Received: 25 July 2022 | Revised: 24 December 2022 | Accepted: 3 May 2023

DOI: 10.1111/birt.12727

BIRTH ISSUES IN PERINATAL CARE WILEY

ORIGINAL ARTICLE

Community midwives' perspectives on perinatal care for asylum seekers and refugees in the Netherlands: A survey study

A.E.H. Verschuuren MD[1] | **J.B. Tankink MD**[2] | **A. Franx MD/PhD**[2] | **P.J.A. van der Lans MD**[3] | **J.J.H.M. Erwich MD/PhD**[4] | **E.I. Feijen-de Jong RM, PhD**[5,6] | **J.P. de Graaf PhD**[2]

[1]Department of Health Sciences, Global Health Unit, University Medical Center Groningen & University of Groningen, Groningen, the Netherlands

[2]Department of Obstetrics and Gynecology, Erasmus University Medical Center, Rotterdam, The Netherlands

[3]Department of Obstetrics and Gynecology, Hospital Twente ZGT/MST, Enschede, The Netherlands

[4]Department of Obstetrics and Gynecology, University Medical Center Groningen, University of Groningen, Groningen, the Netherlands

[5]Department of General Practice & Elderly Care Medicine, University of Groningen, University Medical Center Groningen, Groningen, the Netherlands

[6]Midwifery Academy Amsterdam Groningen, Groningen, the Netherlands

Correspondence
A.E.H. Verschuuren, Department of Health Sciences, Global Health Unit, University Medical Center Groningen & University of Groningen, Hanzeplein 1, 9713 GZ Groningen, the Netherlands.
Email: a.e.h.verschuuren@umcg.nl

J.B. Tankink, Department of Obstetrics and Gynecology, Erasmus University Medical Center, Doctor Molewaterplein 40, 3015 GD Rotterdam, The Netherlands.
Email: j.tankink@erasmusmc.nl

Funding information
ZonMw

Abstract

Background: The rise of forced migration worldwide compels birth care systems and professionals to respond to the needs of women giving birth in these vulnerable situations. However, little is known about the perspective of midwifery professionals on providing perinatal care for forcibly displaced women. This study aimed to identify challenges and target areas for improvement of community midwifery care for asylum seekers (AS) and refugees with a residence permit (RRP) in the Netherlands.

Methods: For this cross-sectional study, data were collected through a survey aimed at community care midwives who currently work or who have worked with AS and RRP. We evaluated challenges identified through an inductive thematic analysis of respondents' responses to open-ended questions. Quantitative data from close-ended questions were analyzed descriptively and included aspects related to the quality and organization of perinatal care for these groups.

Results: Respondents generally considered care for AS and RRP to be of lower quality, or at best, equal quality compared to care for the Dutch population, while the workload for midwives caring for these groups was considered higher. The challenges identified were categorized into five main themes, including: 1) interdisciplinary collaboration; 2) communication with clients; 3) continuity of care; 4) psychosocial care; and 5) vulnerabilities among AS and RRP.

A.E.H. Verschuuren and J.B. Tankink shared first authors.

Conclusions: Findings suggest that there is considerable opportunity for improvement in perinatal care for AS and RRP, while also providing direction for future research and interventions. Several concerns raised, especially the availability of professional interpreters and relocations of AS during pregnancy, require urgent consideration at legislative, policy, and practice levels.

KEYWORDS
asylum seekers, midwives, perinatal care, pregnancy, refugees

1 | INTRODUCTION

The rise of forced migration worldwide requires birth care systems and professionals to respond to the needs of women giving birth in vulnerable situations. In the Netherlands alone, approximately 600 babies per year are born to mothers living in asylum seekers centers (ASC).[33] Severe inequities in maternal and perinatal mortality and morbidity continue to be reported between refugee and majority populations in Europe.[15,16,36] In the process and aftermath of forced migration, women may be exposed to a range of factors associated with maternal and perinatal health risks such as trauma, socioeconomic disadvantage, and a precarious legal status.[2]

Moreover, a substantial portion of the disparities in perinatal and maternal outcomes can be explained by the availability, accessibility, acceptability, and quality of perinatal care.[9,35] Asylum seekers and refugees must navigate a mostly unfamiliar healthcare system and may experience barriers to care ranging from limited financial resources to a lack of trust in care providers.[2,12] These barriers may cause significant delays in seeking and receiving perinatal care, even in high-income settings such as the Netherlands.[1,8,28] Once care has been found, suboptimal care factors such as misdiagnosis and insufficient monitoring may contribute to poor outcomes, including stillbirth and maternal death.[10,29]

Considering the role of suboptimal care factors in perinatal health inequities, there is a need to understand how the organization and provision of perinatal care can meet the needs of disadvantaged migrant populations. Little research has been done to explore the experiences of care professionals and their perspective on perinatal care for forcibly displaced women.[4,19,20,34] In the Netherlands, community care midwives play a crucial role as the primary obstetric care provider throughout most women's pregnancies and births.[26] As such, this study aimed to answer the following research questions:

1. What are the main challenges community midwives in the Netherlands experience when providing perinatal care for asylum seekers and refugees with a residence permit?
2. What do midwives consider opportunities for the improvement of perinatal care for asylum seekers and refugees with a residence permit?

2 | METHODS

2.1 | Population

Our survey was distributed to community care midwives who currently work or have worked with pregnant asylum seekers (AS) or refugees with a residence permit (RRP). For the purposes of this, AS were defined as women living in a Dutch asylum-seeking center (ASC) while awaiting their request for asylum. RRP were defined as women whose asylum request had been granted (i.e. with a legal residence status in the Netherlands).

2.2 | Setting

In midwife-led birth care in the Netherlands, pregnant women receive community midwifery care during their pregnancy, childbirth and postpartum period. In case of high-risk pregnancies or complications, women will be referred to obstetricians in a hospital. Most AS and RRP also start their antenatal care with midwives. In 2012 a collective of care organizations including obstetricians, general practitioners, maternity care nurses, and the Central Agency for the Reception of Asylum Seekers (COA) developed a national guideline on birth care for AS. The guideline describes how tasks and responsibilities should be divided and coordinated between different organizations and professionals involved in their care.[5] There are no specific protocols or guidelines for perinatal care for refugees with a residence permit in regular housing. Professional interpreter services in medical facilities are financed by the national government for AS, but not for RRP.

2.3 | Study design

For this cross-sectional study data were collected through an online survey.

2.4 | Survey development

The survey was developed by researchers from the EGALITE project (Erasmus MC Rotterdam) in collaboration with the University Medical Center Groningen in *LimeSurvey* (version 2.06LTS). Questions were based on previous studies on midwives' experiences caring for refugee populations, interviews with midwives, and the Dutch guideline on perinatal care for pregnant AS.[5,12,24,25,34] The survey was tested by obstetric care professionals and discussed with an implementation scientist and adapted based on their feedback.

The 50–item survey comprised five sections of questions: characteristics of respondents and midwifery practices caring for AS and/or RRP (1), organization of care for AS (2), organization of care for RRP (3), evaluation of care provided for AS/RRP (4) and respondents' perspectives on opportunities for improvement of care for AS/RRP (5). The total survey comprised of 37 close-ended and 13 open-ended questions. Respondents were asked to fill in questions on either AS, RRP or both, depending on which of these groups they had worked with. Formats for close-ended questions included multiple choice, yes/no/do not know statements, and 4- or 5-point Likert scale answer options. The open-ended questions had free text answer formats.

2.5 | Data collection

Data collection took place between March and June 2021. The invitation to the digital survey was sent to midwifery practices known to work with AS or RRP and to all Dutch midwifery practices that claimed expenses from the national insurance fund for AS ($n = 320$). Further recruitment took place through snowballing, several news outlets, online platforms, and social media networks frequented by midwives. Duplicate responses were excluded as were survey responses that only included the "characteristics" section.

2.6 | Outcomes and analysis

Qualitative outcomes included respondents' views concerning the main challenges in birth care for AS and/or RRP. Participants' answers to the open-ended questions were analyzed with an inductive thematic approach which resulted in the themes described. For the analysis, ATLAS.ti software was used.

Quantitative outcomes for both AS and RRP included:

- respondents' perception of the quality of care;
- satisfaction with interdisciplinary collaboration;
- ease of communication with other care professionals;
- the frequency of multidisciplinary meetings;
- the use of protocols and guidelines;
- deployment of professional interpreters;
- frequency of missed appointments among AS and RRP;
- the frequency of screening for psychosocial problems;
- referral to psychosocial care; and
- the extent to which respondents believed interventions would improve care.

For RRP specifically, the perceived intensity of care and additional tasks for obstetric care professionals were added to the survey. For AS these topics were not included in the survey since additional tasks are described in the national guideline. Quantitative data mostly originated from close-ended questions. These questions were analyzed in SPSS using descriptive statistics. For some open-ended questions data were grouped and counted.

3 | RESULTS

3.1 | Response rate

From the 320 invitations sent out to midwives directly, 134 responses were collected. Of these, 70 responses were included and 64 were excluded because responses were duplicate, or because respondents only filled in the characteristics section (total response rate: 22%). Through an open link to the survey distributed online, 32 additional responses were collected.

3.2 | Characteristics of respondents

All 102 respondents worked as community care midwives with AS and/or RRP. For respondents' characteristics, see Table 1.

3.3 | Respondents' perspectives on quality and intensity of care

Most respondents considered the quality of obstetric care for AS and RRP to be either poorer or equivalent compared to care for the Dutch population (Table 2). In addition, 94.4% of respondents considered the intensity of caring for RRP to be higher when compared to caring for non-migrant women.

TABLE 1 Characteristics of respondents ($N = 102$).

Characteristics	Number of respondents
Age	
25–30	23 (22.5)
31–40	36 (35.3)
41–50	20 (19.6)
51–60	15 (14.7)
61–68	8 (7.8)
Migration background of the midwife	
No migration background	94 (92.2)
First or second-generation migrant	8 (7.8)
Number of midwives in practice	
Solo practice	6 (5.9)
Duo practice	23 (22.5)
Group practice (>2)	73 (71.6)
Experience with care for AS (in years)[a]	
1–5	28 (38.9)
6–10	16 (22.2)
11–15	11 (15.3)
>15	17 (23.6)
Total	72 (100)
Experience with care for RRP (in years)[b]	
1–5	21 (23.3)
6–10	22 (24.4)
11–15	23 (25.6)
>15	24 (26.7)
Total	90 (100)
Average number of AS in care, per year[a]	
0	4 (5.6)
1–10	29 (40.2)
11–20	17 (23.6)
21–30	15 (20.8)
31–40	4 (5.6)
>40	3 (4.2)
Average number of RRP in care, per year[b]	
0	0 (0.0)
1–10	51 (56.7)
11–20	21 (23.3)
21–30	8 (8.9)
31–40	2 (2.8)
>40	8 (11.1)

Note: Data are presented as Number of respondents (%).

[a]$N = 72$.

[b]$N = 90$.

3.4 | Challenges in midwifery care for AS and RRP

Thematic analysis of respondents' perspectives on perinatal care for AS and RRP resulted in a series of challenges, including: interdisciplinary collaboration, communication with clients, continuity of care, psychosocial care and vulnerabilities among AS and RRP (Figure 1).

3.4.1 | Interdisciplinary collaboration

Most respondents (54.1% AS vs 55.6% RRP) stated that they were either fairly satisfied or very satisfied with interdisciplinary collaboration in the medical and social domain of care (Table 3).

However, satisfaction varied between different care disciplines (Figure 2). Respondents were most satisfied with communication between their own midwifery practice and maternity care organizations, the hospital, and youth health services. Nevertheless, some respondents felt that maternity care organizations and hospital specialists did not always understand or respond adequately to the complex needs of AS and RPP clients.

In care for AS, respondents considered communication with COA, GZA and social work to be more difficult. Problems included identifying and reaching responsible professionals at these organizations. Additionally, some respondents reported that AS received insufficient support from the COA/GZA.

"Collaboration with the GZA and the COA [is the most important challenge in perinatal care for AS]. The last couple of years, the general opinion of GZA and COA has been: people are autonomous and should take care of their own business. Being involved [with the client] is labelled as 'unprofessional'." - Participant 33.

3.4.1.1 | *Coordination of care*

Respondents struggled with a lack of coordination of care and several respondents reported that they spend more time coordinating care as a case manager for their AS and RPP clients compared to non-migrant clients. Of all respondents, only 15.3% and 7.8% (AS vs RPP) reported having regional, multidisciplinary meetings specifically for AS or RRP, whilst many expressed a need for these meetings and for more intensive collaboration overall.

Although mentioned for both groups, the lack of coordination of care, including the absence of an overview of organizations involved and referral pathways, was specifically mentioned as a challenge in care for RRP.

TABLE 2 Perceived quality of care.

	Much poorer quality	Somewhat poorer quality	Equal quality	Somewhat higher quality	Much higher quality	I do not know
Quality of care AS[a]	0 (0)	30 (47.6)	28 (32.6)	3 (3.5)	1 (1.6)	1 (1.6)
Quality of care RRP[b]	1 (1.2)	34 (39.5)	43 (50.0)	6 (7.0)	0 (0)	2 (2.3)

Note: Data are presented as Number of respondents (%).

[a] $N = 63$.

[b] $N = 86$.

FIGURE 1 Main challenges in perinatal care for AS and RRP.

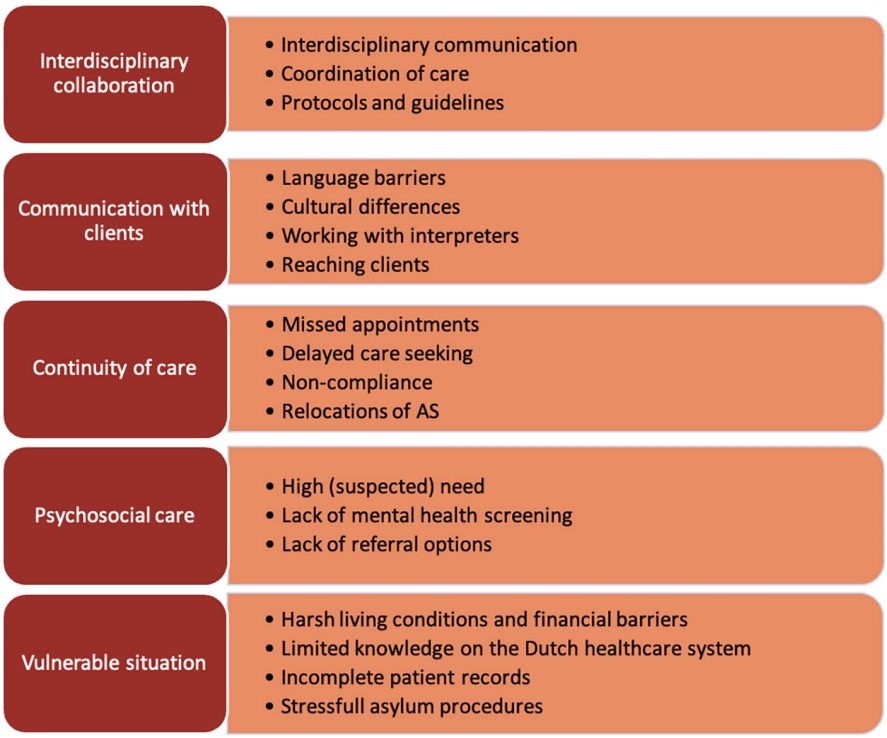

TABLE 3 Overall satisfaction with interdisciplinary communication.

	Very dissatisfied	Somewhat dissatisfied	Neutral	Fairly satisfied	Very satisfied	I do not know
Satisfaction with interdisciplinary communication in care for AS[a]	3 (4.2)	9 (12.5)	10 (13.9)	24 (33.3)	15 (20.8)	2 (2.8)
Satisfaction with interdisciplinary communication in care for RRP[b]	3 (3.3)	9 (10.0)	21 (23.3)	35 (38.9)	15 (16.7)	3 (3.3)

Note: Data are presented as Number of respondents (%).

[a] $N = 63$.

[b] $N = 86$.

3.4.1.2 | *Protocols and guidelines*

Only 16.7% of respondents reported having a protocolized regional care pathway for RRP. Some respondents mentioned the lack of a national guideline as a challenge for the coordination of care. 18.1% of respondents reported that they were fully familiar with the Dutch perinatal guideline for AS women; 23.6% stated they had good knowledge of the content, 19.4% were somewhat familiar, and 38.9% were not familiar with the content of the guideline at all.

3.4.2 | Communication

The main communication challenges mentioned were language barriers, cultural differences, working with

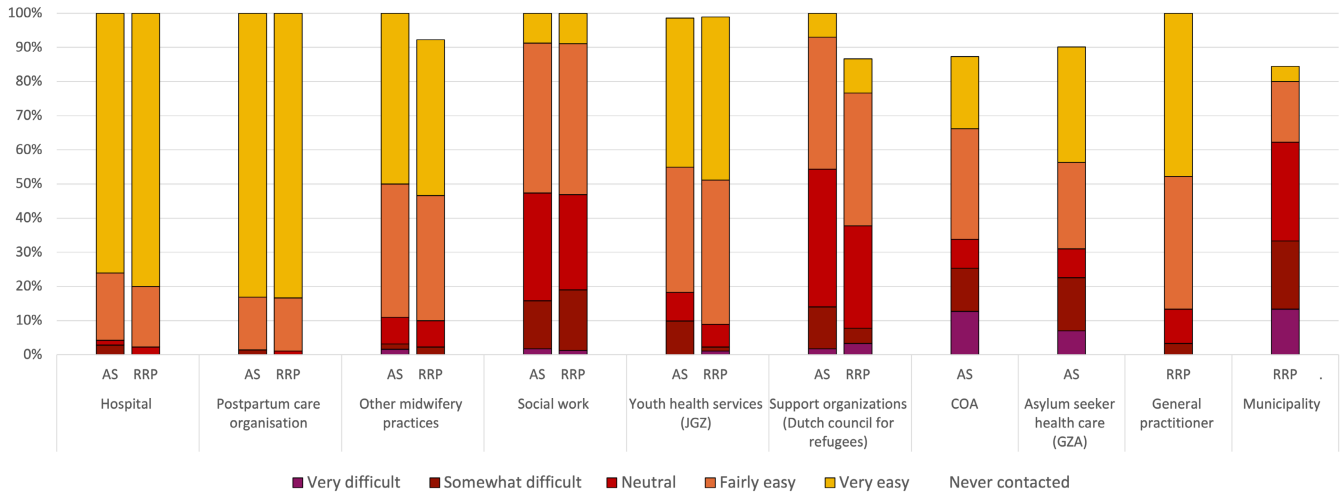

FIGURE 2 How easy is it for you to contact the right person in the organizations mentioned below?

TABLE 4 Interpreters, relocations, and aspects of psychosocial care.

	Never	Sometimes	Often	Always	I do not know
Respondents work with interpreters for AS[a]	0 (0.0)	9 (12.5)	24 (33.3)	39 (54.2)	0 (0.0)
Respondents work with interpreters for RRP[b]	16 (17.8)	46 (51.1)	19 (21.1)	9 (10.0)	0 (0.0)
Respondents are informed by COA in case of relocation of AS[a]	10 (13.9)	20 (27.8)	27 (37.5)	9 (12.5)	6 (8.3)
Respondents receive relevant client history from GZA in case of a new pregnant AS client[a]	10 (13.9)	28 (38.9)	15 (20.8)	17 (23.6)	2 (2.8)
Respondents inquire about migration history of AS client[a]	0 (0.0)	16 (22.2)	22 (30.6)	34 (47.2)	0 (0.0)
Respondents inquire about migration history of RRP client[b]	2 (2.2)	18 (20.0)	35 (38.9)	34 (37.8)	1 (1.1)

Note: Data are presented as Number of respondents (%).

[a]$N = 72$.

[b]$N = 90$.

interpreters, contacting clients by phone, and clients' limited trust in care providers and in the Dutch healthcare system.

3.4.2.1 | *Language barriers & cultural differences*

Respondents described several negative consequences of language barriers, including problems with providing information to the client, clients who are unable to understand the midwife, miscommunications in care, missed appointments and difficulties in building a relationship with the client. Cultural differences were also considered to be challenging, for example, when clients had different expectations of care. Several respondents reported that they had limited knowledge on other cultures' customs and beliefs regarding pregnancy and childbirth.

3.4.2.2 | *Interpreters*

In cases of insufficient language compatibility between the midwife and an AS client, 87.5% of respondents indicated that they often or always work with professional interpreter services. In the case of RPP clients, only 31.1% of respondents often or always work with interpreters (Table 4).

Reasons for not using official interpreters differed. The cost of interpreter services was spontaneously mentioned as one of the main barriers to working with these services by 60.2% of respondents caring for RRP, while only 17.1% of respondents mentioned this barrier in care for AS. Other reasons for not using official interpreters were similar between both groups and included the presence of informal interpreters, sufficient (Dutch or alternative) language proficiency of clients

or midwives, time constraints and technical difficulties with interpreter services by phone. Some respondents preferred communication through Google Translate or with hand gestures, as telephone services were considered impersonal, undesirable, or only necessary in certain consultations.

"The costs of using telephone interpreter services [for RRP] are such, that we decided to not use these any longer. Most of the time people know someone who speaks their language and who also knows English or sometimes Dutch. Then we call through them. Or we use Google Translate." – Participant 101.

3.4.2.3 | *Contacting clients*

Respondents also expressed difficulties in contacting AS and RRP women by telephone or e-mail. Several respondents explained that the limited opportunities to communicate with their clients by these means intensified care due to the necessity for more home visits.

3.4.3 | Continuity of care

Continuity of care was considered a major challenge as a result of missed appointments, delays in seeking care in case of symptoms, non-compliance, and relocation of AS. Among respondents, 73.6% of those caring for AS versus 62.2% of those caring for RRP agreed that these clients miss more antenatal visits without notice than do non-migrant women.

3.4.3.1 | *Relocation of AS*

Respondents expressed major concerns about continuity of care for AS women specifically because of frequent relocation between ASCs and in some cases pending deportation. Potential problems included missed or delayed care, extra costs due to repeated care and setbacks in the relationship with pregnant AS due to alternating care providers. Additionally, respondents stated that the transfer of medical records was often delayed in case of relocation of AS (Table 4).

"Sometimes COA forgets to inform us when a pregnant woman is going to be relocated to another center or sent back to her country of origin. In that case we only find out when she does not turn up for her consultation. That cannot be right." – Participant 37.

3.4.4 | Psychosocial care

Another major challenge in providing perinatal care for AS and RRP concerned the identification, support, and referral of women in need of psychosocial care. Respondents reported the process of finding appropriate support for AS and RPP to be difficult, including long waiting times and a lack of referral options that meet these women's complex needs. This was even more concerning because respondents suspected a high incidence of psychological conditions and social problems among pregnant AS and RRP. A minority of 47.2% and 37.8% of respondents (AS vs RPP, respectively) reported that they always inquire about the personal history of the client, including the reason for migration, family circumstances and trauma exposure. Although prescribed by the national guidelines, 52.8% of respondents indicated that they never or only occasionally received information regarding the psychosocial situation of their AS clients from the GZA (Table 4). In addition, only 17% and 21% of respondents used a specific screening instrument to assess the psychosocial status of their AS or RRP clients.

Table 5 shows the most common referral pathways for psychosocial care as indicated by respondents. Almost 20 percent of the respondents reported that they never made a referral to psychosocial care.

3.4.5 | Vulnerable situation of AS and RRP

The last major challenge in providing perinatal care expressed by respondents was the vulnerable situation of pregnant AS and RRP. Harsh living conditions, financial precarity, limited health literacy, lack of information on the Dutch healthcare system, limited social networks, incomplete patient records and, for AS specifically, stressful asylum procedures were described by participants. Financial precarity was considered a factor for both groups, though more prominently for RRP. Respondents reported how financial barriers resulted in limited uptake of postpartum care by this group, insufficient baby products, and problems with transport to medical facilities.

For RRP, respondents reported additional aspects of vulnerability, such as care providers' limited awareness of women's refugee status. Moreover, RRP were considered to face more difficulties navigating the health care system as they are expected to be responsible for their own care process and receive little guidance after receiving a residence permit.

3.4.5.1 | *Additional tasks*

The vulnerable situation of AS and RRP clients resulted in additional tasks and greater care responsibilities for respondents. When asked about the nature of tasks performed in addition to "care as usual", respondents caring for RRP commonly mentioned practical and material support, spending more time with the client, postpartum care, booking appointments, intensive multidisciplinary

TABLE 5 Most common referral pathways for psychosocial care.

	GZA/COA	Hospital	General physician/ family doctor	Psychologist	Other[c]/ unknown	Never/almost never
AS[a]	26 (34.2)	25 (32.8)	11 (14.4)	N/A	13 (17.1)	14 (18.4)
RRP[b]	N/A	35 (38.4)	45 (49.4)	9	28	18 (19.7)

Note: Data is presented as Number of respondents (%).

[a]$N = 76$.

[b]$N = 91$.

[c]Other, including Municipal Health Services/Youth Health Services, mental healthcare institution, social work, Dutch refugee council, municipality, Veilig Thuis (Safe at Home).

TABLE 6 Most common additional tasks in care for RRP.

Domain	Example(s) of additional tasks	Number of respondents
Practical & material support	Organizing donations of birth or baby products	68
	Support transportation	
	Support filling out forms	
Spending more time with clients	More home visits	46
	Offering additional explanation	
Postpartum care	Admission to postpartum care	41
Booking appointments	Booking appointments with other care professionals	34
	Follow-up after missed appointments	
Intensive multidisciplinary collaboration	Arranging hospital birth at social indication	24
	More frequent contact and sharing information with other professionals	
More psychosocial/extra care	Referrals to psychosocial support	9
	Support in finding "buddies"	

collaboration, and more psychosocial/extra care (Table 6). To bridge transportation problems, multiple respondents indicated that they had used their private cars to drive clients to the hospital during labor.

Besides the practical burdens, some respondents also reported that the vulnerable situations of AS and RRP clients caused an emotional burden which contributed to the intensity of care. This was reflected in statements on how they felt powerless or as if they were "falling short" in caring for these clients.

"I oftentimes feel like I fall short, especially on a social and emotional level." – Participant 69.

3.5 | OPPORTUNITIES FOR IMPROVEMENT

Respondents spontaneously mentioned several facilitators to good care. The most common facilitators included: involvement of a limited number of health care professionals per organization, clear agreements on the allocation of tasks and responsibilities, awareness of AS' situations, consultations at or close to the ASC, and having a positive attitude and interest in caring for this population. Specifically for AS, the availability of professional, on-demand telephone interpreter services was seen as a facilitator for optimal care delivery. As these services were not covered by government funds for RRP, the availability of informal interpreters and financial compensation by local governments were considered facilitators.

Respondents also spontaneously described initiatives that strengthen care. Some examples included strong community networks, local or church initiatives that offer social or material support, and having former clients donate baby products or act as "buddies" during consultations. When asked to score eight initiatives for AS, respondents considered ending relocation of pregnant women to be the best idea for improving care, followed by

matching pregnant AS to a buddy from a similar cultural background, prenatal care in a group setting and having a national shared electronic record for pregnant AS. For RRP, financial compensation for using interpreter services was considered extremely beneficial by almost 75% of respondents, followed by prenatal group care, a buddy project and having a specific protocol/guideline for RRP. For both groups, cultural training programs for midwives and more doula involvement were expected to be slightly less beneficial, but still moderately to extremely beneficial to care by most respondents (Figure 3).

4 | DISCUSSION

This study aimed to identify challenges that community care midwives experience when providing perinatal care for AS and RRP in the Netherlands. Midwives' perspectives on target areas for improvement of care for these specific migrant groups were also explored. While perceived as more intensive and demanding, midwives in this study still considered the overall quality of perinatal care for AS and RRP clients to be lower compared to the quality of care for Dutch women. Major challenges in providing adequate care included interdisciplinary collaboration, communication with clients, continuity of care, psychosocial care, and the vulnerable situation of AS and RPP.

To our knowledge, this study was the first in which midwives reported interdisciplinary collaboration as a major challenge in care for AS and RRP. A possible reason might be the lack of a national guideline with a focus on interdisciplinary collaboration for RPP. With respect to the guideline for AS, our study showed a low awareness rate of the guideline's contents among midwives and a low adherence grade to several recommended practices, such as yearly multidisciplinary team meetings and the exchange of information between disciplines. Based on these findings, efforts are needed to improve the implementation of the national guideline for AS among midwives and to develop a new guideline or local care pathways with a clear task allocation for RRP.

Apart from interdisciplinary collaboration, all other challenges resonate with previous findings on the experiences of midwives who provide care for women with a forced migration background.[4,6,12,13,19,25,34] With respect to communication difficulties, this study demonstrated a clear difference between AS, for whom the costs of interpreter services are covered by basic government health care insurance, and RRP, for whom interpreters are not covered. The resulting financial costs for midwives seemed to be the most important reason for the low rate of interpreter use in the RRP client group as compared to AS. Moreover, our findings indicate that midwives often work with women's personal contacts, Google Translate, or hand gestures for intercultural communication. Such alternatives to formal interpreters may come with serious ethical and medical risks, including risks to informed consent for obstetric procedures, the quality of counseling on birth choices and the wellbeing of underaged children when asked to interpret.[24,31] Generally studies have shown direct and indirect associations between communication difficulties, suboptimal care and adverse birth outcomes, including obstetric trauma and maternal death.[18,21,30,31] Our findings, therefore, add to a body of evidence that calls for increased efforts to ensure obstetric care providers are made aware of and facilitated to work with intercultural interpreters, in line with ethical and legal standards of care.

Furthermore, results indicate that caring for AS and RPP populations comes with an increased emotional and practical burden for midwives, which is in line with previous studies in the field.[4,7,24,25,34] This burden may partially

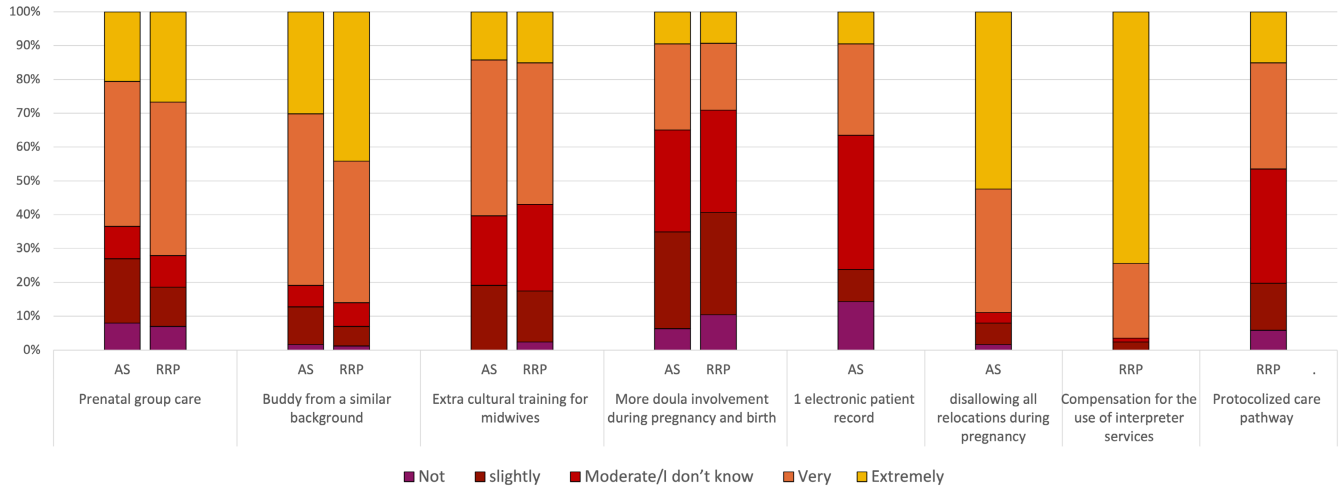

FIGURE 3 To what extent do you believe these initiatives could benefit care?

reflect the vulnerable situation of AS and RPP, which appears to push midwives beyond the boundaries of their role as strictly obstetric care providers, for example, when offering support for practical, financial, and transportation issues.[7] Midwives in this study also struggled with a lack of referral options to psychological care for AS and RPP, while perceiving a high need for such care and for psychosocial support programs. These needs are confirmed by the high rates of perinatal mental health disorders found in forcibly displaced populations in high-income settings (48.2% for PTSD, 41.8% for anxiety and 42.0% for depression[14]). Previous studies also highlighted the lack of adequate screening instruments to assess migrant women's psychosocial situations.[27,32]

Offering continuity of care was another major challenge for midwives in this study and appeared to be mostly hampered by relocations of AS. Midwives described how relocations could cause a setback in the relationship with clients as well as, a delay in care due to the need to transfer medical records while not always being informed of relocations in time. Almost all midwives in this study agreed that ending the relocation of pregnant AS would greatly benefit quality of care. Many studies have highlighted the importance of the patient-care provider relationship in migrant populations and therefore consider continuity of care to be of key importance.[7,23,25] Our study adds to a growing body of evidence on the negative effects of relocations on continuity of care and the wellbeing of clients.[7,11,13,34] There is an urgent need for policy revisions related to relocation of AS women during pregnancy and early motherhood.

Besides stronger interdisciplinary collaboration and policy revisions that would improve continuity of care and communication with clients, this study demonstrated that midwives see potential in a range of interventions aimed at perinatal care for AS/RPP. Most of these, such as antenatal group care, training in intercultural care provision for midwives, peer-support, and doula-support programs, have been or are currently being developed and evaluated and show promising results.[3,12,17,22] More evaluation and implementation research is needed to draw conclusions on these and other potential improvements in care, which should explicitly involve the perspective of pregnant and postpartum AS and RPP women, diverse care-providers, and policy makers.

As a next step, our research teams are further exploring challenges in perinatal care for AS and RRP by interviewing care providers and women with lived experience and reviewing perinatal death audit cases. In addition, a national registry study on pregnancy outcomes and risk factors such as relocation is being conducted within the EGALITE project, while research from the University Medical Center of Groningen focuses on antenatal group care, as well as psychosocial screening tools for pregnant AS and RRP populations.

4.1 | Strengths and limitations

Important strengths of this study include the large sample size and the combination of quantitative and qualitative aspects, since most studies that focus on challenges in perinatal care for AS and RRP are solely qualitative and have very small sample sizes. In addition, by defining two subpopulations of migrants, the design of this study responds to the need for recognizing the heterogeneity of migrants in perinatal health research. The survey was developed in collaboration with the target group but was not formally validated prior to its use in this study. The methods of sample recruitment and data collection could have led to some degree of inclusion bias as midwives who participated in the survey might have had an above-average motivation to provide optimal care for AS and RRP.

5 | CONCLUSION

The main challenges that community care midwives face while providing care for AS and RRP include interdisciplinary collaboration, communication with clients, continuity of care, psychosocial care, and the vulnerable situation of these populations. These findings suggest that there is considerable opportunity for improvement in perinatal care for AS and RRP; results also provide direction for future research and interventions. Several concerns raised, especially the availability of professional interpreters and relocation of AS during pregnancy, require urgent reconsideration at legislative, policy, and practice levels.

ACKNOWLEDGMENTS

The authors wish to thank N. de Gast (medical student) for her help in distributing the survey and F. Santegoets (database manager) for LimeSurvey technical support. Furthermore, J. Koomans, C. Wilhelm, M. Haverkate (midwives/nurses) and R. van der Kleij (implementation scientist) provided valuable feedback on survey drafts. For their contribution to the full language review of the paper we also wish to acknowledge F. Joziasse and E. Joziasse-Fitzpatrick.

FUNDING INFORMATION

This study was partially supported by the Netherlands Organization for Health Research and Development (ZonMw), grant number 543003112.

Data are available upon reasonable request through contacting the corresponding authors.

CONFLICT OF INTEREST STATEMENT

The authors declare no conflict of interest. The sponsors had no role in the design, execution, interpretation, or writing of the study.

DATA AVAILABILITY STATEMENT

The data that support the findings of this study are available from the corresponding author upon reasonable request.

ORCID

A.E.H. Verschuuren https://orcid.org/0000-0002-8954-4850
J.B. Tankink https://orcid.org/0009-0006-0994-2194
A. Franx https://orcid.org/0000-0001-8801-5546
J.J.H.M. Erwich https://orcid.org/0000-0003-1362-4501
E.I. Feijen-de Jong https://orcid.org/0000-0001-5766-296X
J.P. de Graaf https://orcid.org/0000-0003-2354-9744

REFERENCES

1. Alderliesten M, Vrijkotte TGM, van der Wal M, Bonsel GJ. Late start of antenatal care among ethnic minorities in a large cohort of pregnant women. *BJOG*. 2007;114(10):1232-1239.
2. Asif S, Baugh A, Jones NW. The obstetric care of asylum seekers and refugee women in the UK. *The Obstetrician & Gynaecologist*. 2015;17(4):223-231.
3. Balaam M-C, Kingdon C, Haith-Cooper M. A systematic review of perinatal social support interventions for asylum-seeking and refugee women residing in Europe. *J Immigr Minor Health*. 2021;24:1-18.
4. Bennett S, Scammell J. Midwives caring for asylum-seeking women: research findings. *Pract Midwife*. 2014;17(1):9-12.
5. Bo Brancheorganisatie Geboortezorg; Asylum Seeker Healthcare ('GZA'); Central Agency for the Reception of Asylum Seekers ('COA'); Royal Dutch Organisation of Midwives (KNOV); RMA Healthcare. Dutch Guideline Perinatal Care for Asylum Seekers ('Ketenrichtlijn Geboortezorg Asielzoeksters'). 2020 [cited March 13, 2022]; Available from: https://www.kennisnetgeboortezorg.nl/nieuws/actualisatie-ketenrichtlijn-geboortezorg-asielzoekers/.
6. Boerleider AW, Francke AL, Manniën J, Wiegers TA, Devillé WLJM. "A mixture of positive and negative feelings": a qualitative study of primary care midwives' experiences with non-western clients living in The Netherlands. *Int J Nurs Stud*. 2013;50(12):1658-1666.
7. Chitongo S, Pezaro S, Fyle J, Suthers F, Allan H. Midwives' insights in relation to the common barriers in providing effective perinatal care to women from ethnic minority groups with 'high risk'pregnancies: a qualitative study. *Women Birth*. 2022;35(2):152-159.
8. Choté AA, de Groot CJM, Bruijnzeels MA, et al. Ethnic differences in antenatal care use in a large multi-ethnic urban population in The Netherlands. *Midwifery*. 2011;27(1):36-41.
9. de Graaf JP, Steegers EA, Bonsel GJ. Inequalities in perinatal and maternal health. *Current Opinion in Obstetrics and Gynecology*. 2013;25(2):98-108.
10. Esscher A, Binder-Finnema P, Bødker B, Högberg U, Mulic-Lutvica A, Essén B. Suboptimal care and maternal mortality among foreign-born women in Sweden: maternal death audit with application of the 'migration three delays' model. *BMC Pregnancy Childbirth*. 2014;14(1):1-11.
11. Fair F, Raben L, Watson H, et al. Migrant women's experiences of pregnancy, childbirth and maternity care in European countries: a systematic review. *PloS One*. 2020;15(2):e0228378.
12. Fair F, Soltani H, Raben L, et al. Midwives' experiences of cultural competency training and providing perinatal care for migrant women a mixed methods study: operational refugee and migrant maternal approach (ORAMMA) project. *BMC Pregnancy Childbirth*. 2021;21(1):1-13.
13. Feldman R. When maternity doesn't matter: dispersing pregnant women seeking asylum. *Reprod Health Matters*. 2013;21(42):212-217.
14. Fellmeth G, Fazel M, Plugge E. Migration and perinatal mental health in women from low-and middle-income countries: a systematic review and meta-analysis. *BJOG*. 2017;124(5):742-752.
15. Gieles NC, Tankink JB, van Midde M, et al. Maternal and perinatal outcomes of asylum seekers and undocumented migrants in Europe: a systematic review. *Eur J Public Health*. 2019;29(4):714-723.
16. Heslehurst N, Brown H, Pemu A, Coleman H, Rankin J. Perinatal health outcomes and care among asylum seekers and refugees: a systematic review of systematic reviews. *BMC Med*. 2018;16(1):1-25.
17. Johnsen H, Ghavami Kivi N, Morrison CH, Juhl M, Christensen U, Villadsen SF. Addressing ethnic disparity in antenatal care: a qualitative evaluation of midwives' experiences with the MAMAACT intervention. *BMC Pregnancy Childbirth*. 2020;20(1):1-10.
18. Kallianidis, A, Schutte, J, Schuringa, L et al., *Confidential Enquiry into Maternal Deaths in The Netherlands, 2006–2018: a Retrospective Cohort Study*. 2021.
19. Kasper A, Mohwinkel LM, Nowak AC, Kolip P. Maternal health care for refugee women-a qualitative review. *Midwifery*. 2022;104:103157.
20. Kurth E, Jaeger FN, Zemp E, Tschudin S, Bischoff A. Reproductive health care for asylum-seeking women-a challenge for health professionals. *BMC Public Health*. 2010;10(1):1-11.
21. Martijn L, Jacobs A, Amelink-Verburg M, Wentzel R, Buitendijk S, Wensing M. Adverse outcomes in maternity care for women with a low risk profile in The Netherlands: a case series analysis. *BMC Pregnancy Childbirth*. 2013;13(1):1-6.
22. Mendel WE, Sperlich M, Finucane A. The doulas of the Priscilla project: understanding the experience of refugee women navigating the US maternity-care system. *Journal of Refugee Studies*. 2021;34(2):2275-2290.
23. O'Mahony JM, Donnelly TT. Health care providers'perspective of the gender influences on immigrant women's mental health care experiences. *Issues Ment Health Nurs*. 2007;28(10):1171-1188.
24. Origlia Ikhilor P, Hasenberg G, Kurth E, Asefaw F, Pehlke-Milde J, Cignacco E. Communication barriers in maternity care of allophone migrants: experiences of women, healthcare professionals, and intercultural interpreters. *J Adv Nurs*. 2019;75(10):2200-2210.

25. Oscarsson MG, Stevenson-Ågren J. Midwives experiences of caring for immigrant women at antenatal care. *Sex Reprod Healthc*. 2020;24:100505.
26. Perined. Kerncijfers Nederlandse Geboortezorg 2020. 2021 [cited May 5, 2022]; Available from: https://www.perined.nl/onderwerpen/publicaties-perined/kerncijfers-2020.
27. Playfair RL, Salami B, Hegadoren K. Detecting antepartum and postpartum depression and anxiety symptoms and disorders in immigrant women: a scoping review of the literature. *Int J Ment Health Nurs*. 2017;26(4):314-325.
28. Posthumus AG, Schölmerich VLN, Steegers EAP, Kawachi I, Denktaş S. The association of ethnic minority density with late entry into antenatal care in The Netherlands. *Plos One*. 2015;10(4):e0122720.
29. Saastad E, Vangen S, Frederik Frøen J. Suboptimal care in stillbirths–a retrospective audit study. *Acta Obstet Gynecol Scand*. 2007;86(4):444-450.
30. Schrot-Sanyan S, Kolanska K, Haimeur Y, et al. Language barrier as a risk factor for obstetric anal sphincter injury–a case-control study. *Journal of Gynecology Obstetrics and Human Reproduction*. 2021;50(8):102138.
31. Sentell T, Chang A, Ahn HJ, Miyamura J. Maternal language and adverse birth outcomes in a statewide analysis. *Women Health*. 2016;56(3):257-280.
32. Soldati E.V.A., Postma IR, Veling W, Stekelenburg J, Feijen-De Jong EI, Pregnant asylum seekers' perspective on mental health screening: a qualitative study. Manuscript submitted for publication, 2022.
33. Tankink JB, Verschuuren AEH, Postma IR, et al. Childbirths and the prevalence of potential risk factors for adverse perinatal outcomes among asylum seekers in The Netherlands: a five-year cross-sectional study. *Int J Environ Res Public Health*. 2021;18(24):12933.
34. Tobin CL, Murphy-Lawless J. Irish midwives' experiences of providing maternity care to non-Irish women seeking asylum. *Int J Womens Health*. 2014;6:159.
35. van den Akker T, van Roosmalen J. Maternal mortality and severe morbidity in a migration perspective. *Best Pract Res Clin Obstet Gynaecol*. 2016;32:26-38.
36. Verschuuren AEH, Postma IR, Riksen ZM et al. Pregnancy outcomes in asylum seekers in the north of The Netherlands: a retrospective documentary analysis. *BMC Pregnancy Childbirth*. 2020;20(1):1-10.

How to cite this article: Verschuuren A, Tankink J, Franx A, et al. Community midwives' perspectives on perinatal care for asylum seekers and refugees in the Netherlands: A survey study. *Birth*. 2023;00:1-12. doi:10.1111/birt.12727