Research Article

Access to Health Care for Pregnant Arabic-Speaking Refugee Women and Mothers in Germany

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Abstract

Refugee women often encounter multiple barriers when accessing ante-, peri-, and postnatal care. The aim of this study was to investigate how premigration experiences, conceptions about pregnancy and childbirth, health literacy, and language skills influence access to health care, experiences of health care, and childbirth. A total of 12 semi-structured interviews with refugee women from Iraq, Syria, and Palestine were conducted in the city of Dresden. Content analysis was applied using Levesque's access model as a framework. Results indicate that conceptions of pregnancy and childbirth and premigration experiences influence women's behaviors and experiences of pregnancy and childbirth. They contribute to barriers in accessing health care and lead to negative health outcomes. In view of limited health literacy, poor language skills, lack of information, and missing translators, female relatives in countries of origin remain an important source of information. Improved access to services for refugee women is needed.

Keywords

access to health care; pregnancy; childbirth; refugees; qualitative; Germany; phenomenology

Introduction

Pregnant women need reliable access to health care to maintain their health and the health of their babies during pregnancy, childbirth, and puerperium. Refugee women, however, are frequently confronted with problems and barriers during this time. Not only do they experience restricted care provision during their flight, but when they arrive in Western host countries, they are confronted with seemingly impenetrable and highly complex health systems. Their own conceptions about obstetric care may conflict with biomedical paradigms, and in addition, limited command of the language of the host country may impede successful communication with health-care providers (Khanlou, Hague & Skinner, Mantini, & Kurz, 2017).

Previous research has highlighted the connection between these multiple barriers and negative reproductive health outcomes. In the United Kingdom, the lack of knowledge about preexisting illnesses of women, inadequate availability of interpreters, or certain culturally related practices of refugee women led to an increase in maternal mortality (Lewis, 2007). In Australia, migrant women with limited health insurance were more often subject to postnatal depression than Australian women (Dennis, Merry, & Gagnon, 2017). In Germany, the lack of female interpreters made access to care difficult for women from Somalia and Eritrea, leading in several cases to wrong, and in some cases, life-threatening misdiagnosis (Schouler-Ocak & Kurmeyer, 2017).

Although these barriers to health care have been studied earlier, little research has focused on women's conceptions about obstetric care or the impact of previous experience with pregnancy and health care in their countries of origin. Gaining knowledge about women's conceptions and premigration experiences is of great importance for health-care providers in host countries, as health-seeking behaviors during pregnancy, childbirth, and puerperium in host countries may remain influenced by previous experiences. This so-called "maternal migrant effect" is of high significance, especially for women migrating from countries of high maternal mortality to countries of low maternal mortality, as it may affect maternal health outcomes negatively (Binder, 2012). Maternal mortality rates in these countries are dropping with a decrease of direct causes of maternal death, such as hemorrhage or infections, and a shift

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toward indirect causes, like diabetes or cardiovascular diseases (Say et al., 2014). At the same time, the increasing institutionalization and medicalization of childbirth, rising rates of obstetrical interventions, and a tendency toward overmedicalization lead to negative results on reproductive health outcomes, in the context of overburdened health-care systems (Souza et al., 2014).

Today, a great majority of refugee women in Germany originate from Syria and Iraq (Federal Agency for Migration and Refugees, 2018), countries considered to be in obstetrical transition. Although in Germany, pregnant refugee women and mothers are legally entitled to free obstetrical care during pregnancy, childbirth, and puerperium, barriers in access to health care may still occur. To elucidate the influence of conceptions of pregnancy and childbirth, of premigration experiences, health literacy, and language skills on access to health care in Germany, we posed the following research questions:

- How do conceptions about pregnancy, childbirth, and puerperium, premigration experiences, health literacy, and language skills influence refugee women's perceived needs and expectations of health care?
- How do refugee women experience care during pregnancy, childbirth, and puerperium?
- What strategies do refugee women develop to compensate for restricted access to health care?

The study was conducted in the city of Dresden, the capital of the federal State of Saxony, as part of a larger research program focusing on services provided by Refugee Clinics in Saxony.

Access to Health Care

The theoretical foundation of this study is based on the model of access to health care by Levesque, Harris, and Grant (2013) who define access as "opportunity to reach and obtain appropriate health-care services in situations of perceived need of care." We adopted this model, because it allows for the analysis of the quality of care and barriers to access from a patient-centered perspective. The model posits that to access health care a potential patient must, first of all, be able to identify a need for health care and be aware of possible health-care options. This ability depends largely on notions of health or illness, which oftentimes are culturally determined. It is also related to knowledge about different options of health-care services. All this may be subsumed under the term health literacy, which is defined as knowledge, motivation, and competences to search, find, understand, evaluate, and apply health-related information (Sorensen et al., 2012).

To be approachable by a patient, health-care providers need to draw attention to their services, for example, by circulating information or offering outreach programs. However, being aware of a service is not sufficient for patients to approach them, when the services are not acceptable due to personal, cultural, or religious reasons. A mismatch between a patient's notions of health care and the values of health-care professionals may lead patients to avoid seeking treatment.

The patient's ability to seek and reach health-care services depends also on the availability of facilities. This includes their geographical proximity to patients' home, their opening hours, or their scheduling procedures. Being situated too far away and not being accommodating in a sense of having restricted opening times or complicated appointment mechanisms may let patients hesitate to seek treatment or to reach treatment facilities. The affordability of health care also remains a critical issue. Patients without health insurance or limited legal eligibility may experience barriers to health care, when costs of treatment and the patient's financial resources do not match and services or even transport need to be paid out of their own pocket.

Finally, to be perceived as appropriate and of high quality, health-care services must correspond to the patient's needs. Levesque et al. (2013) argued that patients should be able to choose services that not only offer effective treatment but also match their notions of health care. Here, intercultural competences of health-care providers, including language competences, play an important role to offer patient-centered health care that is culturally sensitive and geared to their specific needs (Levesque et al., 2013).

In this perspective, access to health care is a multifactorial process that can be facilitated or compromised at many different levels. When interactions between patients and health-care providers are disturbed, barriers occur, that directly influence the process of searching, finding, and obtaining health care. To ensure access, health care must be provided in a way that motivates and empowers patients, to engage with the health-care system in a participative way (Levesque et al., 2013).

Study Design and Methodology

To answer the research questions, a qualitative phenomenological research design was selected. This seemed appropriate to generate an insight into individual realities, concepts, experiences, and perspectives of pregnant refugee women and mothers. To be flexible enough to deviate from preformulated questions and to react to unforeseen issues, semistructured interviews with open-ended questions were chosen for data collection (Gall, Gall, & Borg, 1996). An interview guide was developed

and tested in advance. The ethics committee of the German Association for Nursing Science approved the study (Application No. 17-009b).

During August and September 2017, interviews were carried out in the city of Dresden with 12 Arabic-speaking women from Iraq and Syria and with one Palestinian woman, who had lived in Syria. They had all arrived in Germany between 2014 and 2017. Inclusion criteria for participation were to be at least 18 years of age, having an ongoing or completed asylum procedure in Germany, being pregnant or having given birth to a child in Germany.

The selection of only Arabic-speaking participants was based on two considerations: first, Syrian and Iraqi represented the largest group of refugees in Dresden at the time of the research. Second, for reasons of gender sensitivity and quality standards of translations only certified female interpreters were to be hired. Those, at the time, were only available for the Arabic language. In addition, also two German-speaking Arabic women were employed as language mediators to assist in the recruitment of participants. Interpreters as well as mediators were trained in ethical aspects concerning research with vulnerable persons. They were informed about their tasks, their role as translators, and the contents of the interviews.

Prospective participants were recruited through personal contacts of the interviewer, recommendations from social workers, referrals among refugees, or in the waiting room at the refugee clinic in Dresden. With the help of the language mediators, the participants received both written and oral information in Arabic regarding the objectives and modalities of the study, the voluntary nature of participation, and their right to withdraw at any time without any effect on their asylum procedure or on health care. Potential participants had the opportunity to reflect on their decision to participate at least 24 hr before signing a consent form. At this point, one woman refused to participate because her husband fell ill; another withdrew because her husband did not agree to her participation.

A total of 12 women, nine Syrian, two Iraqi, and one Palestinian, who had lived in Syria, agreed to participate in the interviews. They were all married and between 19 and 38 years old. They had been living in Germany between 4 months and 3 years. At the time of the interviews, eight of the women were pregnant, two of them for the first time. Six women had given birth in Dresden. Nine of the participants had given birth to children in Syria or in Iraq, four of them by cesarean section. Three women mentioned that they had suffered miscarriages; one of them reported having lost her child in the seventh month of pregnancy. The participant had not been brought up intentionally during the interviews because of ethical considerations, but some of the women spoke about it on their own.

The interviews were conducted face to face,[1] at either the university or the women's homes; some of the interviews also took place in the presence of the women's husband or children. This sometimes influenced the interaction with the women. In one case, the husband tried to answer questions instead of the woman; in another case, children kept coming into the room and disturbed the interview by arguing in the neighboring room.

The interviews lasted between 40 and 105 min and were recorded with a digital voice recorder after permission of the participants. Interview questions comprised concepts of pregnancy and childbirth, knowledge about pregnancy-related prevention and health promotion in their countries of origin and in Germany, experiences of health care during pregnancy and childbirth in Germany, and compensation mechanisms when access was impaired. Interview questions and answers were translated from German into Arabic and vice versa.

Directly after the interviews, additional notes were taken about the interview setting, nonverbal reactions of the interviewees, of own emotions, thoughts, and impressions. These notes served later as basis for reflection of possible bias, for example, introduced by the researcher's personal experience of pregnancy that might have influenced the quality of data collection or that of later analysis.

All interviews were transcribed by an experienced transcriber or by the researcher herself and checked for completeness. A reverse translation was not carried out because the quality of the translation was insured by the academic qualification of the certified translators and because of lack of financial resources. Saturation of data was achieved after 12 interviews, when information provided by participants did not elucidate new insights (Morse, 2015). All transcripts were imported to MAXQDA qualitative analysis software.

Data Analysis

For data analysis, a qualitative content-analysis approach was selected, allowing filtering relevant core themes with the help of theory-guided categories (Mayring, 2015). First, the transcripts were read and reread in their entirety. Categories were constructed deductively and were provided with definitions. They were based on Levesque's et al.'s "access to patient-centered health care" model. They included "perceptions of health-care needs," "health-care seeking," "health-care reaching," "health-care utilization," and "health-care consequences." Subcategories, such as "approachability," "acceptability," "availability," "affordability," and "appropriateness of care" as well as "ability to perceive health care needs," "ability to seek,"

ability to reach," "ability to pay," and "ability to engage" were subordinated. Memos to emerging results were written. Categories and results were discussed extensively with all co-authors.

Although all steps to access to health care were adopted as categories and subsequently analyzed, the main themes, out of the women's experiences and perspectives, emerged in the following categories and subcategories:

1. Perceptions of health-care needs: ability to perceive health-care needs, conceptions of pregnancy and birth, health literacy, and the additional subcategory "premigration experiences.
2. Health-care seeking: ability to seek, personal and social values, culture, and gender.
3. Health-care consequences: ability to engage, empowerment, information, and adherence.
4. Health-care experiences during pregnancy and childbirth in Germany.
5. Compensation mechanisms.
   We added, for better understanding of contexts, a diagram of the model to Appendix.

Results

Conceptions of Pregnancy and Childbirth, Premigration Experiences

The ability to perceive the need for health care is closely related to beliefs about health and health care (Levesque et al., 2013) and, in this regard, about pregnancy and child birth. As these ideas and notions about health care during this time may be influenced by experiences from the countries of origin of the refugee women, this section of the article reports on how participants perceived care usually provided for them during this time.

Health care for pregnant women in Iraq was considered deficient. One woman reported that state hospitals appeared dirty and that women were not well looked after. According to her, corruption was a widespread phenomenon and women only received treatment after money had been given to staff. For this reason, some women preferred to give birth at home with the help of a midwife. Apart from state hospitals, private hospitals provided better care for pregnant women, but were not financially affordable for families with limited financial resources.

> If you are pregnant in Iraq, it is not so good. There is no care, no special care. If you have money, everything is possible, but if not . . . A poor person has no possibilities. Every month it costs around 80 Euro every time you go there, more or less.

In Syria too, women could choose between public and private hospitals, also depending on their financial resources. Although health care in public hospitals is free, long waiting times and many other patients are to be expected there. The quality of care was reported to be worse than that in private hospitals.

Information about pregnancy and childbirth and about healthy behavior during these times is usually passed on by female relatives, in Syria as well as in Iraq. Prevention of complications, in both countries, is conceptualized as rest. In Iraq, women sometimes give up work as early as the third month of pregnancy; in Syria, women are even advised to lie down during the first weeks to ensure the nidation of the embryo. Exertion, carrying heavy objects, or getting upset is to be avoided. Good nutrition in general seems to be of high priority, but women also reported that no special dietary provisions or behaviors were necessary to protect the pregnancy and the unborn child. One of the women commented: "You eat the same and live the same life. You have simply got a child in your stomach."

The importance of clinical antenatal care was perceived in various ways by the participating women. Although both women from Syria and Iraq mentioned that they had attended antenatal visits every 3 to 4 weeks during their previous pregnancies, one woman also reported that she had consulted her female doctor only twice, once for confirmation of the pregnancy and the second time to give birth. She commented: "If I don't notice anything, I don't need to go to the doctor." By contrast, ultrasound examinations seemed to be highly important for many of the interviewed women from Syria. One woman said that it had helped her to feel more secure and she thought that they were necessary to intervene at an early stage in case of complications:

> To get a good feeling. When you see the baby, you have a good feeling and can perhaps do something, if something has happened.

In Syria and in Iraq, antenatal care is mostly provided by female medical doctors. They also assist the women, alongside with nurses, in childbirth. Certified midwives are not common. Gender-conform care generally seemed to be important, but it was not always a priority for the participating women. One of them commented:

> There are people who take their religion a bit too seriously and who say they don't want that, but really it is that the doctor is there as a doctor and he has taken an oath that he is there as a doctor and not as anything else.

For many first-time mothers, the actual beginning of labor seemed to be associated with great uncertainty and

a lack of knowledge. Here again, the women resorted to female relatives for advice.

> It was like this, I just didn't know I was having labor pains. I thought it was a chill. When I noticed the first pain and didn't know what I had, my mother-in-law said, drink hot peppermint tea; it's either labor pains and the mint will make them worse, or it goes away. And then the labor pains got worse and I went to the hospital.

Women in Syria and in Iraq are usually accompanied to the hospital by their mothers or mothers-in-law, sometimes also by their husband. The relatives are allowed to stay with them in a waiting room, but they may not enter the delivery room. There, women are assisted by doctors and nurses only. In general, women deliver in a supine position, usually in a gynecological chair:

> In Syria you are first in a little room that looks like an operating room and then you lie on one of those normal gynecological chairs and under it is a kind of little bed and you hold tight and then the birth happens. Your legs are up in the air all the time, as if you are being examined.

Most of the participants had no knowledge about noninvasive pain-relieving measures during childbirth; only one woman from Iraq mentioned that female relatives would instruct women how to relax and breathe. In view of this, medical interventions, like episiotomies or the augmentation of contractions, were considered to be of great help to reduce suffering by shortening the birth process.

> When I had my first daughter, I was given medication to increase the contractions. I'd have perhaps been in labor for a whole day. After I was given the medication, I went to the hospital at 12 o'clock and the baby arrived at one or half-past one.

Cesarean sections were considered helpful as well, and women were reported to opt for this operation instead of going through the natural birth process because of their fear of pain. Furthermore, women in the war zones in Syria also chose to give birth by cesarean section for safety reasons.

> For instance, if there's a lot of shooting and attacks, it is dangerous and these fights between the two sides are mostly during the night. You have no way to reach the place you need to reach. Most of us had a caesarean section to take off the pressure, that this might happen.

Furthermore, because of the targeted bombings of medical facilities in Syria, cesarean sections are also performed to protect the women by keeping their hospital stay as short as possible. Although this may save the women's life, an immediate discharge after a C-section without any postpartum care may not only be dangerous to the health of the woman and the baby but can also be a traumatic experience.

> With my son, before the labor pains started, a car exploded; it had been filled with explosives and after it had gone up, there were attacks and . . . there was shooting, bombing . . . and we had to leave our flat and I couldn't be taken to hospital. Sometime or another my waters broke and the contractions stopped. I got to the hospital the next morning and had no contractions and the baby had to be delivered by caesarean section. The time after that was awful . . . Normally, you stay in the hospital for two days . . . two days! But because the hospitals were under fire . . . I was discharged quickly. My husband wasn't there and his brothers got me out of the hospital and it was . . . very hard. His brother's wife was there, she was the only support I had . . . We went to the village where his grandfather lives and no one examined me and the stitches were removed only after 15 days.

Although this report is an example of the difficult and sometimes dramatic conditions of giving birth in war zones, most women in Syria and Iraq are used to being discharged from a hospital several hours or 1 day after an uncomplicated delivery. Follow-up postpartum care by professional staff is not customary and usually female relatives care for the new mother and her baby.

The Impact of Premigration Experiences on the Women's Perceptions of Health Care Needs

The women's premigration experiences of obstetrical care influence their perceptions of health-care needs and their expectations toward the health care provided. Being used to be attended to by one and the same physician during pregnancy and childbirth in their home countries, the idea of being attended by a physician or midwife unknown to them during childbirth gave cause for great concern:

> That worried me most, having to go to a strange person, well, someone doing the birth whom I had never seen before . . . I had assumed that the same female doctor would look after me who had cared for me during the whole time.

Vaginal examinations in early pregnancy also caused anxiety. As they are commonly not performed in Syria in early pregnancies, many women are critical of them or even refuse to be examined in this way.

The limitation of free ultrasound examinations to only three during healthy pregnancies by the statutory health insurance in Germany is perceived as a shortcoming in

medical care in Germany. Women who experienced frequent ultrasound examinations in their countries of origin considered close monitoring of the pregnancy and the fetus by ultrasound as vital.

> The only thing which I don't like that much is, that you, as statutory insured woman, are only allowed three ultrasound examinations. Really, we ought to have one each time!

Preventive measures, such as antenatal care provided by midwives or antenatal classes, were partly or entirely unknown to the participants because of the lack of similar health-care services in their native countries. At the same time, accessing information about pregnancy and delivery seemed in some cases to be difficult. Contact with female relatives in the native countries could not be maintained on a regular basis and detailed information from health-care providers were sometimes missing. Some of the women, for example, had only inaccurate knowledge about the appropriate time of going to the hospital for childbirth. Although some of them stated that they had gone, when amniotic fluid had appeared or they had noticed bleeding, others said: "I go, when the pain gets bad." Not being instructed in measuring the time gap between contractions in their countries of origin, they usually had asked their gynecologist for advice.

> The difference in Syria is that the doctor . . . you had before, the one who treated you during the pregnancy, is also in charge of the birth itself . . . When contractions start, I call the doctor up and she asks: Well, how much time is there between one pain and the other and then she tells me: ok, now you have to come to the hospital!

In the absence of such a contact person in Germany, women rely on their premigration experiences and their knowledge acquired by it. In the case of an Iraqi woman, this proved not only to be insufficient but also misleading. Convinced to be well informed about the birth process due to her first delivery in Iraq, she hesitated to go to the hospital in a timely manner the second time. Having been in painful labor for an extended period of time with her first child and perceiving the beginning contractions in the current situation as not very painful, she assumed, even when contractions intensified during the night, that she had enough time to wait until the next morning, to let her husband take her daughter to day care, before going to the hospital. However, as soon as he had left, the birth started.

> And I sat on the toilet and . . . and noticed that the head was coming out and I pressed and pressed and pressed. Then I stood up and held the head with my hand so that it didn't fall out. Then I sat down on the floor and leaned against the bathtub with my legs open and brought it to a close. Then I saw the baby girl and was really very scared. She made no sound at all when she came out. So I took her in my arms and smacked her buttocks a little and she started crying. Then I put her on the floor and took a deep breath. My husband rang up and we had four mobiles in the house and neither of them was close by. I couldn't get up because I was still attached to the baby with the umbilical cord. And the whole floor was full of blood and everything else that comes out. I was afraid to stand up and slip and I was afraid to pick the baby up again. It was cold at that time, too. I had stomachache and backache and the placenta was still inside. It wasn't completely over with. Well, then, ten minutes after the birth had taken place my husband came home.

The husband immediately called emergency services and the mother and her baby were taken to the hospital in time. Both survived and are well today, but the example shows that premigration experiences and the knowledge associated with them, respectively, the women's health literacy, may not be sufficient to perceive a need for health care or to initiate timely health care during pregnancy and childbirth.

Experiences of Antenatal and Obstetric Care and Compensation Mechanism for Access Barriers

In the city of Dresden, most participants had received antenatal care in the refugee clinic. This facility was considered to be easily accessible because no appointments are needed to arrange for a medical consultation and care was thought to be appropriate, as it was provided by a female gynecologist, assisted by an interpreter. In spite of this and because waiting times were sometimes perceived as too long, some women preferred consultations with resident gynecologists outside the refugee clinic. Here, in some cases, they were asked to bring their own interpreters to ensure communication. This sometimes proved to be problematic and women had to ask neighbors, relatives, or friends to accompany them to the gynecologist or pay interpreters out of their own pocket.

Especially for women who gave birth in the delivery room, the language barrier posed a particular problem. Not being able to understand clinician's explanations or directions led to anxiety and put a lot of pressure on the women. One of them reported that her biggest fear was not to be able to communicate with the midwife or the doctor during childbirth. To avoid this kind of situation, she took her 15-year-old daughter as language mediator with her. The birth proved to be very difficult and although the woman tried several times to send her daughter away, the girl refused to leave her mother. Although her presence was perceived as helpful, the mother later worried about the emotional well-being of her daughter.

> I was a bit worried about her experiencing a birth for the first time and it is her mother and I was a little afraid that she might not want to have children later and that it would affect her psyche. It was all very difficult for her and she was actually out of action for two to three days afterwards.

Not being able to understand explanations of procedures can also lead to feelings of powerlessness. One of the women reported, that, during labor, treatment was carried out without her understanding the explanations given by caregivers. She said: "And then they do what they want." Her husband explained:

> They tried to explain the treatment. They tried to explain, we are going to do this and that. But when she didn`t understand, they performed the procedure anyways. Without telling exactly, what they were going to do!

For this woman, communication problems continued after her discharge and the language barrier between her and the midwife caused further health complications.

> Sometimes she recommended medication, over the counter medication, which I then bought. For instance, when the little one . . . got oral thrush. And I didn't know how to use it. So, I didn't use it.

Because she was not able to treat her daughter's thrush, the infection spread to her breast. Again, she called her mother in Syria, who advised her to immediately consult a physician.

Not being able to communicate with caregivers because of language barriers, many of the women showed knowledge deficits concerning health-care services during pregnancy, birth procedures, pain-management, transport to a hospital, and ante- and postnatal care by midwifes. Being aware of this lack of information, some women resorted to Arabic health information from the Internet.

> There is an Arab woman . . . who explains in Arabic what a birth is like and what exercises you should do. And for the time after the delivery there are instructions about how to put a nappy on the baby or how to bathe it.

A few women were also able to speak some German or English. One woman reported that she had been able to communicate in German and in English with the midwife in the delivery room to a limited extent, and in addition, she had used a translation app on her smartphone. She felt that her wishes and needs had been understood and met. Also for her, the experience of childbirth in Dresden had been completely different from the one she had had in Syria. Instead of having been strapped to a gynecological chair without being able to move, she was allowed to walk around and was comforted by her husband, who was present throughout the birth. Another Syrian woman, also able to speak English, had received ante- and postnatal care by a midwife in her home. She reported having received a great deal of helpful information from her. The communication with her gynecologist had also been successful, as she could communicate with her in English as well. When asked what would improve access to health care for pregnant refugee women and mothers, all women recommended the use of interpreters in health-care facilities to ensure communication and understanding during pregnancy and childbirth.

Discussion

This qualitative study was conducted to gain an understanding of Arabic-speaking pregnant refugees' and mothers' experiences of access to health care in Germany during pregnancy, childbirth, and puerperium. The participating women provided insight into their notions of pregnancy, birth, and obstetric health care and their knowledge about prevention and health promotion during pregnancy. They shared their sometimes difficult and traumatic premigration experiences and showed in their narratives the correlations between these experiences and their thinking and behavior. Furthermore, they shed light on their experiences of childbirth in Dresden and on difficulties involved and showed their competences and their creativity to cope with barriers to health care.

Within the process of accessing health care, the first step entails the perception of needing health care or having a wish for it (Levesque et al., 2013). Our research results show in accordance with this model that this step is influenced by conceptions and by knowledge about pregnancy, delivery, and puerperium, which influence further notions and behaviors. This was demonstrated in the case of some of the Syrian women, who depreciated vaginal examinations in early pregnancy while appreciating multiple ultrasound examinations, which were perceived as a form of health care, needed to insure the well-being of the baby.

Needs for health care are also influenced by the women's level of health literacy. This became particularly evident as one woman, who accessed antenatal care only once during her pregnancy, did not have any understanding of the significance of regular antenatal consultations. Other women with higher health literacy, however, perceived regular and frequent antenatal care as important, to ensure the mother's and baby's health.

In addition to the factors influencing perceptions of needs for health care, as depicted in Levesque's model, this study shows that premigration experiences of refugee women play a significant role in regard to health-related behavior, as women's efforts to seek health care and their

perceptions of its appropriateness were influenced by these experiences. Being used to be cared for by the same doctor during pregnancy and childbirth, women disapproved of being attended to by a doctor unknown to them during birth.

Together with low health literacy, premigration experiences also led to anxiety. The lack of knowledge about pain management during childbirth let them perceive the idea of a "natural birth" as threatening. Instead, an augmentation of labor appeared to them as the appropriate way of pain relief. Furthermore, the combination of low health literacy, premigration experiences, insufficient information about the appropriate time to attend a hospital, and a lack of significant others to turn to when questions arose meant that the need for timely health care was not perceived and care was sought belated. Ultimately, it caused the possibility for negative health outcomes, the so-called "near-miss" events, as the woman was hemorrhaging due to the still attached placenta. "Near-miss" events are conceptualized as serious health complications that almost lead to the death of the mother or the newborn child. They are considered to be quality indicators in obstetric care and are a sign of health-care barriers (World Health Organization [WHO], 2011). In the case of the aforementioned woman, multiple barriers contributed to the possibility of such an event.

Cultural or religious notions may also lead to an omission to seek care or to perceive health care as unacceptable, when not given by a same sex care provider. As shown in this study, women commonly preferred female gynecologists, but some of them judged this preference as exaggerated and considered a consultation with a male gynecologist also as acceptable.

Health-care utilization, according to Levesque, is also influenced by the women's assets and their social capital (Levesque et al., 2013). These include the women's social support system and their ability to communicate in German or English. Women who could not speak these languages and who did not have neighbors or friends to support them as language mediators preferred to attend the refugee clinic for antenatal care. Access there is facilitated through a walk-in system for consultations and on-site interpreters. Other women who were able to communicate in German or English or who were able to afford interpreters or who had friends, who could translate sometimes preferred antenatal visits at resident gynecologists to omit long waiting hours at the clinic, which they perceived as inappropriate. Another helpful asset comprised media and Internet competence, which allowed women, to access digital information about pregnancy and childbirth and contributed to raising their health literacy and their ability to perceive the need for health care and seek for it.

Women have formed transnational networks, which also contributed to their access to health care. By receiving vital information about pregnancy, delivery, and child care from female relatives in their countries of origin, they compensated for information gaps and were able to perceive needs for health care, seek health-care providers, and utilize health-care services. As shown in this study, one of the participants decided to seek health care only after calling her mother in Syria, who alerted her to the urgency of the situation.

The appropriateness and quality of care and its consequences to health depend strongly on successful interactions between health-care providers and the women (Levesque et al., 2013). Here, not only the language difficulties of the women but also the failure of hospitals to provide interpreters led to anxiety concerning childbirth and to feelings of powerlessness, when treatment was performed without consent. It also led to negative health outcomes, such as difficulties in breastfeeding or infections, when techniques or treatment could not be explained. One woman's attempt to overcome the language barrier by taking her minor daughter to the delivery room proved to be less than optimal, as the birth became an emotionally stressful experience for the girl.

Our findings indicate considerable deficits in the appropriateness and quality of obstetric care. Successful communication with health-care providers is important for all pregnant women, but especially for pregnant refugees and mothers. Coming from war-torn countries and countries of the obstetric transition, experiences of pregnancy and childbirth might have been traumatic and need to be assessed thoroughly before childbirth to provide appropriate women-centered obstetric care.

Despite a decade long history of migrant women giving birth in hospitals, in Germany health-care providers are still not obligated to provide free interpreters (Rieger, 2009). Although health-care-related costs during pregnancy, childbirth, and puerperium are covered by health insurance and migrant and refugee women are entitled to the same health-care provisions as German women, equity in health care is not granted, because of the prevailing language barriers and its impact on communication between health-care providers and the women. It threatens the access to appropriate health care for pregnant refugees and mothers and excludes them from preventive and educational services, such as antenatal classes. It also compromises the quality of perinatal care and the women's right to make informed decisions about their care. Such, it represents a structural barrier for pregnant women and mothers, who try to access health care. The negative impact on the quality and appropriateness of care including negative health outcomes was demonstrated in this study.

Successful communication between pregnant women and mothers and health-care providers is essential to ensure their health during pregnancy, childbirth, and puerperium (German Federation of Midwives, 2010). As this is only

possible with the help of interpreters for women without German language proficiency, a serious omission and institutionalized discrimination against women is to be assumed here. Not ensuring communication between health-care providers and refugee women, especially during childbirth can be considered as "structural violence," a term, which describes a form of violence that originates from economic, political, legal, or cultural structures and hinders individuals or groups of people from attaining their full potential (Galtung, 1969). Here, this form of violence is exercised by the structure of the prevailing political, social, and medical system. In Germany, health insurances are still not obligated to reimburse costs for interpreters. This configuration of services means that the fundamental principle of informed consent for medical treatment is undermined and potentially negative health-related outcomes, arising from miscommunication and subsequent flawed clinical decision-making processes, are tolerated. Furthermore, women are denied adequate and patient-centered health care, by refusing to ensure successful communication and emotional support by health-care providers.

It is the responsibility of health-care providers to develop appropriate quality standards to achieve the aforementioned care (WHO, 2016).With the opening of the Dresden refugee clinic, a first step has been taken to reduce this form of structural violence and to provide access to adequate and to the refugees' needs tailored health care by the deployment of interculturally sensitized employees and interpreters.

Conclusion

From this study, it is apparent that obstetric care, tailored to the specific needs of pregnant refugees and mothers, is important to ensure access to adequate health care. Gaining access to this kind of care is problematic, as premigration experiences, conceptions of pregnancy, childbirth and obstetric care, limited health literacy, and missing language skills limit perceptions of health-care needs, the seeking of health-care providers, and the use of health-care services. In some cases, barriers occurred because of these factors and resulted in negative health outcomes. Women tried to compensate for deficiencies by resorting to seeking advice in transnational networks and using friends, relatives, or self-paid interpreters as language mediators, to be able to communicate with health-care providers.

To ensure access to appropriate health care, successful communication between pregnant refugees and mothers and health-care staff needs to be ensured by the deployment of paid interpreters in all health-care facilities. These measures would be a significant step toward equity within the realm of maternal health care and the intercultural opening of the German health-care system.

Appendix

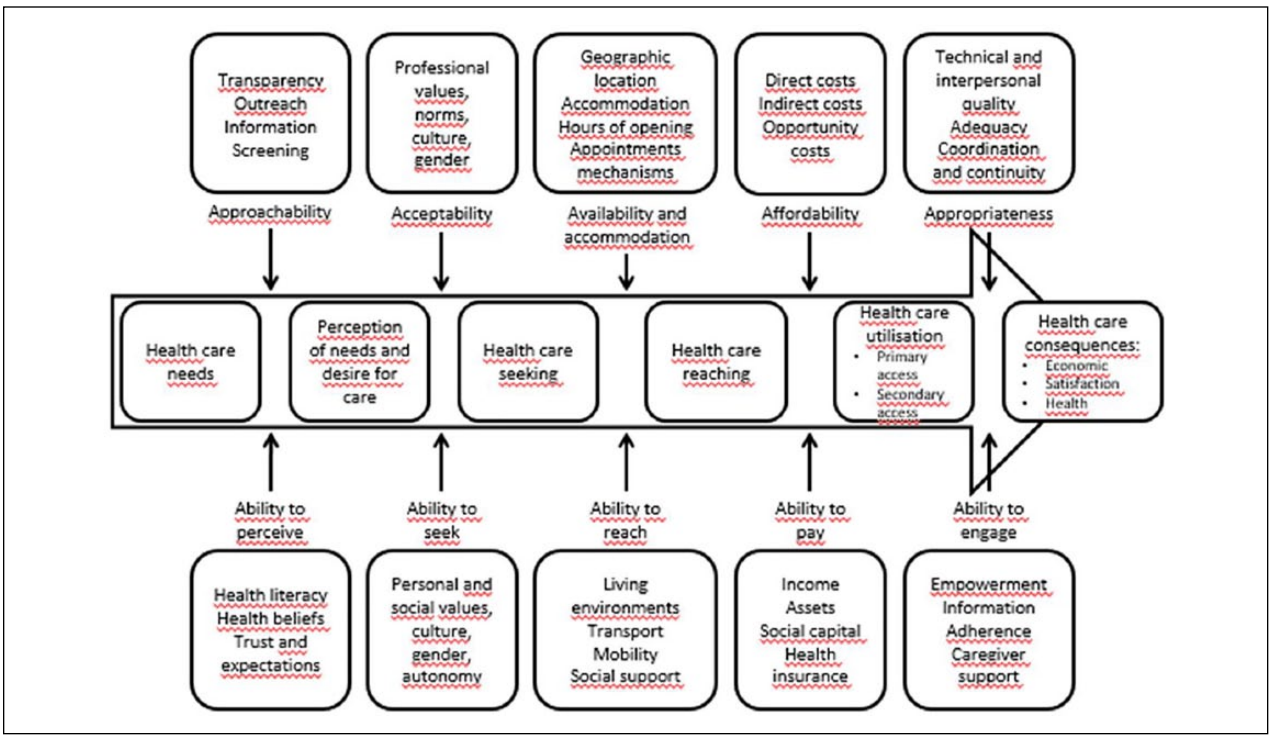

Figure A1. A conceptual framework of access to health care (Levesque et al., 2013, published under Creative Commons license CC BY 2.0, https://creativecommons.org/licenses/by/2.0/).

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Note

1. Interviews were conducted by the main researcher, J.H. She is a social- and cultural anthropologist (MA) and a research fellow at Evangelische Hochschule (ehs), Dresden, Germany. She has extensive working experience with refugees in Germany and in Africa. She has also worked as a registered nurse in OB/GYN in the United States and has conducted anthropological research with pregnant women and mothers in Uganda and with refugees and migrants in Italy. Preparation of the study design, data analysis, and preparation of this manuscript were supported by C.B., Master of Health Sciences (MSc), who is a research fellow at Evangelische Hochschule (ehs), Dresden, Germany, with experience in research on primary health care for refugees. Professor Dr. T.F., MPH, supervised the research team and contributed to all aspects of the conduct of this study.

References

Binder, P. (2012) *The maternal migration effect: Exploring maternal health care in Diaspora* [Using Qualitative Proxies for Medical Anthropology. Acta Universitatis Upsaliensis. Digital Comprehensive Summaries of Uppsala Dissertations from the Faculty of Medicine 827]. Retrieved from http://uu.divaportal.org/smash/get/diva2:561154/FULLTEXT01.pdf

Dennis, C. L., Merry, L., & Gagnon, A. J. (2017). Postpartum depression risk factors among recent refugees, asylum-seeking, non-refugee immigrants and Canadian born women: Results from a prospective cohort study. *Social Psychiatry and Psychiatric Epidemiology*, *52*, 411–422. doi:10.1007/s00127-017-1353-5

Federal Agency for Migration and Refugees. (2018, April). Current statistics on asylum [Bundesamt für Migration und Flüchtlinge. 2018. Aktuelle Zahlen zu Asyl]. Retrieved from http://www.bamf.de/SharedDocs/Meldungen/DE/2018/20180509-asylgeschaeftsstatistik-april.html

Gall, M. D., Gall, J. P., & Borg, W. R. (1996). *Educational research: An introduction*. New York: Longman.

Galtung, J. (1969). Violence, peace and peace research. *Journal of Peace Research*, *6*, 167–191. doi:10.1177/002234336900600301

German Federation of Midwives. (2010). *Geburtsarbeit. Hebammenwissen zur Unterstützung der physiologischen Geburt* [Birth work. Midwives' knowledge in support of physiological births]. Stuttgart, Germany: Hippokrates Verlag.

Khanlou, N., Hague, N., Skinner, A., Mantini, A., & Kurz, L. (2017). Scoping review on maternal health among immigrant and refugee women in Canada: Prenatal, intrapartum, and postnatal care. *Journal of Pregnancy*, *2017*, 8783294. doi:10.1155/2017/8783294

Levesque, J. F., Harris, M., & Grant, R. (2013). Patient-centered access to health care: Conceptualizing access at the interface of health systems and populations. *International Journal for Equity in Health*, *12*, Article 18. doi:10.1186/1475-9276-12-18

Lewis, G. (Ed.). (2007). *The Confidential Enquiry into Maternal and Child Health (CEMACH). Saving mothers' lives: Reviewing maternal deaths to make motherhood safer: 2003 – 2005. The seventh report on confidential enquiries into maternal deaths in the United Kingdom*. London: Confidential Enquiry into Maternal and Child Health.

Mayring, P. (2015). *Qualitative Inhaltsanalyse. Grundlagen und Techniken* [Qualitative content analysis. Basics and techniques]. Weinheim, Germany: Überarbeitete Auflage.

Morse, J. M. (2015). Data were saturated. *Qualitative Health Research*, *25*, 587–588.

Rieger, H.-J. (2009). Aufklärung ausländischer Patienten [Educating foreign patients]. *Deutsche Medizinische Wochenschrift*, *134*, 2245–2246. doi:10.1055/s-00000011

Say, L., Chou, D., Gemmil, A., Tuncalp, Ö., Moller, A.-B., Daniel, J., Gülmezoglu, A. M., Alkema, L. (2014). Global causes of maternal death: A WHO systematic analysis. *The Lancet Global Health*, *2*, 323–333. doi:10.1016/S2214-109X(14)70227-X

Schouler-Ocak, M., & Kurmeyer, C. (2017). *Study on Female Refugees*. Eine repräsentative Untersuchung von geflüchteten Frauen in unterschiedlichen Bundesländern in Deutschland. Die Beauftragte der Bundesregierung für Migration, Flüchtlinge und Integration [A representative survey of refugee women in various federal states of the federal republic of Germany. The representative for migration, refugees and Integration of the Federal Republic of Germany]. Retrieved from https://female-refugee-study.charite.de/fileadmin/user_upload/microsites/sonstige/mentoring/Abschlussbericht_Final_-1.pdf

Sorensen, K., van den Broucke, S., Fullam, J., Doyle, G., Pelikan, J., Zofia, H., & Brand, H. (2012). Health literacy

and public health: A systematic review and integration of definitions and models. *BMC Public Health*, *12*, Article 80. doi:10.1186/1471-2458-12-80

Souza, J. P., Tuncalp, Ö., Vogel, J. P., Bohren, M., Widmer, M., Oladapo, O. T., Temmermann, M. (2014). Obstetric transition: The pathway towards ending preventable maternal deaths. *BJOG*, *121*, 1–4. doi:10.1111/1471-0528.12735

World Health Organization. (2011). *Evaluating the quality of care for severe pregnancy complications: The WHO near-miss approach for maternal health*. Geneva, Switzerland. Retrieved from http://apps.who.int/iris/bitstream/10665/44692/1/9789241502221_eng.pdf

World Health Organization. (2016). *Standards for improving quality of maternal and newborn care in health facilities*. Geneva, Switzerland: Author. Retrieved from https://www.who.int/maternal_child_adolescent/documents/improving-maternal-newborn-care-quality/en/

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