Humanitarian Migrant Women's Experiences of Maternity Care in Nordic Countries: A Systematic Integrative Review of Qualitative Research

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Highlights

- Humanitarian migrancy increases the risk for suboptimal maternity care
- This article synthesises experiences of 198 participants in ten qualitative studies
- Humanitarian migrant women’s negotiation power on care is sometimes diminished
- Participants reported questioned or denied access to care in Nordic countries
- Sense of insecurity can hinder especially the care seeking behaviour
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Authors declare no conflict of interest.

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Abstract

BACKGROUND Maternal morbidity and sub-optimal maternity care are more common in humanitarian migrants in comparison to country-born population in the Nordic countries. Statistical reviews on the issue are plenty, whereas little synthesis on humanitarian migrants’ lived experiences exists.

AIM This systematic integrative literature review investigated humanitarian migrant women’s experiences on maternity care in Nordic countries, aiming to address possible hindrances for optimal care.

METHODS Electronic search in PubMed, CINAHL, SocIndex, Scopus, PsycINFO and Web of Science yielded 474 papers. PICoS inclusion and exclusion criteria were used. Critical appraisal was conducted utilising 32-item COREQ tool. The findings of the review articles were synthesised through thematic analysis.

FINDINGS Ten qualitative studies were included in the review. Altogether 198 women in Sweden, Norway and Finland had participated interviews or focus group discussions. Analysis of the women’s reported experiences of care emerged three themes: Diminished negotiation power on care, Sense of insecurity, and Experienced care-related discrimination.

KEY CONCLUSION Humanitarian migrant women’s maternal morbidity and sub-optimal care has multiple potential explanations, and their experiences of care reflect those earlier reported.

IMPLICATIONS FOR PRACTICE Recommendations for tackling the addressed hindrances are: 1) enabling humanitarian migrant women’s negotiation power by acknowledging their vulnerability but also competency, 2) increasing the sense of security, and 3) improving care providers’ cultural competence.

Key words
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Maternal Health
Maternity Care
Qualitative Methods
Systematic Review

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INTRODUCTION
Organising and developing humanitarian migrants’ sufficient maternity care requires continuous recognition of the potential obstacles and delays for care, both those monitorable in numbers, as well as the experienced ones. (Pangas et al. 2019) This paper reviews and synthesises experiences on maternity care in the Nordic countries from the viewpoint of humanitarian migrant women. Humanitarian migrant, in this paper, refers to women whose main reason for international migration is a “well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group, or political opinion” as defined in the Convention and Protocol Relating to the Status of Refugees 1951 and 1967 (UNHCR 2010, 3). Humanitarian migrants’ legal status in the country of current residence can be a documented asylum seeker, refugee, quota refugee, and also an undocumented migrant, “a paperless”, in cases in which the above-mentioned “fear of being persecuted” has been the main reason for the migration. Humanitarian migrancy as a term differs, therefore, substantially from e.g. economic or family reunification related migrancy, and needs to be considered as its own determinant for potential challenges in the maternity care process of internationally migrated people.

culture, religion, or residential status in a foreign country. This predicts that the health gaps determined by one’s ethnicity or residential status are issues of social justice, and thus, by a collective decision ought to be avoided. (Stronks et al. 2016) Here, the Nordic countries are at a risk of facing a paradox of an unmet ideal. The governments of these welfare states are providing affordable and good quality of maternal health care, but yet the evidence shows that optimal maternal health remains unreachable or insufficient for some groups of women.

In investigation of this kind of social disparity, especially in a marginalized or a specifically vulnerable group, essential knowledge can be captured by applying social justice lens in the research methodology. (Creswell 2015) Therefore, this systematic review acknowledges social justice as the moral foundation for public health (Krieger & Birn 1998; Powers & Faden 2008) and investigates the phenomenon through this lens. In other words, it recognises that in a just world, all women should have the same possibility for health in terms of pregnancy and child birth.

This state of justice is, according to a number of earlier meta-analyses and systematic reviews, yet to be reached. Risk for maternal morbidity and mortality is significantly higher in migrant population in comparison to the receiving country-born population in Western high-income settings (Malin & Gissler 2009; Wahlberg et al. 2013; Esscher et al. 2014). Statistically measurable factors report significant risks for maternal morbidity in humanitarian migrants, manifesting as a higher proportion iron deficiency anaemia (Gibson-Helm et al. 2015), gestational diabetes mellitus, overweight (Gibson-Helm et al. 2015; Bakken et al. 2015), tuberculosis, hepatitis B and C, syphilis, vitamin D deficiency (Gibson-Helm et al. 2014), and high blood pressure during pregnancy (Bakken et al. 2015).
In Sweden, immigrant women’s risk for severe maternal morbidity has been reported to be 2.5-folded in comparison to women born in Sweden (Wahlberg et al. 2013), and 1.8-folded in comparison to women born in Denmark (van den Akker & van Roosmalen 2016), both findings being statistically significant. A registry analysis by Malin and Gissler (2009) points out a two-fold risk for pre-term labour among Middle East-born women, and for caesarean section among African-born women in comparison to the Finnish-born women (Malin & Gissler 2009). Pre-term birth and caesarean section both are well-known health risks for both mother and the new-born. (Zhang et al. 2019)

Coexisting with above listed somatic morbidities, humanitarian migrant women also are at a higher risk of receiving suboptimal health care during pregnancy and giving birth in contexts statistically the safest for mothers. In antenatal care, international migration predicts statistically significant risk for delayed first contact to care (David et al. 2006; Gibson-Helm et al. 2015) less antenatal check-ups (David et al. 2006) and prenatal screenings (Malin & Gissler 2009). In perinatal care, immigrant women have less analgesia and assist in vaginal birth, and more caesarean sections and emergency caesarean sections. (David et al. 2006) After giving birth, immigrant women carry an increased risk for excessive bleeding (Reed et al. 2005) infections (Philibert et al. 2008), post-partum depression (Ganann et al. 2008), and avoidable maternal death. (Philibert et al. 2008; Esscher et al. 2014) Here, according to Esscher and colleagues (2014), in Sweden up to two out of three maternal deaths among immigrants can be linked to suboptimal care during pregnancy and child birth.

These numbers give us solid evidence that humanitarian migrant women’s poorer maternal health outcomes are an unarguable statistical fact. To the best of our knowledge, the lived experiences – the stories - of the women living this reality are, however, less systematically
researched in the Nordic countries. Therefore, this paper presents our systematic review of qualitative research on humanitarian migrant women’s lived experiences on maternity care in the Nordic countries. This aim is approached aiming to answer the following research questions:

1. What kinds of qualitative approaches have research studies used in exploring humanitarian migrant women’s experiences of maternity care?

2. What hindrances for optimal maternity care do these studies report as described in humanitarian migrant women’s lived experiences?
METHODS

Inclusion and exclusion criteria
Data extraction process began setting PICoS [Population, phenomenon of Interest, Context, and Study design] criteria in order to define key concepts for the study, and the inclusion and exclusion criteria for potential review articles (Stern et al. 2014). These criteria are presented in Table 1.

Considerations on defining the study population
In the data extraction process, we ran into articles where the study population’s refugee or asylum-seeking status had not been precisely stated, but participants were generally described as migrants or immigrants. In these situations, we consulted the official statistics of the context country in order to define, whether the participants could potentially be humanitarian migrants. (Utledningsdirektoratet 2018; Migrationsverket 2018) If the study context had received asylum seekers or refugees from a country of origin that was stated in the article prior or in the year of the data collection, and all the other inclusion criteria were fulfilled in the article, the participants of the study were inspected as potential humanitarian migrants and the article was included in the review.

Search strategy
Suitable electronic databases were identified in collaboration with university library’s information specialist. An electronic search was conducted in December 2018 by the first author in PubMed, CINAHL, Scopus, PsycINFO, and Web of Science databases. The search was re-conducted by university library’s information specialist. The search results were
compared and found aligned. Boolean phrase used in these searchers was is presented in Figure 1.

The search criteria were limited to include articles published in peer-reviewed journals in English language. The time of publishing was limited in articles published in 2013-2018 for the following two reasons:

1) According to electronic search in Joanna Briggs Database of Systematic Reviews and Implementation Reports, as well as in Cochrane library, the latest systematic reviews on immigrant and non-immigrant women’s experiences of maternity care have been conducted in 2014, that is, five years from current. These reviews by Small and colleagues (2014), and Benza and Liampitpong (2014) extracted their data from literature published in 1989–2012 and 2003-2013, respectively, leaving us with an assumption that literature up to 2013 would not provide any novel aspects to this review.

2) Syrian conflict, and thus overall instability in the Middle-East area escalated notably in 2012 - 2013, causing increased humanitarian migration from these areas to the Nordic countries, intensifying in 2015 to what we know as “European Refugee Crisis”. (European commission 2015) Therefore, we predict that as the general state of humanitarian migration to the Nordic countries has notably changed since the year 2013, its potential implications to maternity care need timely re-evaluation.
# Data extraction

The electronic search on the above listed conditions produced altogether 474 hits. The first author (A1) reviewed all of these hits by topic, excluded duplicates (n=38) and the papers obviously irrelevant to the research question according to the prior-set PICoS criteria (n=392). Thereafter, authors A1, A2, and A3 [anonymised for the blinded peer-review process] each co-reviewed all the remaining 44 abstracts, and chose 14 articles for full text inspection. Of these articles, five were excluded due to not-qualitative design, or the phenomenon of interest focusing not specifically in maternity care, but on other sexual and reproductive health issues in humanitarian migrant women. Reference lists of the earlier mentioned 14 articles were additionally hand searched by A1, and one more article meeting the inclusion criteria was found. Figure 2 illustrates the full data extraction and review process. The articles meeting the inclusion criteria and included in the review are marked with an asterisk (*) in the reference list.

# Critical appraisal

Three authors [A1, A2 and A3, anonymised for the blinded peer-review process] evaluated independently the potential review articles utilising the 32-item Consolidated Criteria for Reporting Qualitative research COREQ tool (Tong et al. 2007). The purpose of this tool is both reporting standards for qualitative papers, as well as for critical appraisal in a qualitative evidence synthesis (Majid & Vanstone 2018, 2120). Of the many potential critical appraisal tools, we chose to use COREQ (Tong et al. 20017) in this review because of its definite strength of being established on systematically synthesised findings of other critical appraisal tools, its especial focus in interview and focus group studies, and its wide recognition in international qualitative research journals (Majid & Vanstone 2018).
The COREQ form was used giving points in yes/no manner, describing whether the review paper authors had reported or not on the items listed in the COREQ tool. The results of this critical appraisal process were compared between the review authors and differences were discussed. With a mutual decision all ten articles passed the critical appraisal and were included in the review. (Noyes et al. 2018, 53)

Analysis

Inductive thematic analysis (Green & Thorogood 2014) was utilised to synthesise the findings of the reviewed studies. The review articles were read thoroughly by authors A1, A2, and A3. A1 identified emerging codes relevant to the review question, that is, women’s self-reported hindrances for maternity care at any of its phases, condensed them into codes, and grouped in data-derived sub-themes, which were reviewed, discussed and commented by authors A2, A3 and A4. Finally, the sub-themes formed the three major themes presented in the Findings section. Table 2 provides an example of this process.
FINDINGS

Ten studies met the inclusion criteria, passed the critical appraisal, and were included in the review. Table 3 attached presents the author(s) and year, topics, setting, participants, methods, key findings, and the COREQ (Tong et al. 2007) scores of the included articles.

Population

Sample size in the reviewed studies varied from nine to 70, mean participant number being 19.8 and both median and mode being 17 women. Altogether the reviewed studies had explored 198 refugee or asylum seeker women’s experiences of maternity care in different stages of the care process.

The studies that stated their participants’ precise ethnicity or country of birth reported them originating from 29 different countries. Of these countries, the largest representation was in Somalia (Garnweidner et al. 2013; Degni et al. 2014; Lillrank 2015; Byrskog et al. 2016; Carlsson et al. 2016; Glavin & Saeteren 2016; Barkensjö et al. 2018; Hjelm et al. 2018), Afghanistan (Garnweidner et al. 2013; Lillrank 2015; Barkensjö et al. 2018), and Morocco (Robertson 2015; Barkensjö et al. 2018; Hjelm et al. 2018). The distribution of all of the study participants’ reported countries of origin shared as to follow in Table 4.

One of the studies mentioned not the countries where their participants originated, but stated the areas of emigration as “South-America, Europe, the Middle East, Asia, and Africa”. (Viken et al. 2015) However, the article elaborated further that Somali, Amharic, and Kurdi interpreters were used when communicating with some of the participants, giving a lead of the interviewees’ potential areas of origin. (Viken et al. 2015)
Context

Five studies were conducted in Sweden (Robertson 2015; Byrskog et al. 2016; Carlsson et al. 2016; Barkensjö et al. 2018; Hjelm et al. 2018), three in Norway (Garnweidner et al. 2013; Viken et al. 2015; Glavin & Saeteren 2016), and two in Finland (Degni et al. 2014; Lillrank 2015). Other Nordic countries were not represented in the articles that met all of the inclusion criteria.

Phenomenon of Interest

Six of the reviewed studies had their focus in humanitarian migrant women’s general experiences on maternal health and maternity care in their new home country (Lillrank 2015; Robertson 2015; Degni et al. 2014; Glavin & Saeteren 2016; Barkensjö et al. 2018). Four, on the other hand, had narrowed the study’s focus on a specific theme within the phenomenon of maternity care: Byrskog and colleagues (2016) in disclosure of intimate partner violence at ANC; Carlsson and colleagues (2016) in experiences of prenatal diagnosis of congenital heart condition; Garnweidner and colleagues (2013) in nutrition-related information in maternity care; and Hjelm and colleagues (2018) in development of beliefs on health, illness, and health care in mothers with gestational diabetes.

Study Designs

All included articles had employed a qualitative design. Variety of explorative qualitative design (Lillrank 2015; Degni et al. 2014; Robertson 2015; Byrskog et al. 2016; Carlsson et al. 2016; Glavin & Saeteren 2016; Barkensjö et al. 2018; Hjelm et al. 2018), hermeneutics (Viken et al. 2015), and phenomenology (Garnweidner et al. 2013) approaches were reported. Data were collected in individual interviews in seven of the studies. (Garnweidner et al. 2013; Lillrank 2015; Viken et al. 2015; Byrskog et al. 2016; Glavin & Saeteren 2016; Barkensjö et
al. 2018; Hjelm et al. 2018) One study had collected data only in focus group discussions (Degni et al. 2014), one had employed both individual and couple interviews (Carlsson et al. 2016), and one triangulated individual and couple interviews, and FGDs (Robertson 2015). In all studies interviews were audio-recorded and analysed as per the study’s specific design and phenomenon of interest required. Reported data analysis methods were qualitative content analysis in six (Robertson 2015; Viken et al. 2015; Carlsson et al. 2016; Glavin & Saeteren 2016; Barkensjö et al. 2018; Hjelm et al. 2018) thematic analysis in three (Degni et al. 2014; Lillrank 2015; Byrskog et al. 2016), and interpretative phenomenological analysis (Garnweidner et al. 2013) in one of the studies.

Synthesized findings

Thematic data analysis of the review data produced altogether 71 individual codes. The codes formed eight sub-themes and three major themes: Diminished negotiation power on care, Sense of insecurity, and Experienced care-related discrimination. These themes elucidate the similarities in the experienced hindrances that humanitarian migrant women reported in the reviewed articles when seeking, accessing, and attending maternity care in Nordic countries. Table 5 compiles the sub-themes and themes of the data analysis, whereas the following sub-headings explain the content of each theme in a more precise manner.

Diminished Negotiation Power on Care

The first theme emerged from the data analysis was named as diminished negotiation power on care. Three factors for this diminishment were found: humanitarian migrant women’s pre-existing gaps in health literacy; late, lacking and incongruent provision of health information in the current country of residence, and diminishment or unrecognition of care needs by care professionals.
Pre-existing gaps in health and health care literacy

Viken and colleagues (2015) stated that certain aspects of health knowledge were less familiar to humanitarian migrant mothers. This kind of limitation in health literacy in versatile forms was reported as a potential hindrance for optimal maternal health in altogether five of the reviewed studies. (Garnweidner et al. 2013; Viken et al. 2015; Byrskog et al. 2016; Carlsson et al. 2016; Glavin & Saeteren 2016) Carlsson and colleagues’ (2016) study participants had described a difficulty to understand very specific medical terminology in relation to pre-natal diagnostics in antenatal care. Byrskog and colleagues (2016), on the other hand, had more vague findings handling limited health knowledge. Their study investigated refugee women’s wellbeing and questions about violence in antenatal care encounters, and reported that their Somali participants had some unfamiliarity with psychological symptoms. Furthermore, their participants did not always associate questions about violence as a part of antenatal care, and consequently did not necessarily recognise all components of Nordic antenatal care as antenatal care. (Byrskog et al. 2016) Glavin and Saeteren (2016), again, found that their participants sometimes declined invitations to participate antenatal care group sessions because they perceive not knowing how to behave in these groups.

Controversially, both lack of knowledge, as well as increase in knowledge seemed to cause some fright in the humanitarian migrant women. Participants in Lillrank’s (2015) study reported that lacking knowledge escalated sometimes into great fear of childbirth, whereas Barkensjö and colleagues (2018) reported that increase in knowledge about pregnancy-related dangers induced ambiguity, guild, and even acute panic in their participants.
Late, lacking, and incongruent provision of health information

Where antenatal care had aimed to increase participants’ knowledge, its timing, content, and congruency in relation to participants’ lived reality sometimes did not succeed as had been aimed. Received information about childbirth, postpartum period, (Glavin & Saeteren 2016) and on participant’s experienced near-miss (Lillrank 2015) was reported insufficient by the study participants.

Garnweidner and colleagues’ study (2013) explored migrants’ experiences on nutrition-related information in antenatal care, and found that provision of information was unsystematic, and necessary topics of information had not always been initiated in the ANC. Some participants found problematic that information had been offered only on request, only in writing, or too late in regards to the gestation weeks. (Garnweidner et al. 2013) Large amount of information at a time had been difficult to remember for some participants. Additionally, information sometimes was incongruent with participants’ cultural beliefs and habits. As an example, multi-ethnic migrant participants had been advised to follow “a so-called normal diet” (43, p. 133) with little elaboration on the content of “normal”.

(Garnweidner et al. 2013) Glavin and Saeteren’s (2016) article mentions similar type of incongruency in nutrition-related advisement of Somali mothers. Care professionals’ lacking recognition of culture-specific issues among maternity care professionals was also reported among the participants in Degni and colleagues’ study. (Garnweidner et al. 2013)

Diminished or unrecognised care needs by care professionals

Three of the reviewed papers reported participants’ experiences on health professionals diminishing their ability to estimate the seriousness of the situation and perceived care need. (Lillrank 2015; Robertson 2015; Barkensjö et al. 2018) Multiple narratives in these papers
described how health professionals had persuaded the mother to leave the already reached care facility. (Lillrank 2015; Robertson 2015) This had, in a couple of case reports, resulted the mother being transferred to emergency obstetric care later on due to premature childbirth, or due to heavy bleeding after a miscarriage. (Lillrank 2015; Robertson 2015) Also, one premature infant death was reported in relation to these case descriptions. (Robertson 2015)

Mutual for all these cases was that the mother had already decided to seek care, reached a health facility “begging for better attention and care” (Robertson 2015, 63) and still, found herself in a situation where she either had been persuaded or demanded to leave the health facility before receiving sufficient care. Care professionals’ unrerecognition and underestimation of mothers’ perceived care needs were raised in detail in narratives of Lillrank’s (2015) study participants, leaving participants feel themselves unheard, or endangered. Robertson’s (2015) study results reflect similar discourse, her participants reporting “being treated as an incompetent person” (Robertson 2015, 62), and conveying mothers’ wishes “to be taken seriously” among the maternity care professionals.

Sense of Insecurity

Theme named sense of insecurity describes the reasons that had hindered especially the care-seeking behaviour among the participants in the reviewed studies. This theme builds of humanitarian migrant women’s limited ability to convey their needs, fear of negative consequences if seeking care, and general suspicion and mistrust towards authorities – a stakeholder group to which maternity care professionals were also counted in participants’ narratives.
Limited ability to convey one’s needs

Language barrier was a significant barrier for seeking and receiving adequate maternity care. This was reported in five out of the ten reviewed studies. (Lillrank 2015; Robertson 2015; Degni et al. 2014; Glavin & Saeteren 2016; Barkensjö et al. 2018) Not only language issues counted in this limited ability to convey one’s needs. Scare time resources in the antenatal care hindered women to “tell how you feel”, as Hjelm and colleagues (2018, 7) reported in their study. Robertson (2015) reported that not only the language, but also the technological form of using it can set obstacles for those not mastering a mutual language with the maternity care. Participants in her study reported telephone booking system as a huge problem for care-seeking, and stated being insecure in usage of this contact method. This insecurity, again, made participants’ communication abilities more dependent on third parties, such as family members in care-seeking decision and forms. (Robertson 2015)

Fear of negative consequences if seeking care

Three of the reviewed studies reported different fears that humanitarian migrant face when seeking maternity care. Byrskog and colleagues (2016) reported fear of “community talk” hindering women from disclosing about intimate partner violence in antenatal care when asked about it. Barkensjö and colleagues (2018) had found that humanitarian migrant women sometimes feared of mistreatment, being reported about, and deceived if seeking maternity care. Also, in this context Barkensjö and colleagues (2018) bring up humanitarian migrant mothers’ perceived lack of control over their situation in the new country. Women participating Glavin & Saeteren’s (2016) study described fears of dying if going under caesarean section.
Suspicion and mistrust to authorities

Women reported fear of being misinterpreted in maternity care by incorrect language translation (Barkensjö et al. 2018), illustrating both above-described language barrier, but also mistrust towards interpreters. Three studies reported about women’s mistrust towards authorities, including maternity care professionals and interpreters in maternity care (Robertson 2015; Byrskog et al. 2016; Barkensjö et al. 2018). Maternity care professionals’ true intentions (Barkensjö et al. 2018), as well as usefulness of the provided care had been questioned (Byrskog et al. 2016) among the participants.

Experienced Care-Related Discrimination

The last presented theme illustrates the discrimination that participating women reported having experienced in their maternity care process. This discrimination formed of complicated, questioned or denied access to care, and care professionals’ negative attitudes and behaviour towards humanitarian migrant women.

Complicated, questioned or denied access to care by care professionals’ actions

Humanitarian migrant women’s access to care was seen as complicated, questioned or even declined by care professionals’ actions. (Lillrank 2015; Robertson 2015; Barkensjö et al. 2018) Lillrank (2015) presented a case report where a seriously ill mother’s help-seeking was repeatedly questioned in the maternity hospital. Both Robertson (2015) and Barkensjö and colleagues (2018) also bring up similar issues. Their participants have reported feeling the need to argue on their right to care (Barkensjö et al. 2018), experiencing worry over being rejected to enter the care facility, or professionals refusing from caring the mother in it (Robertson 2015).
Care professionals’ negative attitudes and behaviour

Unfriendly communication, lack of interest, intolerance and inflexibility (Barkensjö et al. 2018), lack of respect, distant and absent behaviour, treating one with indifference (Viken et al. 2015) indicated care professionals’ negative attitudes and behaviour. Glavin and Saeteren (2016), as well as Degni and colleagues (2014) reported humanitarian migrant women having experienced negative or unfriendly attitudes from maternity care professionals. Robertson (2015) raised an issue of more ambivalent experienced prejudices and ignorance in health encounters, whereas one of Lillrank’s (2015) study participant reports how she perceived her “immigrant name” leading to negatively indifference treatment.
DISCUSSION

This article analysed hindrances that humanitarian migrant women have experienced in maternity care in the Nordic countries as reported in earlier peer-reviewed qualitative research studies. The scope of the review targeted on the reported negative experiences due to social justice lens (Creswell 2015), guiding to address experienced issues of social justice in humanitarian migrants’ maternity care. This scope was not selected in means of seeking reasons to prosecute or reproach the professionals working in the maternity care. Instead, it was chosen as an instrument to explore and communicate disparities in the voices of people whose narratives, to the best of our knowledge, are not systematically synthesised in the Nordic context after the European Refugee Crisis 2015 (European Commission 2015).

Several reasons guided to investigate disparities in maternity care of humanitarian migrants from the very aspect of this specific service user group. Global health researchers collectively address in the paper by Abbas and colleagues (2018) that the healthy migrant effect – a prediction that recently-migrated individuals are less prone to sustain poor health (Fennelly 2007) – might not apply in the current global migrant crisis. Therefore, public health research recognises humanitarian migrants as a unique sub-group of immigrants, with some very unique health determinants and needs. (Abbas et al. 2018) Also, this service user group has been earlier reported to “consider it important to accept what was offered” (Viken et al. 2015, 7), and to see a maternity care service as an asset rather than as a right, and compare it to their less resourceful country of fleeing. (Viken et al. 2015) Such gratitude and resilience, as positive matters as they are, sometimes can colour the early settling-phase of the migration process and lead to overlooking or under-reporting potential issues in the care at the first place. (Haavikko & Bremer 2009) Here, especially those humanitarian migrants still waiting
for their residence permit might feel pressure to convey only good things about their care experience, especially if asked by a person who can be interpreted as a representative of the care system. (Haavikko & Bremer 2009) The forced cause of migration holds potential to put humanitarian migrants in a position where our earlier knowledge about migrants in general might not apply. (Abbas et al. 2018)

The evidence from earlier statistical research confirms that humanitarian migrant women’s maternal health is suboptimal in multiple settings and forms. This health disparity encouraged us to investigate the reasons that possibly could hinder women from reaching optimal maternal health and maternity care as they have perceived the issue themselves. The findings in this review succeeded to provide some possible explanations for the above-asked question. Nevertheless, care-related hindrances’ explanatory potential for the statistically addressed adverse maternal health outcomes is more complicated due to a number of reasons discussed below.

It is rather difficult to present absolute comparisons between immigrant and country-born women. Suboptimal maternal health, as well as experiences of care, can result from quite a complex web of interlinked causes. Women who have migrated from low-income countries to Nordic countries have statistically higher parity (Malin & Gissler 2009); Wahlberg et al. 2013) and less education (Wahlberg et al. 2013). Furthermore, women from typical humanitarian source countries sustain more often over-generational malnutrition-caused stunting (Wells 2017), have greater genetic risk for many severe diseases such as thalassemia and sickle cell anaemia (Hemminki et al. 2015), and a higher probability for earlier tropical and communicable diseases with potentially life-long health implications. (Eiset & Weise 2017) Combined with language barrier and possible traumatisation experiences (Munz &
Melcop 2018), similar background characteristics are nearly non-existent in the country-born control groups in Nordic contexts. Thus, despite many excellent quality statistical studies published this far, absolute comparison of these groups is non-viable by any imaginable methodology in the current time.

This impossibility of rigorous comparison does not, however, diminish the suffer-causing and resource-dense situation of migrant women sustaining greater proportion of preventable adverse health outcomes – and also, as reported in each of the reviewed articles – experiencing suboptimal care, which in some of its dimensions can be claimed even to be systematic. Here, it is the responsibility of health sector to focus on tackling those hindrances that directly can be linked to care professionals: the knowledge, attitudes, and behaviour towards the humanitarian migrants seeking care during pregnancy and birthing.

Of the reported hindrances, many demonstrate a lack in transcultural competence in nursing. (Papadopoulos et al. 2004) Highlighted disinterest towards understanding different cultures, insufficient knowledge of specific cultural characteristics, and lacking sensitivity to face clients in a distinctively vulnerable position - these characteristics appeared repeatedly in the review articles. Study participants had felt themselves unheard (Robertson 2015), insulted (Degni et al. 2014) or received information controversial to their cultural knowledge-base. (Garnweidner et al. 2013; Glavin & Saeteren 2016) To awake one’s urge to develop in this field, health care working units can provide support in cultural awareness raising, knowledge gaining, and sensitivity development – and as a result, enhance care personnel’s cultural competence. As an example, Papadopoulos, Tilki and Lees (2004) article provides practical tools and guidance to implement this process in health care working places.
Strengths and limitations

This systematic review followed the PRISMA 2009 checklist (Moher et al. 2009) in its planning, conducting, and reporting phases. Review protocol was reviewed and accepted by all authors prior the data extraction. Data inclusion and exclusion criteria were prior-set strictly according to PICoS criteria (Stern et al. 2014), and the data extraction process was designed and conducted in consultation and guidance of a professional information specialist. Three individual authors read and chose the review articles, and also critical appraisal was conducted by three authors independently. Despite these careful considerations, the paper still has some limitations.

Considering the basic principles of qualitative research, the description of methodological reflexivity and researcher’s role in the data collection and analysis is essential. (Green & Thorogood 2014) Six of the reviewed papers did present a description on reflexivity, for example reporting on the established relationship with the participants, whereas four of the reviewed papers did not provide this information. Also, only one of the papers articulated having reached a data saturation. Consequently, the obscurity of the data saturation in the majority of the reviewed papers is a definite limitation to both the articles not reporting on it, as well as for this paper reviewing them. (Green & Thorogood 2014)

Our aim was to report experienced hindrances in humanitarian migrants’ maternity care in the Nordic countries. However, Denmark and Iceland lacked relevant literature, and thus only studies from three out of five countries were represented. Also, within these countries the areal distribution was heavily stressed in Swedish metropolitan areas. Degni and colleagues’ (2014) big number of participants could compensate this issue a little, but only by population
size. Furthermore, considering the relatively small number of review articles, publication bias that we failed to identify, may exist.

**Conclusion and recommendations**

All Nordic countries have legislation which provides immediate and urgent care for undocumented migrants. (Gissler et al. 2017) The analysis of this systematic review concludes that humanitarian migrant women face obstacles in maternity care due to diminished negotiation power, sense of insecurity, and experienced care-related discrimination. To prevent such experiences, and consequently, to be able to follow the national legislation and Nordic care professionals’ ethical guidelines in the maternity care of humanitarian migrants, this paper makes three recommendations for action in the health sector basing on the review findings:

1. **Enable negotiation power by:**
   - Providing sufficient, timely, and understandable information;
   - Acknowledging humanitarian migrant women’s vulnerable position but facing the person as a competent adult, and
   - Ensuring woman’s ability to convey needs at all stages of care process though a professional and trustworthy interpreter in case of language barrier

2. **Increase the sense of security by:**
   - Recognising care professional’s ethical responsibility to provide safe, good-quality, and trustful care-relationship

3. **Prevent care-related discrimination by:**
   - Improving care providers’ cultural competence, and
   - Educating stakeholders on humanitarian migrant’s legal position in maternity care
Table 6 presents these recommendations with a concise assessment of Confidence in the Evidence from Reviews of Qualitative research (CERQual) in terms of methodological limitations, relevance, and coherence (Lewins et al. 2015).
REFERENCES


*Glavin K, Saeteren B. 2016. Cultural Diversity in Perinatal Care: Somali New Mothers’ Experiences with Health Care in Norway. Health Science Journal Vol.10 No.4:17


Figure 1. Search terms

(immigra* OR migra* OR humanitarian OR refugee OR asylum) AND (“maternal health” OR pregnan* OR gestation OR childbirth OR “child birth”) AND (Sweden OR Norway OR Finland OR Denmark OR Iceland OR Nordic OR Swedish OR Finnish OR Danish OR Norwegian OR Scandinav*)
Figure 2. Data extraction and review process
<table>
<thead>
<tr>
<th>Key concept</th>
<th>Keywords for electronic search</th>
</tr>
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<tbody>
<tr>
<td><strong>Population</strong></td>
<td>Humanitarian migrant women</td>
</tr>
<tr>
<td><strong>Phenomenon of Interest</strong></td>
<td>Pregnancy and/or giving birth during asylum seeking process</td>
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<tr>
<td><strong>Context</strong></td>
<td>Nordic countries</td>
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<td><strong>Study design</strong></td>
<td>Qualitative interview studies</td>
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<td></td>
<td><em>(evaluated further in the review process)</em></td>
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</table>
Table 2. Examples of data analysis process

<table>
<thead>
<tr>
<th>Emerging code in the original text</th>
<th>Code</th>
<th>Sub-theme</th>
<th>Theme</th>
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</thead>
<tbody>
<tr>
<td>Both women experienced that their particular needs of care were unrecognised by the health care provider. (Lillrank 2015)</td>
<td>Experience of unrecognition of the needs</td>
<td>Diminished or unrecognised care needs by care professionals</td>
<td>Diminished negotiation power on care</td>
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<td>Medical personnel once persuaded her to go home and she suffered a miscarriage with heavy bleeding in her bathroom, resulting in ambulance transport and a long hospital stay. (Robertson 2015)</td>
<td>Professionals diminished woman’s perceived need for care</td>
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<td>They stated that being treated like they were children or legally incompetent made them feel stupid and doubt their capabilities. (Robertson 2015)</td>
<td>Experience of being treated as incompetent persons</td>
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<td>Observing health care professionals’ behaviour closely to assess intentions (Barkensjö et al. 2018)</td>
<td>Suspicion on professionals’ true intentions</td>
<td>Suspicion and mistrust to authorities</td>
<td>Sense of insecurity</td>
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<tr>
<td>Usefulness of dealing with traumatic memories was questioned (Byrskog et al. 2016)</td>
<td>Questioning usefulness of the provided care</td>
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<td>Some women mentioned that coming from war-torn countries and being persecuted, interrogated, or tortured made them suspicious of everyone. (Robertson 2015)</td>
<td>Suspicion of professionals</td>
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<tr>
<td>Author(s) and year</td>
<td>Topic</td>
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<tr>
<td>Barkensjö, M., Greenbrook, J. T. V., Rosenlundh, J., Ascher, H., &amp; Elden, H. (2018)</td>
<td>The need for trust and safety inducing encounters: a qualitative exploration of women’s experiences of seeking perinatal care when living as undocumented migrants in Sweden.</td>
<td>Sweden</td>
<td>n =13 undocumented migrant women - eight rejected asylum seekers - three unregistered immigrants - two whose visa was expired Women from Macedonia, Romania, Bosnia, Albania, Somalia, Afghanistan, Serbia, Chechnya, Morocco, and Kosovo</td>
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<tr>
<td>Authors</td>
<td>Title</td>
<td>Country</td>
<td>Sample Size</td>
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<td>Carlsson, T., Marttala, U. M., Mattsson, E., &amp; Ringnér, A. (2016)</td>
<td>Experiences and preferences of care among Swedish immigrants following a prenatal diagnosis of congenital heart defect in the fetus: a qualitative interview study</td>
<td>Sweden</td>
<td>n = 9 (four mother-father dyads and one single mother)</td>
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<tr>
<td>Degni, F., Suominen, S. B., El Ansari, W., Vehviläinen-Julkunen, K., &amp; Essen, B. (2014)</td>
<td>Reproductive and maternity health care services in Finland: perceptions and experiences of Somali-born immigrant women</td>
<td>Finland</td>
<td>n = 70 Somali women living in Finland</td>
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<tr>
<td>Study</td>
<td>Participants</td>
<td>Methods</td>
<td>Findings</td>
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</table>
| Garnweidner, L. M., Sverre Pettersen, K., & Mosdol, A. (2013) | 17 women, of whom 12 originally from Algeria, Afghanistan, Pakistan, Thailand, Turkey, Russia, Sri Lanka, and Somalia | Individual interviews, Interpretative phenomenological analysis | High quality maternal care and clinics that are available to all  
Dissatisfaction to:  
Lack of knowledge of Somali culture and religion, e.g. vaginal vs. caesarean delivery, genital circumcision, attitudes towards contraception  
Communication  
Language challenges, lack of knowledge of Finnish among Somali  
Cultural challenges unfriendly attitudes of some doctors, nurses and midwives  
Nutrition-related information received during ANC was generally sparse and focused on food safety  
Midwife-given information was incongruent with immigrant participants’ original food culture.  
Nutrition-related communication in ANC should be more tailored towards women’s dietary habits, cultural background, and nutritional knowledge and nutrition literacy |

| Glavin, K. & Saeteren, B. (2016) | 10 Somali women  
| Cultural Diversity in Perinatal Care: Somali New | Semi-structured individual interviews | Inadequate integration to Norwegian society  
limited women’s full beneficence of maternity care | 18 |
Mothers' Experiences with Health Care in Norway

Caesarean sections were both excessively needed for and feared among the participants.

Women seemed unprepared for birth and perceived receiving very little support, but also some good experiences were reported.

All had a positive experience with the post-partum visits of PHNs, which increased their confidence and confirmed that what they were doing was good.

| Hjelm, K., Bard, K., & Apelqvist, J. (2018) | A qualitative study of developing beliefs about health, illness and healthcare in migrant African women with gestational diabetes living in Sweden | Sweden | n = 9 refugee women from Algeria, Ethiopia, Morocco, Gambia, and Somalia | Qualitative content analysis | Access to care was perceived unproblematic in each stage of the care process.

Communication with health care professionals was described unproblematic, but time was perceived to be too limited.

Ideal nurse or doctor was described as having positive attitude by being calm and good listener, giving proper information and having knowledge, and providing help and support. |

| Lillrank, A. (2015). | Trust, Vacillation and Neglect. Refugee women's experiences regarding | Finland | n = 11 refugee women from Somalia, Chechnya, Iran, and Afghanistan | Individual semi-structured thematic interviews | All women valued reciprocal relationship with care providers.

Social recognition as an equal partner helped |
| Study | Maternal health coping strategies of migrant women in Norway | Norway | n = 17 women from South-America, Europe, the Middle East, Asia, and Africa | Qualitative explorative, descriptive design with hermeneutic approach | Information and support received helped women to cope with pregnancy and childbirth. | Migrant women were concerned with keeping their own traditions in pregnancy and childbirth while at same time showing willingness to integrate in Norwegian society. |
|---|---|---|---|---|---|
| Viken, B., Lyberg, A., & Severinsson, E. (2015). | ‘To be taken seriously’: women’s reflections on how migration and resettlement experiences | Sweden | n = 25 women from Bosnia, Chile, El Salvador, Ethiopia, Eritrea, Iran, Iraq, Kosovo, Lebanon, Morocco, Slovenia, Spain, Syria, Turkey, | Three focus group discussions, two pair interviews and ten individual interviews | The hardships of migration, resettlement, and constraints in the daily life made the women feel overstrained, tense, and disembodied. | Being treated as a stranger and ignored or rejected in healthcare encounters was |
influence their healthcare needs during childbearing in Sweden. Uzbekistan, and former Yugoslavia. Thirteen were refugees, nine migrated due to family reunification, and three from labour causes. The women stressed that they felt stronger and had fewer complications during pregnancy and labor when they were “taken seriously” and felt that they had a confident, caring relationship with caregivers/midwives. This, therefore, enabled the women to boost their sense of self, and to recognize their capabilities, as well as their “embodied knowledge”. Caregivers should be aware of the hardships the women face.

* relevant to the research question of this review
Table 4. The countries of origin for participants in the reviewed studies

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*Note: The table contains placeholder values.*
Table 5. Sub-themes and themes

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<thead>
<tr>
<th>Sub-themes</th>
<th>Theme</th>
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<tbody>
<tr>
<td>Pre-existing gaps in health and health care literacy</td>
<td>Diminished negotiation power on care</td>
</tr>
<tr>
<td>Late, lacking and incongruent provision of health information</td>
<td>Diminished or unrecognised care needs by care professionals</td>
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<td>Diminished or unrecognised care needs by care professionals</td>
<td>Limited ability to convey one’s needs</td>
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<td>Limited ability to convey one’s needs</td>
<td>Fear of negative consequences if seeking care</td>
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<td>Fear of negative consequences if seeking care</td>
<td>Sense of insecurity</td>
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<td>Suspicion and mistrust to authorities</td>
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<td>Complicated, questioned or denied access to care by care professionals’ actions</td>
<td>Experienced care-related discrimination</td>
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<tr>
<td>Care professionals’ negative attitudes and behaviour towards</td>
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Table 6. Recommendations

<table>
<thead>
<tr>
<th>Recommendation on the base of the review findings</th>
<th>Studies contributing to the review finding</th>
<th>Assessment of Confidence in the Evidence</th>
<th>Coherence</th>
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<tbody>
<tr>
<td><strong>Enable negotiation power by:</strong></td>
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<tr>
<td>• Providing sufficient, timely, and understandable information</td>
<td>Barkensjo et al. 2018, Degni et al. 2014, Lillrank 2015, Robertson 2015, Byrskog et al. 2016, Glavin &amp; Saeteren 2016</td>
<td>Relevance of these reviewed papers was strictly assessed by specific inclusion criteria by study population, phenomenon of interest, context, and study design. (Stern et al. 2014)</td>
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<tr>
<td>• Acknowledging humanitarian migrant women’s vulnerable position but facing the person as a competent adult</td>
<td></td>
<td>Methodological quality of all of the reviewed studies was evaluated with a standard (Hannes et al. 2015) critical appraisal tool COREQ-32 (Tong et al. 2007)</td>
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<tr>
<td>• Ensuring woman’s ability to convey needs at all stages of care process though a professional and trustworthy interpreter in case of language barrier</td>
<td></td>
<td>All reviewed studies passed the critical appraisal. Collective limitations were found in the reporting of reflexivity and data saturation, which limits the rigour of the synthesised findings.</td>
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<tr>
<td><strong>Increase the sense of security by:</strong></td>
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<td><strong>Prevent care-related discrimination by:</strong></td>
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<tr>
<td>• Improving care providers’ cultural competence</td>
<td>Degni et al. 2014, Lillrank 2015, Robertson 2015, Barkensjo et al. 2018</td>
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<td>• Educating stakeholders on humanitarian migrant’s legal position in maternity care</td>
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