them.

Finding strategies

Some midwives reported being unsure about how to classify the status of the women they encountered, and hence did not know the rights to which the women were entitled. For purposes of clarification, they noted that it was helpful to ask for instructions from the NGO clinic. For the midwives who had more experience providing care to pregnant undocumented migrants, seeking clarification was unnecessary; they stated that they provided these women with the same care that they provided to other pregnant women. One midwife described how, when the health secretary asked her about what to do, she had answered: '*Oh yeah, she doesn't have a personal identification number? Just refer her*'. And as another explained: '*We do not have many [pregnant undocumented migrants], and I am uncertain about their rights. But when they show up, we include them*'.

None of the community midwives at MCHCs in the study had received guidelines on caring for pregnant undocumented migrants; rather, the midwives reported that they had to find their own strategies and solutions. When there was need for a doctor, there were occasionally doctors present at MCHCs who could help, or sometimes local doctors would offer free consultations.

Discontinuity of care

All the midwives pointed to their inability to maintain continuity of care as a source of frustration. They all felt a great responsibility to care for the women in a vulnerable situation, but the women often did not show up for consultations or just 'disappeared'. As the women lacked Norwegian identification numbers, the midwives reported that it was difficult to keep track of women's appointments. The midwives would try to follow up women via cell phone, but this proved complicated, as the women often lost their phones or switched phone numbers. One midwife referred to an instance in which she was unable to follow up a pregnant undocumented migrant close to term, after which she was called by the midwife at the hospital who told her she had not done her job properly.

The midwives noted that the pregnant undocumented migrants were a heterogeneous group and not always difficult to follow up. One midwife described the challenges of this heterogeneity in further detail:

> '*There are sort of two categories of pregnant undocumented migrants. Some have a partner or husband who is here legally and life with a baby is easier to plan for. However, then you have those who are staying with friends and moving often, and this makes it much more unstable—then you are more at the mercy of God. It is sort of goodbye and good luck. You are supposed to talk about nutrition, but they might not be able to decide their own diet…One woman had gestational diabetes, and she was dependent on the people she stayed with, so it is not always easy. You can give as much advice as possible, but it does not seem to help*.'

Postpartum follow up of the undocumented migrants also proved difficult for the midwives. Although the women were entitled to one postpartum home visit, none of the midwives had carried out such visits. The pregnant undocumented migrants sometimes declined the offer of the visit, or the midwives were unable to get in touch with them following delivery. This was a source of concern for the midwives, as they wanted to be able to have this final consultation. As one explained: '*They sort of just disappear. And we worry so much about how they are coping. It would have been nice to see them a final time*'.

Lack of trust

Midwives with several years of experience with pregnant undocumented migrants described how the women's levels of trust had changed in recent years. They felt that today's pregnant undocumented migrants were much more reserved and did not access the care to which they were entitled in the same way as they did before. They also pointed out that some of the pregnant undocumented migrants were afraid of being registered in the health care system, of being reported and detained, and insecure about who they would encounter at the hospital. One midwife noted that some women skipped appointments at the hospitals due to these concerns: '*They do not have the security. They are insecure—will they be reported? Will the police be told…?*'

Another aspect relating to trust centred on the pregnant undocumented migrants' concerns that childbirth would be dangerous, and that they would be taken advantage of by the hospital. As one midwife explained:

> '*Some start talking about relatives who have died during childbirth, and they are worried about the hospital wanting their money. 'Maybe they will give me an operation, maybe they will perform an early caesarean, maybe they will fool me at the hospital'. Women from Somalia are unsure whether the hospital will do the best for their patients. In their home country they are used to paying for extra treatment.*'

Moreover, one midwife mentioned that pregnant undocumented migrants did not want to be tested for contagious diseases – something that is required by the public health authorities. She stated: '*Some do not want to be tested, for HIV, hepatitis or syphilis. They are unsure of the consequences. So I think – maybe they have been sexually abused? They have not told anyone and might be scared of being contagious*.'

Although sexual abuse and violence is a common issue for female refugees and asylum seekers, the midwives noted that this issue may be painful for them to talk about – opening up about such incidences demands both time and trust. As this midwife explained:

> '*Several women may have been exposed to violence, and I think this may be difficult. They may say they have been exposed to violence or abuse but have no further wish to talk about it. This may have serious consequences during childbirth.*'

Strict hospitals

The midwives described challenges when they referred pregnant undocumented migrants to hospitals. As the women lack a Norwegian identification number, they were automatically presented with a bill for

the hospital visit. As this midwife related:

> '*Back in 2018, when I referred pregnant undocumented migrants, I felt there was a general agreement that they have access to free birth…I never heard about any getting a bill for ultrasound…It all went very smoothly. Then this year [2020], something happened. We had a woman who was asked during birth how she was going to pay for the treatment – she received a bill for the ultrasound, and the birth was premature, [and] she had experienced a lot of stress*.'

The challenges in referring pregnant undocumented migrants to hospitals was addressed by several of the midwives. One felt that this only had become a problem in the last two years:

> '*Two years ago, there was never a problem to refer a woman without a registered Norwegian identity number. The hospital said, 'Yes, just refer her'. My experience now is that they are much more reluctant. They say, 'But who is going to pay for her?', like they are much more aware of the cost.*'

One midwife talked about how one of her clients was (mis)treated by the hospital where she had planned to give childbirth:

> '*The hospital has called (several women) and been very impolite before delivery. One of the women has been called 4 to 5 times and had conversations lasting up to 20 minutes. She felt she was being pressured financially. She was told she had to guarantee that she was able to pay 40,000 Norwegian kroner [approximately 4,000 euros] for the delivery. These impolite calls from the hospital made her avoid the hospital. She says that she hates the hospital.*'

The manager at the NGO clinic also noted that several pregnant undocumented migrants had received bills after being referred to hospitals. They were billed for the routine ultrasound in weeks 17 to 19 of their pregnancy, or for other issues later in pregnancy, even though the hospital was supposed to cover these expenses.

Discussion

This study found that community midwives' work experience is important for their management of pregnant undocumented migrants. The community midwives wanted to provide the best possible care to pregnant undocumented migrants but did not have any guidelines and were often unable to provide continuity of both prenatal and postpartum care. They experienced increasing challenges in establishing trusting clinical relationships with pregnant undocumented migrants and experienced strict management of coverage for childbirth at the hospitals.

Lack of professional support

Information about the rights of pregnant undocumented migrants is not easily obtained, nor is it a priority for health care workers in Norway. Moreover, as there are relatively few pregnant undocumented migrants in Norway, midwives rarely encounter them in their practice. The topic is not covered in midwives' education programmes, nor are there official guidelines for providing care for pregnant undocumented migrants in a vulnerable situation with restrictive rights, no official address, and without a Norwegian identity number. Consequently, when midwives do encounter pregnant undocumented migrants, they must navigate on their own. The midwives in this study described several strategies they have developed to help pregnant undocumented migrants, which they enact independently of their supervisors. This corresponds with an earlier study from Denmark [19]. Another study has suggested that specific training increases midwives' abilities to identify pregnant women who need more midwifery care [26]. Midwives reported colleagues who had prejudices toward pregnant undocumented migrants. Having professional support from leaders to provide prenatal care to undocumented migrants may also help reduce arbitrary practice and increase women's access to such care.

Access to childbirth

While the Ministry of Health and Care Services has declared that expenses for women unable to pay for childbirth and hospital care will be covered by the hospital [17], it is seems unclear how this agreement is to be managed and implemented by hospitals. With the current situation, the pregnant undocumented migrants are still being billed for hospital care, and all the community midwives in this study reported this as a stressor for the women – and for the midwives trying to provide them with the best care possible. The midwives expressed concerns that pregnant undocumented migrants may hesitate to seek care at the hospital if needed during pregnancy; this could negatively impact their pregnancy outcomes, as it is known that migrant women are at risk of severe complications during pregnancy and childbirth [13,27,28].

In the spring of 2021, the Norwegian newspaper *Klassekampen* published a series of articles describing the situation faced by many pregnant undocumented migrants giving birth in Norway. These articles depicted situations in which women received debt collection notices for up to NOK 250,000 (app. EUR 25,000) and noted that it varied from hospital to hospital as to how the cost related to pregnant undocumented migrants giving birth was managed. The Minister of Health was cited that he would ensure that coverage of childbirth would be made clear to all hospitals [29]. Clear guidelines are crucial to prevent arbitrary decision-making around the issue of coverage, and also because the pregnant undocumented migrants are not in a position to argue their rights for health care. While they largely appreciate the help they receive, the fear of being reported to the authorities is omnipresent. Correspondingly, lack of clarity may hinder them from accessing the perinatal care to which they are entitled.

Trusting clinical relationship

Reflecting on the relationships between human beings, Danish theologist and ethicist Knut Løgstrup argues that, '*in a relationship, an individual will always hold part of the other person's life in their hands' ['Den enkelte har aldri med et annet menneske å gjøre uten å holde noe av dette menneskets liv i sine hender*'] [30]. In a similar vein, the midwives in this study all agreed that they had a special responsibility to meet the needs of pregnant undocumented migrants.

Midwives reported that all pregnant undocumented migrants had their own story, with different reasons for staying in Norway: some spoke several languages (including Norwegian) and were in a stable relationship with their child's father, while others had little education and lived in vulnerable situations. Moreover, many of the women had been faced with long, challenging journeys to get to Norway and their pregnancy represented a new journey, with a new set of challenges. As was pointed to by the midwives in this study, continuity in perinatal care is essential in helping these women feel secure. Indeed, a study of undocumented women seeking perinatal care in Sweden, by Barkensjö et al., highlighted the importance of developing trusting relationships with health care professionals [31]. Public health nurses in Norway also pointed out that building relationships with undocumented mothers based on trust was crucial [20]. This may be a challenge in the current Norwegian system, as midwifery care is fragmented. While the women may attend one midwife during their pregnancy, they will be cared for by different midwives during childbirth, and other midwives or care providers at the maternity ward. Following childbirth, a public health nurse will then provide childcare at the MCHCs. In addition, since pregnant undocumented migrants do not have a Norwegian identity number, there is a risk of having several different medical records. A Danish study found that not having access to previous medical records on undocumented migrants is a challenge to health personnel in providing quality care [18]. However, a first step is to facilitate a trusting clinical relationship in prenatal care to reduce stress and risk of adverse pregnancy outcomes.

Another approach might be to provide the women with a 'cultural

doula'. A doula is a woman who provides emotional and informational support to childbearing women with a similar background throughout the perinatal period. This approach was introduced as part of a three-year project in Norway, although such interventions show varying results [32].

Strengths and limitations

Research about undocumented migrants, especially research that is related to experiences of the health personnel who provide the services, is scarce. This kind of research is essential to further facilitate universal health coverage in Norway. This is the first study in Norway and one of very few in Europe exploring community midwives' experiences of providing prenatal care to undocumented migrants. All interviews and transcriptions were performed by the principal investigator which we consider as a strength.

The study included only ten interviews, and few of the midwives had prior experience with pregnant undocumented migrants; this limited the richness of data. The study was done at one location, Oslo, which presumably has the highest density of undocumented migrants in Norway. However, the results might not be transferable to other cities or to other countries with other practices, regulations, and health care systems. The analysis was conducted by the principal investigator only.

Conclusion

Ensuring adequate perinatal care accessible for pregnant undocumented migrants is urgently needed. This study suggests measures such as reassuring pregnant undocumented migrants, professional support to community midwives in establishing trusting clinical relationships, and facilitating continuity in prenatal and postpartum care. There is also a need for clear guidelines stating hospitals' responsibility in coverage of childbirth to reduce maternal stress and ensure the best possible care.

Data statement

The data is available on reasonable request to corresponding author.

Ethical approval

The study was conducted in accordance with the Declaration of Helsinki and approved by the Data Protection Officer at VID specialized university (VID00001 and 19.02.2019) after assessment was obtained from the Norwegian Data Protection Service (NSD, ref.no. 378796).

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Declaration of Competing Interest

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

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