





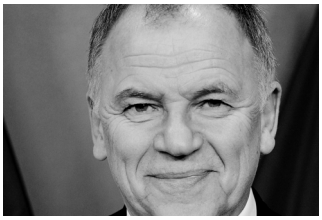


WPL
Women Political Leaders Global Forum

2018

IMPROVING MATERNAL HEALTHCARE FOR VULNERABLE WOMEN IN EU28: WHAT CAN YOU DO?

Assessment of EU Status and Call for Political Action

A report by Women Political Leaders Global Forum (WPL), supported by MSD for Mothers

MSD

MSD for mothers

Mapping, data analysis and reporting facilitated by:

EY

IMPROVING MATERNAL HEALTHCARE FOR VULNERABLE WOMEN IN EU28: WHAT CAN YOU DO?

FOREWORD

"Equitable and dignified maternal health is an issue of fundamental human rights."

I believe that healthier mothers are an essential investment in the wellbeing of our communities and our societies. All of our countries have a clear duty, to safeguard and to protect every mother.

Our commitment emanates from both the United Nations Declaration of Fundamental Human Rights, and from the United Nations Convention on the Rights of the Child, which clearly commit us to provide effective prenatal and postnatal healthcare for all mothers and their children.

Our universal commitment is also clearly reflected in the United Nations' Agenda 2030, and its seventeen Sustainable Development Goals, to which all of our countries are signatories.

Sustainable Development Goal Number 3, Target 1, explicitly states that we have a global responsibility, to reduce the world's maternal mortality ratio.

In the light of these commitments, it is therefore worrying to realise that, even in some of the most affluent countries in the world, there is still so much to be done to protect pregnant women, who do not have access to quality maternal healthcare.

There is a clear need to safeguard all aspects of an expectant mother's

experience. This is especially important because of the vast differences in approach and practices, which characterise the maternal health systems of our different countries. These differences are even present across the Member States of the European Union.

According to data from the World Health Organisation, every year there are about 1,800 maternal deaths in the European region. Indicators reveal that one in ten pregnant women in Europe has no access to maternal healthcare during early pregnancy.

This situation is even worse, when we consider the challenges faced by highly precarious groups, such as migrant and refugee women.

Migrant and refugee women face elevated risks of marginalisation and social exclusion, when it comes to accessing even the most basic maternal healthcare.

I believe that we must ensure greater synergies between our national and regional efforts, to end such risks of marginalisation and exclusion when dealing with maternal health.

Let me therefore urge our European authorities to create the necessary harmonisation, amongst all of our countries.

I augur that this Women Political Leaders report, supported by MSD for Mothers, will be used by the relevant authorities, policy-makers, activists, and professionals, in order to raise awareness about the challenges being faced by vulnerable pregnant women in Europe.

I urge our European authorities to take urgent action, to uphold the fundamental dignity of our women, our children, and our families.

Her Excellency, Marie-Louise Coleiro Preca,
President of Malta

FOREWORD

"We know what must be done and how it must be done, we just have to do it!"

Dear reader,

The report you have in your hands is not an academic exercise to illustrate a fine point of policy: what you are about to read is a stark reminder that, for an astonishing number of women, becoming a mother is at best a life-threatening ordeal - and at worst a death sentence that could have been avoided.

Every two minutes, somewhere on Earth a woman dies while pregnant or giving birth. That's nearly 3.000 women every day and over a million every year. Even in Europe today, where health care systems are more effective, accessible and resilient than in most other parts of the world, we face some very troubling numbers and disparities on maternal health:

- Every year there are about 1,800 maternal deaths in the WHO European region
- One in ten pregnant women has no access to maternal healthcare during early pregnancy
- The maternal mortality rate of the worst-performing EU country is ten times higher than the ones with the lowest rates
- More than half of all the pregnant women who visit the Doctor of the World clinics in Europe lack access to antenatal care.

These striking numbers will come as a surprise to many: indeed, of the merits of this report is to show that there is not just a lack of comprehensive and reliable data on maternal health, but also a lack of political and professional awareness of the specific plight of vulnerable pregnant women in Europe.

There are several global and important initiatives to improve maternal health. Think for instance of Sustainable Development Goal number 3 of the UN Agenda 2030 to reduce maternal mortality; or of the UN convention on Rights of the Child, which aims to safeguard mothers and children. These initiatives show that it is possible to come together as a united front (governments, NGOs, academia and the private sector, international institutions) and give a higher political and policy priority to maternal health care - especially for the increasing numbers of vulnerable women. Yet we have to face the numbers and admit that more needs to be done.

The important point to bear in mind is that most maternal deaths could be prevented - and that preventing them does not require an unrealistically high level of medical care, but only a high level of political will and strong policy focus. With the right tools and resources, in any well-functioning health care system the most common causes of maternal death, such as severe bleeding or pregnancy-induced high blood pressure, become treatable complications – not death sentences. It can be done.

We must believe, and hope, that times are changing for women, that discrimination and inequalities that were tolerated in the past are becoming unacceptable to civilized society. A stronger focus on improving maternal healthcare for vulnerable pregnant women in the European Union can be a necessary remedy to an unacceptable situation and a sign of broader change.

The recommendations of the Women Political Leaders Global Forum report are clear and to the point. We know what must be done and how to do it, and we have the means to do it. It is time for action.

Xavier Prats Monné,
Director General, DG Health and Food Safety, European Commission

FOREWORD

Empowering female Parliamentarians to improve access to maternal healthcare

Access to maternal healthcare is a fundamental human right. The health of mother and child is a critical concern, not only in the developing world, but also in Europe. In the EU region, there has been a substantial decrease in maternal mortality rates over the past 30 years. However, there are still challenges in ensuring equal access to maternal healthcare in Europe.

Many women are unable to gain access to timely and quality healthcare, putting them in a particularly vulnerable situation. Lack of information and gaps in the knowledge base of maternal healthcare have led to these women slipping through health system nets, especially during pre- or post-natal periods. This situation is exacerbated when considering the challenges faced by vulnerable communities, such as migrant and refugee women.

Despite this reality, maternal health often takes a backseat on the healthcare agenda. The Women Political Leaders Global Forum (WPL), supported by MSD for Mothers, has been steadily working to shed light on this issue and empower female Parliamentarians to push the topic in their respective Parliaments. A Call for Action (Outcome Declaration) has been developed which identifies concrete policy action that needs to be taken at EU and national levels for improving access to maternal healthcare for vulnerable pregnant women.

This maternal healthcare mapping project was developed to gain on the one side an overview and understanding of the political realities on issues vulnerable women (such as migrants, refugees and asylum seekers) face when accessing maternal healthcare, and on the other side, the challenges governments are confronted with to provide solutions. The study had three phases: a mapping of maternal health data indicators to scope the current situation in the EU; an online survey to collect insights from political leaders regarding the national policies in place for ensuring access to maternal healthcare for vulnerable women; and qualitative interviews to develop a better insight into implementation of policies to improve access.

The findings have led to the development of key recommendations to EU member states which will act as a stepping stone to integrate access to maternal healthcare for vulnerable pregnant women into EU policies.

Silvana Koch-Mehrin
President, Women Political Leaders Global Forum

FOREWORD

Maternal Mortality can strike any one of us, anytime and anywhere. But we know that it strikes more often at the vulnerable and it looks for where there are vulnerabilities in societies to take hold. The disparities in maternal health outcomes in Europe are reflective of patterns we see across the globe. It is women who are young, poor, marginalized, displaced or from minority ethnic groups who are most likely to be at risk of poor maternal health outcomes. This is unacceptable.

As you will read in this report, even now in 2018, more needs to be done to support and protect the lives of mothers around the world, including here in Europe. The report uncovers how European healthcare systems are not able to meet the needs of women who come from vulnerable backgrounds and minority groups. As the number of vulnerable pregnant women continues to increase in every country in the region, women – and those around them – will continue to suffer unless greater action is taken. More importantly, the report also identifies pathways for improving the health of vulnerable pregnant women, identifying opportunities for each of us to ensure all women across the European region have access to quality maternal health services, regardless of their socio-economic status, ethnicity or nationality.

To solve for this crisis, solutions must be centered on the mother and comprehensively address all the factors contributing to decreased access to quality maternal healthcare. The drivers of poor maternal health are multi-sectoral – so we must engage in multi-sectoral partnerships to identify and mplement ways to break down barriers to access, and close the maternal

health gap that too many women are currently falling through.

The good news is we know what it will take. Together with our partners like the Women Political Leaders (WPL) Global Forum, we're working to identify scalable solutions to this growing challenge, including linking pregnant women to care and raising awareness of safe motherhood practices. Partnerships are essential to stay ahead of the curve in the rapidly changing world of global healthand meet the United Nations' Sustainable Development Goals, and at the end of the day, it will take greater commitment from all of us – from policy makers and NGOs, to health care professionals, community leaders, the private sector and more – to work together and improve maternal health outcomes. We all have a role to play - including sharing expertise, resources and best practices - to create a world where no woman dies giving life.

When a mother dies or suffers grave injury, it has far-reaching repercussions for her family, her community, and society at large. It negatively impacts her children's future health and wellbeing, their ability to complete their education and reach their full potential. In contrast, we know that a healthy pregnancy and childbirth leads to a lifetime of benefits - both for a woman's own health and prosperity - as well as that of her children, family, community, and nation. We call this the Mom Effect.

Let's all work together to support, strengthen and sustain the Mom Effect for generations to come.

Dr. Mary-Ann Etiebet
Lead and Executive Director, MSD for Mothers
(MSD for Mothers is an initiative of Merck & Co., Inc., Kenilworth, NJ USA)

OUTCOME DECLARATION

Meeting in Malta on Maternal Health and Refugee Women

Taking Effective Policy Action to Ensure Maternal Health for Refugee and Migrant Women Malta, 20-21 March 2017

Under the Distinguished Patronage of Her Excellency, Marie-Louise Coleiro Preca, the President of Malta, a High-Level Meeting on Maternal Health and Refugee Women, hosted by the Women Political Leaders Global Forum, in partnership with MSD for Mothers, took place in Malta on 20 and 21 March 2017.

The High-Level meeting on Maternal Health and Refugee Women was convened to address the challenges migrant and refugee women face with regard to accessing high quality, affordable, timely and equitable maternal healthcare across Europe. Parliamentarians and Stakeholders attending the High-Level Meeting make the following outcome declaration:

- Maternal Health is an issue of Fundamental Human Rights, which must be applied equally, and equitably, to all;
- EU Member States are committed internationally to the UN Convention on the Rights of the Child, in particular art. 24 (d), which refers to appropriate pre-natal and post-natal health care for mothers;
- EU Member States are committed internationally to the Sustainable Development Goals, in particular to SDG 3.1, stating that the global maternal mortality ratio must be reduced to less than 70 per 100,000 live births by 2030;
- Although great progress has been made to reduce maternal mortality in Europe, there are still significant differences in the

quality of, and access to, maternal healthcare across the Member States of the European Union, including for migrant and refugee women;

- In spite of positive developments, still today, 1 in 10 women in the European Union have no access to maternal health services in the first months of pregnancy, nearly 1800 maternal deaths occurred in Europe in 2015 and 54% of pregnant women seen at Doctors of the World clinics in nine European countries lack access to maternal healthcare and are living in poverty;
- Vulnerable groups such as migrant and refugee women are especially marginalised with regard to accessing maternal healthcare in Europe; taking in to account the root of the problem in countries of destination and transit which needs to be addressed as part of the EU external and development policy actions as well as in conditionality-based policies such as the European Neighbourhood Policy; also ensuring safer transit routes and a health system response to violence that occurs during transit;
- Synergies between Migration and Health Policy Agendas on EU level must be created and reinforced (for example, the inclusion of healthcare in the European Agenda on Migration) as currently these policies operate in silos, in order to create effective and coordinated strategies for the provision of high quality maternal healthcare for migrant and refugee women; better coordination between EU and national level is essential;

Under the Distinguished Patronage of Her Excellency, Marie-Louise Coleiro Preca, the President of Malta, Parliamentarians and Stakeholders attending the High-Level Meeting on Maternal Health and Refugee Women, urge the EU Commissioner on Health and Food Safety and all Members of the Council of Health Ministers of the European Union to:

- Make the health of every mother and her child, regardless of nationality, ethnicity, religion, culture, skills, physical or mental capacity or administrative status, a political priority in Europe;

- Make Europe a role model for high quality, accessible and equitable maternal healthcare, ensuring that maternal health is mainstreamed in all relevant policy discussions and legislation on migration and asylum, respecting the safety and dignity of all migrant and refugee women;
- Guarantee a supranational funding mechanism targeted at EU neighbourhood countries and EU Member States, ensuring the delivery of a free package of standard maternal healthcare developed with the EU Member States for every migrant and refugee woman; the package must take into consideration maternal health services, including ante and postnatal care, mental health care and provide essential supplies. The maternal healthcare package should be financed through a supranational funding mechanism, established through a EU level initiative, with the joint support of EU Member States, Private sector and Civil Society;
- Building on existing initiatives on data collection and expertise on current migration trends in Europe, develop a roadmap on Maternal Health and Migrant and Refugee Women to be implemented at EU level. The focus of the roadmap should be twofold: improved mechanisms and coordination for data collection and research on the maternal healthcare needs of migrant and refugee women, as well as improved data collection for digital medical records serving to improve intra EU-transit, while still protecting personal data privacy as a safeguard towards migration authorities;
- Based on the outcomes of the roadmap, develop a common EU approach using effective and relevant policy instruments to address high quality maternal healthcare in a holistic way, based on need not status, taking into account social determinants of health and ensuring physical, mental and economic safety.
- Launch a supra-national and national level information and awareness-raising campaign on maternal health focusing on migration as well as the benefits of inclusive societies, which targets the general public but also migrant and refugee women specifically, and is adapted for individual EU Member States;

- Ensure support actions for systematic and coordinated training of the health- and social care workforce in Member States, including aspects of cultural competence, and which is co-developed with migrant and refugee women; the training will also optimise the efficient finance and human resource coordination for specific programmes aimed at improving the situation of migrant and refugee women.

H.E. Marie-Louise Coleiro Preca
President of Malta

Silvana Koch-Mehrin
Founder of the Women Political Leaders Global Forum

2017, Malta, High-level meeting on Maternal Health and Refugee Women, Christopher Fearne, Minister for Health, Malta; Vytenis Andriukaitis, EU Commissioner for Health and Food Safety; Marie-Louise Colerio Preca, President of Malta; Silvana Koch-Mehrin, Founder of WPL

ACKNOWLEDGEMENTS

The Women Political Leaders Global Forum (WPL), supported by MSD for Mothers, with mapping, data analysis and reporting facilitated by EY, conducted this study in the last quarter of 2018 and the first quarter of 2019, focusing on maternal mortality and improving access to maternal healthcare for vulnerable pregnant women. The study provides key recommendations to member states as a call to action for ensuring access to maternal healthcare for all women in the EU.

Many people have been instrumental in the realisation of this project. Silvana Koch-Mehrin, Founder and President of WPL, together with the leadership of MSD for Mothers, had the vision to launch this project, under the patronage of H.E. Marie Louise Coleiro Preca, President of Malta. The project was under the guidance of a high-level political board including Xavier Prats-Monné, Director General of DG Santé at the European Commission and Vice-President of the Italian Senate, Linda Lanzilotta.

We are also very grateful to the members of the project's Advisory Panel: France Donnay, Marian Knight, Elena Ateva, Nilsy Desaint and Caroline Hickson, for their valuable insights, knowledge, experience and feedback throughout the project.

2017, Malta, Site Visit to Refugee Open Centre

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EXECUTIVE SUMMARY

This project provides an overview and understanding of the political reality on issues vulnerable pregnant women (VPW) are facing when accessing maternal healthcare, and the challenges governments face to provide it.

The findings have led to the development of key recommendations to EU member states which will act as a stepping stone to integrate into EU policies access to maternal healthcare for vulnerable pregnant women. The results will provide politicians and policymakers with an authoritative benchmark, facilitating better policymaking.

In the sections that follow, we report our findings from: the mapping of maternal health indicators in which the analysis gives us an indication of which countries are falling behind and which policy areas require focus; the analysis of the online survey with political leaders which provides the current policy scenario and region-wide insight into access for vulnerable women and; interviews with policy makers and healthcare professionals for a deeper perspective of implementation and adaptation of policies to improve access.

The following key recommendations have been derived from the mapping, interviews and survey and have been validated by the project's Advisory Panel:

1. Design and implement mandatory training of health professionals in delivering culturally-sensitive care.
2. Design and implement a basic maternal healthcare benefits package for vulnerable pregnant women that covers 1) Information/ advice on family planning, 2) Access to contraception and 3) Antenatal, delivery, neonatal and postnatal care.
3. Ensure and make clear that using maternal healthcare services does not pose the threat of having to leave the country due to one's immigration status.
4. Develop specific indicators to measure maternal health and pregnancy outcomes for vulnerable pregnant women.

The following table provides a summary of the interpretation of the results derived from the mapping, interviews and survey:

TABLE 1	
Interpretation of results	
General	1. Disparity in maternal mortality ratio (MMR) exists between EU countries, with the highest rates in the eastern region being more than tenfold the lowest rate. Several factors are responsible including unbalanced access to adequate care, discriminatory/ xenophobic attitudes towards vulnerable groups in certain regions, and differences in the reliability of reported MMR. 2. MMR follows the overall performance of the health system, e.g. poor primary care and less training of health professionals is associated with a higher MMR. 3. Although the survey results suggest, particularly in the eastern region, that interventions are in place to prevent mortality of VPW, the mapping indicates otherwise (i.e. higher MMR in this region). 4. With the high degree of migration and influx from countries outside the EU, it is a challenging environment to organise maternal healthcare in a way that ensures equal/balanced access for everybody.
Acceptability	1. Cultural sensitivity of care: EU28 performs poorly on the cultural sensitivity of maternal healthcare, for both vulnerable pregnant women (VPW) and non-VPW. 2. VPW are usually asked for proof of identification and address upon accessing health services, which could affect the degree to which they seek care. 3. A higher MMR is often accompanied with a relatively high number of undesired pregnancies, as witnessed by higher postpartum depression and adolescent birth rates.
Approachability	1. Information and awareness about maternal healthcare: Both the survey and mapping demonstrate that public information about entitlements and the use of maternal healthcare is accessible for VPW, especially in the eastern and northern regions. 2. However, VPW seem to be neither aware of, nor knowledgeable about how to use maternal health services. In addition, undocumented migrants and the poor/homeless seem much less exposed to information about maternal healthcare than other vulnerable groups.

EXECUTIVE SUMMARY

TABLE 1	
Interpretation of results	
Availability and facilities	1. Results are inconclusive regarding waiting times for antenatal appointments for VPW, the existence of suitable appointment mechanisms for working VPW and standards that monitor maximum waiting times for antenatal appointments and access to labour rooms.
Affordability	1. Insurance coverage: The mapping shows that, in most countries, approximately 100% of the overall population* is covered by social health insurance. This is confirmed in the survey for VPW in particular. (*vulnerable groups, particularly undocumented VPW, are potentially omitted in these statistics) 2. A free basic benefits package for VPW was the one policy change all interviewees mentioned would have the most impact on improving maternal healthcare. Such a package would be particularly beneficial for undocumented pregnant women, who are required to pay for maternal healthcare in many EU nations. 3. A high MMR is often accompanied by a poor score on the wealth of young women, whereas countries with a low MMR score well on the wealth of young women.
Appropriateness	1. Adherence to national standards: The survey suggests that most governments enforce adherence to a national standard in the care that is delivered to VPW, especially in the eastern region. 2. Results are inconclusive in regards to the extent to which the gestational age at first antenatal check-ups is less than 12 weeks.

INTRODUCTION

Every year, 8 out of 100,000 women in the EU die while giving birth. With an average of 216 women on a global level, the EU seems to be performing rather well.

A more detailed analysis reveals shocking differences between EU countries and cultural subgroups within these countries:
For example: in 2015, the Maternal Mortality Ratio in low income countries was nearly 50 times higher than in high income countries (496 vs. 10 per 100.000 live births)[1].

Moreover, the group of vulnerable (pregnant) women is growing in every country of the EU, in part due to the rapid influx of migrants, many of whom are women of a childbearing age.

Combined with a generally negative attitude towards migrants, the situation for many vulnerable pregnant women has worsened.

At the same time, there exists a lack of comprehensive and reliable data, as well as a lack of both political and professional awareness for this issue. Conducting a benchmark of publicly available indicators regarding maternal health, a survey and interviews among political leaders, we assess the state of maternal healthcare for vulnerable pregnant women in EU28. Finally, we provide clear recommendations to improve maternal healthcare.

"NO WOMAN SHOULD DIE GIVING LIFE"

Mary-Ann Etiebet, MSD for Mothers, WPL Summit 2017

BACKGROUND, AIM AND APPROACH FORTHE STUDY

On a global level, the EU seems to be performing well with regards to maternal mortality rates, however, we face some very troubling numbers and disparities on maternal health:

- 1 in 10 women don't have access to maternal healthcare during the first months of pregnancy [3]
- Approx. 1,800 maternal deaths in EU in 2015[4]
- Vulnerable groups are marginalised
- Significant differences exist in quality & access
- Lack of (scientific) data

Outcome Declaration Malta 2017

- Maternal healthcare: a human right
- UN Convention on the Rights of the Child
- Sustainable Development Goals 2030

The aim of this study is to:

- Raise political awareness and
- Increase political insight into existing systems and current situations
- By providing parliamentarians and policy makers with:
- An authoritative mapping containing publicly available information
- Patterns and lessons by analysing data
- Policy differences, examples of best practice, and areas where

BACKGROUND, AIM AND APPROACH FORTHE STUDY

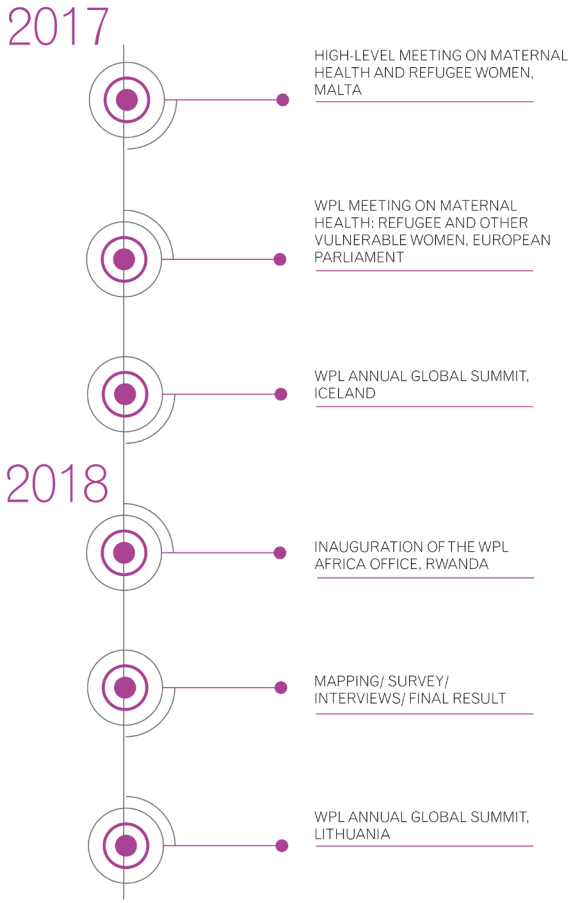
improvement is needed

The study's approach includes:

- 5 dimensions of access to maternal healthcare [8]
- Mapping of public data sources of maternal healthcare in EU28
- Interviews with policy makers and healthcare professionals to provide context for mapping
- Online survey to collect insights from political leaders
- Validation with WPL Advisory Panel

Presentation of final report at WPL Summit 2018 (Vilnius)

POLICY ACTION TIMELINE



DEFINITIONS

Definition of vulnerable pregnant women (VPW):

Pregnant women who experience a distance in accessing maternal healthcare, as refugees/ migrants/ ethnic minorities/ second or third generation immigrants, due to problems in speaking the language and/ or understanding the culture, and/ or due to lack of income, housing or social support.[5,6,7]

This study focuses on the following groups of vulnerable women:

- Undocumented migrants
- Refugees and asylum seekers
- Roma women
- Poor and homeless women
- Migrants from outside the EU, such as third-country nationals
- Adolescent women
- EU migrants

Accessibility of maternal healthcare is defined according to the 5 A's [8]:

1. Approachability
   - Transparency, outreach, information, screening
2. Acceptability
   - Professional values, norms, culture, gender
3. Availability and accommodation
   - Geographic location, accommodation, hours of opening, appointments mechanisms
4. Affordability
   - Direct costs, indirect costs, opportunity costs
5. Appropriateness
   - Technical and interpersonal quality, adequacy, coordination and continuity

MAPPING: OVERALL APPROACH

The mapping* compares EU28 countries on publicly available indicators, grouped by the 5 dimensions of accessibility of maternal healthcare.

Countries covered:
Austria, Belgium, Bulgaria, Croatia, Cyprus, Czech Republic, Denmark, Estonia, Finland, France, Germany, Greece, Hungary, Ireland, Italy, Latvia, Lithuania, Luxembourg, Malta, Netherlands, Poland, Portugal, Romania, Slovakia, Slovenia, Spain, Sweden, United Kingdom

The following sources were used (see also the mapping in Appendix):

Doctors of the World, IOM including MIPEX Health Strand, Alliance for Maternal Healthcare Equality, EC, WHO, OECD, PICUM, IPPF, EPF, White Ribbon Alliance, CIA, Euro-Peristat, Commonwealth Fund, United Nations, UNFPA, UNICEF and European IVF-monitoring (EIM) Consortium for European Society of Human Reproduction and Embryology (ESHRE)

Indicators

A total of 89 publicly available indicators were identified, collected and mapped to nine segments, including the 5 A's of maternal health (see Table 1).

NB:

- In identifying the indicators, emphasis was placed on vulnerable pregnant women as much as possible.
- The sources used and final selection of indicators were validated with the advisory panel.

*Per indicator, the latest available information is included. As such, reality on the ground may deviate. See also the mapping in the Appendix. Please refer to full forms of data sources in the Appendix

TABLE 2

No.	Segment	No. of indicators
1	General: Demographics	14
2	General: Availability and expediture	9
3	General: Maternal health	13
4	Approchability	10
5	Acceptability	16
6	Availability and facilities	7
7	Affordability	5
8	Appropriateness	4
9	Other	10

MAPPING: LIMITATIONS

The limitations of this study include:

- No validation of the data available from public sources was conducted.
- As the data available from public resources was not always disaggregated/profiled to vulnerable groups, the mapping may be of limited value in assessing the status of maternal healthcare specifically for vulnerable (pregnant) women.
- Several indicators (see mapping) shown throughout the analysis of the mapping may lack validity, in particular as follows:

Indicator 25 Maternal Mortality Ratio

- The measurement of MMR continues to pose a major challenge, with underreporting and high diversity of methods as the two key issues (Trends in Maternal Mortality: 1990 to 2015 (2015))

Indicator 19 Population coverage

- Some (vulnerable) groups may be omitted from % covered by social health insurance, resulting in overstated scores.

Indicator 58 Provision of “cultural mediators” or “patient navigators” to facilitate access for migrants

- Data in the mapping deviates from what some NGOs observe in the field, in particular for Greece and Italy.

Indicator 81 Extent to which migrants’ health is regarded as a concern throughout the health system

- Data in the mapping deviates from what some NGOs observe in the field, in particular for Greece and Italy.

Indicator 82 Has government published an explicit plan for action on migrant health?

- Data in the mapping deviates from what some NGOs observe in the field, in particular for Greece and Italy.

SURVEY: OVERALL APPROACH

The overall approach regarding the survey is:

- Survey was sent out to approx. 300 parliamentarians from national ministries
- Responses were collected from 19 EU28 countries
- The average completion rate of responses was 82%
- Respondents typically spent 32 minutes on the survey
- Average age of the respondents was 48
- Most respondents were female (71%)

Please refer to the Appendix for the survey questions

TABLE 3

Gender	Responses	%
Female	25	71%
Male	7	20%
Unknown	3	9%
	35	**100%**

TABLE 4

Country	Responses	Competion Rate
Germany	4	43%
Sweden	3	96%
Lithuania	3	96%
Greece	3	64%
Latvia	2	98%
Estonia	2	97%
Slovenia	2	96%
Czechia	2	94%
Croatia	2	79%
Belgium	2	67%
Romania	2	61%
Italy	1	96%
Austria	1	96%
Luxemburg	1	96%
France	1	94%
Finland	1	94%
Hungary	1	94%
Portugal	1	93%
Malta	1	74%
	35	**82%**

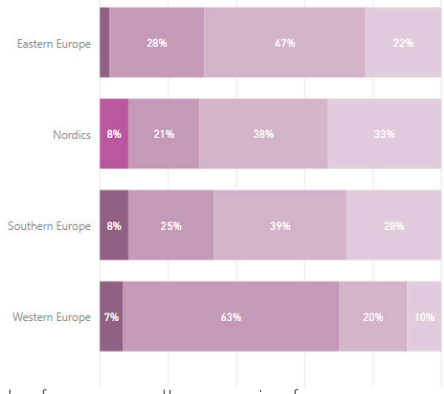
The survey results were analysed from two main perspectives:

- Overall EU results per question, categorised by the 5 dimensions of maternal healthcare
- Overall results for each of the 5 dimensions of maternal healthcare, categorised by region

TABLE 5

Region	Country
Eastern Region	Czech Republic
	Estonia
	Hungary
	Lithuania
	Romania
	Slovenia
	Latvia
Northern Region	Finland
	Sweden
Southern Region	Greece
	Croatia
	Portugal
	Italy
	Malta
Western Region	Belgium
	Luxemburg
	Austria
	France
	Germany

Region specification of included countries



Example of survey results per region for dimension Acceptability

INTERVIEWS: OVERALL APPROACH

General information and how questions were formulated:

- WPL conducted interviews with policy makers and healthcare professionals, to gain a better insight into live political topics and provide context for the interpretation of conclusions.
- In total, 13 interviews were conducted (see appendix for list of interviewees).

Analysis

Each interview question was analysed as follows:

- Qualitative summary of the main findings
- Where applicable:
- Assessment of the degree of coherence in responses (e.g. whether recurring themes arise in the responses)
- Remarkable insights (e.g. outliers) and country specific findings

ASSESSMENT OF RESULTS

EU28 MAPPING ON MATERNAL HEALTHCARE

COUNTRIES WITH HIGHEST REPORTED MMR

TABLE 6	Maternal Health		Affordability			Availability and facilities	Acceptability	
Country	MMR (Number of deaths per 100.000 live births)	Neonatal mortality (Early -day 0-6-)	Self-reported unmet needs for medical examination (Too expensive)	Females aged 15-29 at risk of poverty or social exclusion	Females aged 16-29 who cannot afford o spend a small amount of money each week n themselves	Self-reported unmet needs for medical examination by detailed reason (Too far to travel), females (16 years and over)	Training and education of health service staff on needs of migrants	Provisio "cultura mediato or "pati navigat facilitat cess for migr
Romania	31	3,7	7%	44%	50%	0,7%	At local or organisational level	Not avai
Latvia	18	2,5	6%	23%	17%	0,6%	Neither of these	Not avai
Hungary	17	2,6	1%	30%	24%	0,4%	Neither of these	Not avai
Differentiation	High	High	High	Medium	High	Low	Low	Low

See Appendix for full indicator descriptions

- See chapter 3 for limitations in regards to the mapping

			Migrant health		General		
on of al ors" ent ors" to eac- rants	Estimates of contraceptive prevalence (modern methods) among married or in-union women aged 15 to 49	Availability of "culturally competent" or "diversity-sensitive" services	Has government published an explicit plan for action on migrant health	Extent to which migrants' health is regarded as a concern throughout the health system	% covered by social health nsurance	Adolescent birth rate	Severe housing deprivation rate (females aged16-29)
ilable	54 %	Standards or guidelines exist	Only ad hoc policies	No systematic attention at all	86%	39	26%
ilable	60 %	Neither standards nor monitoring by authority	No policy measures	No systematic attention at all	100%	15	18%
ilable	68 %	Standards or guidelines exist	Only ad hoc policies	No systematic attention	95%	20	21%
	High	Medium	High	Low	Medium	High	High

REPORTED MMR PATTERNS

TABLE 7	Maternal Health		Affordability		Acepta
Country	MMR (Number of deaths per 100.000 live births)	Neonatal mortality (Early -day 0-6-)	Self-reported unmet needs for medical examination (Too expensive)	Females aged 16-29 who cannot afford to spend a small amount of money each week n themselves	Provisi "cultur or "pati to facili for migr
Romania	High	High	High	High	Low
Latvia	High		High		Low
Hungary	High	High			Low
Poland	Low	High			
Czechia	Low	Low			
Austria	Low			Low	
Italy	Low		High		Medium
Greece	Low		High	High	Low
Sweden	Low	Low		Low	Medium
Finland	Low	Low		Low	Medium
Differenciation	High	High	High	High	Low

bility		General			
on of al mediators" ent navigators" tateaccess rants	Prevalence of postpartum depression (% of total births)	Severe housing deprivation rate (females aged 16-29)	Birth rate	Birth rate	Life expectancy at birth (female)
	High	High	Low	High	Low
		High		High	Low
		High	Low	High	
	Low				
			Low		Low
			Low		
			High		
	Medium	High	Low	High	Medium

A HIGH MMR IS OFTEN ACCOMPANIED WITH A POOR SCORE ON

- Provision of cultural mediators to facilitate access to healthcare
- Prevalence of postpartum depression
- Housing deprivation rate
- Adolescent birth rate a high ABR but the overall birthrate is relatively low, which could be reported as high amount of undesired pregnancies
- Affordability of medical examination

A LOW MMR IS – COMPARED TO COUNTRIES WITH A HIGH MMR – OFTEN ACCOMPANIED WITH A

- Better score on wealth (i.e. housing deprivation, risk of poverty or social exclusion [except for Greece] and money for young females)
- Better score on adolescent birth rate (i.e. lower)
- Better score on provision of cultural mediators
- Slightly better score on postpartum depression and life expectancy
- Not better/very different on availability of culturally sensitive services, smoking and drinking during pregnancy.

2017, Belgium, WPL Meeting on Maternal Health: Refugee and other Vulnerable Women, Xavier Prats Monné, Director General of DG Santé; Marie-Louise Colerio Preca, President of Malta; Gesine Meissner, Member of European Parliament; Silvana Koch-Mehrin, Founder of WPL

INDICATORS EU28 COUNTRIES GENERALLY SCORE WELL ON

- Sanctions against helping undocumented migrants: In 19 EU countries, there are no legal sanctions or other pressures against helping undocumented migrants
- Information concerning entitlements and use of health services is often disseminated via more than 1 method (e.g. websites, brochures and classes)
- Percent of population covered by social health insurance is often 100%
  - Some (vulnerable) groups may be omitted from % covered by social health insurance, resulting in overstated scores.
- Heavy episodic drinking among lower educated women aged 15-29 is generally below 3%, except for a few outliers like Denmark

INDICATORS EU28 COUNTRIES GENERALLY SCORE POORLY ON

- Explicit plan for action on migrant health:
  - Only Ireland scores very well, having both a published plan as well as policies to support the plan
- Cultural mediators:
  - Only Belgium guarantees mediators across the system and in major immigrant areas
- Availability of culturally-competent or diversity-sensitive services
  - In most countries there are no standards for culturally-sensitive health services, let alone a monitoring system
- Extent to which migrants' health is a concern throughout the health system:
  - Only in Sweden, the UK and Ireland is there a clear commitment to equitable care

INDICATORS EU28 COUNTRIES GENERALLY SCORE WELL ON

TABLE 8	Acceptability	Approachability	General	
Country	Any sanctions against helping undocumented migrants	Information for migrants concerning entitlements and use of health services	% Covered by social health insurance	Heavy episodic drinking among lower educated women aged 15-29
Ireland	No legal sanctions or other pressures	> 1 method	100%	8%
Malta	No legal sanctions or other pressures	> 1 method	100%	7%
Sweden	No legal sanctions or other pressures	> 1 method	100%	6%
Czechia	No legal sanctions or other pressures	> 1 method	100%	1%
Portugal	No legal sanctions or other pressures	> 1 method	100%	1%
Latvia	No legal sanctions or other pressures	> 1 method	100%	0%
Slovenia	Only organisational sanctions	> 1 method	100%	3%
Denmark	No legal sanctions or other pressures	1 method	100%	11%
Finland	No legal sanctions or other pressures	1 method	100%	5%
Italy	No legal sanctions or other pressures	1 method	100%	0%

INDICATORS EU28 COUNTRIES GENERALLY SCORE WELL ON

TABLE 8	Acceptability	Approacha-	General	
Country	Any sanctions against helping undocumented migrants	Information for migrants concerning entitlements and use of health services	% Covered by social health insurance	Heavy episodic drinking among lower educated women aged 15-29
UK	Only organisational sanctions	1 method	100%	5%
Germany	Legal sanctions	1 method	100%	8%
Croatia	Legal sanctions	1 method	100%	1%
France	No legal sanctions or other pressures	> 1 method	100%	
Austria	No legal sanctions or other pressures	> 1 method	100%	2%
Spain	No legal sanctions or other pressures	> 1 method	100%	2%
Netherlands	Only organisational sanctions	> 1 method	100%	
Belgium	Only organisational sanctions	> 1 method	99%	1%
Luxemburg	Only organisational sanctions	> 1 method	95%	1%
Hungary	No legal sanctions or other pressures	None	95%	0%

INDICATORS EU28 COUNTRIES GENERALLY SCORE WELL ON

TABLE 8	Acceptability	Approacha-	General	
Country	Any sanctions against helping undocumented migrants	Information for migrants concerning entitlements and use of health services	% Covered by social health insurance	Heavy episodic drinking among lower educated women aged 15-29
Estonia	No legal sanctions or other pressures	> 1 method	94%	0%
Slovakia	No legal sanctions or other pressures	1 method	94%	0%
Lithuania	Only organisational sanctions	1 method	92%	0%
Poland	No legal sanctions or other pressures	> 1 method	91%	1%
Bulgaria	No legal sanctions or other pressures	1 method	88%	0%
Romania	No legal sanctions or other pressures	> 1 method	86%	2%
Greece	Legal sanctions	1 method	86%	0%
Cyprus	No legal sanctions or other pressures	>1 method	83%	0%
Differentiation	Low	Low	Medium	High

INDICATORS EU28 COUNTRIES GENERALLY SCORE POORLY ON

TABLE 9	Migrant health		Acceptability	
Country	Extent to which migrants' health is regarded as a concern throughout the health system	Has government published an explicit plan for action on migrant health	Provision of "cultural mediators" or "patient navigators" to facilitate access for migrants	Availability of "culturally competent" or "diversity-sensitive" services
France	No systematic attentio at all	No policy measures	On a smaller or ad hoc basis	Neither standards nor monitoring
Germany	No systematic attention at all	No policy measures	On a smaller or ad hoc basis	Standards or guidelines exist
Sweden	Commitment to equitable care for migrants present in all providers/agencies	No policy measures	On a smaller or ad hoc basis	Neither standards nor monitoring
Finland	No systematic attention at all	No policy measures	On a smaller or ad hoc basis	Standards or guidelines exist
Slovenia	No systematic attention at all	No policy measures	Not available	Neither standards nor monitoring
Luxembourg	No systematic attention at all	No policy measures	On a smaller or ad hoc basis	Neither standards nor monitoring
Poland	No systematic attention at all	No policy measures	Not available	Neither standards nor monitoring
Belgium	No systematic attention at all	No policy measures	Guaranteed across the system/ major immigrant areas	Standards or guidelines exist
Italy	Migrant health only a concern in specialized providers/ agencies	No policy measures	On a smaller or ad hoc basis	Standards or guidelines exist

INDICATORS EU28 COUNTRIES GENERALLY SCORE POORLY ON

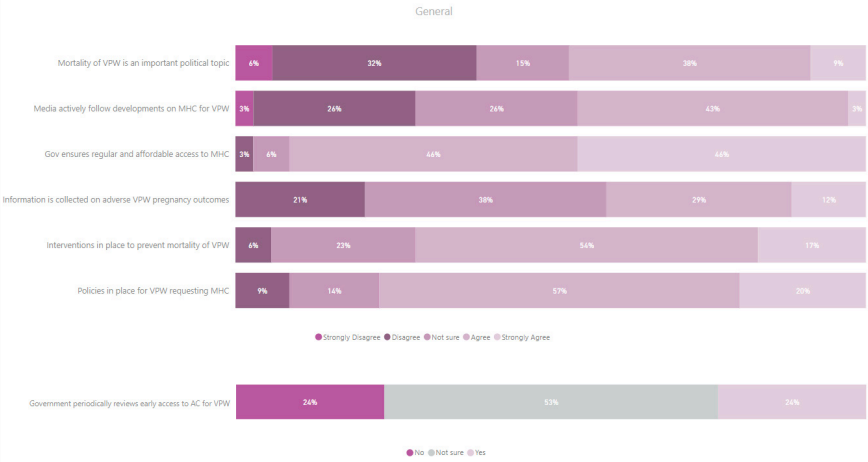
TABLE 9	Migrant health		Acceptability	
Country	Extent to which migrants' health is regarded as a concern throughout the health system	Has government published an explicit plan for action on migrant health	Provision of "cultural mediators" or "patient navigators" to facilitate access for migrants	Availability of "culturally competent" or "diversity-sensitive" services
Lithuania	No systematic attention at all	No policy measures	On a smaller or ad hoc basis	Neither standards nor monitoring
Bulgaria	No systematic attention at all	No policy measures	Not available	Neither standards nor monitoring
Latvia	No systematic attention at all	No policy measures	Not available	Neither standards nor monitoring
Greece	No systematic attention at all	No policy measures	Not available	Neither standards nor monitoring
Slovakia	No systematic attention at all	No policy measures	On a smaller or ad hoc basis	Neither standards nor monitoring
UK	Commitment to equitable care for migrants present in all providers/agencies	Only ad hoc policies	Not available	Standards or guidelines exist
Spain	Migrant health only a concern in specialized providers/agencies	Only ad hoc policies	Not available	Neither standards nor monitoring
Romania	No systematic attention at all	Only ad hoc policies	Not available	Standards or guidelines exist

INDICATORS EU28 COUNTRIES GENERALLY SCORE POORLY ON

TABLE 9	Migrant health		Acceptability	
Country	Extent to which migrants' health is regarded as a concern throughout the health system	Has government published an explicit plan for action on migrant health	Provision of "cultural mediators" or "patient navigators" to facilitate access for migrants	Availability of "culturally competent" or "diversity-sensitive" services
Czechia	No systematic attention at all	Only ad hoc policies	On a smaller or ad hoc basis	Neither standards nor monitoring
Croatia	No systematic attention at all	Only ad hoc policies	Not available	Neither standards nor monitoring
Portugal	No systematic attention at all	Only ad hoc policies	Not available	Neither standards nor monitoring
Estonia	No systematic attention at all	Only ad hoc policies	Not available	Neither standards nor monitoring
Hungary	No systematic attention at all	Only ad hoc policies	Not available	Standards or guidelines exist
Cyprus	No systematic attention at all	Only ad hoc policies	Not available	Neither standards nor monitoring
Ireland	Commitment to equitable care for migrants or ethnic minorities present in all providers/agencies	Both a plan and supporting policy	Not available	Standards or guidelines exist
Differentiation	High	Medium	Low	Low

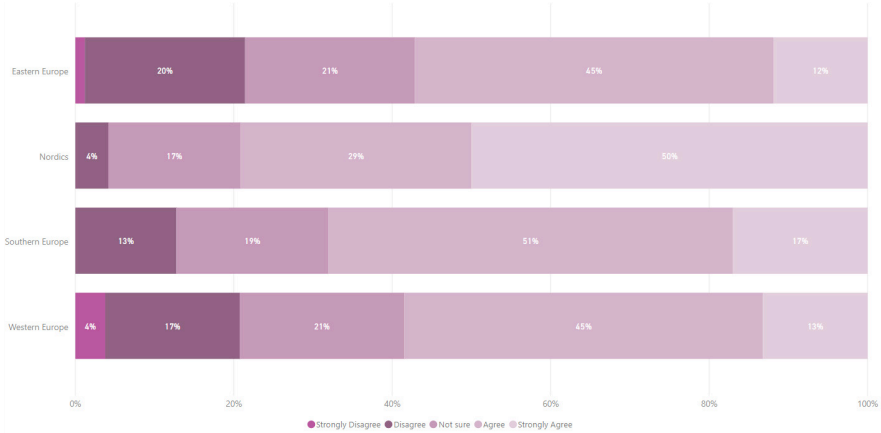
ASSESSMENT OF RESULTS: EU28 SURVEY ON MATERNAL HEALTHCARE

GENERAL

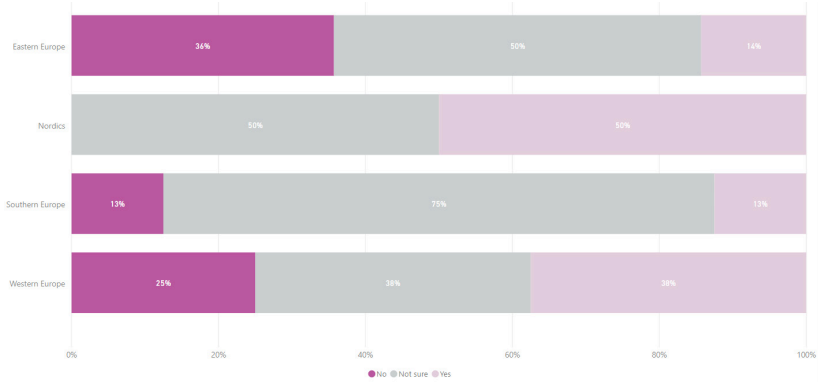


- 38% (n=13) of all respondents (strongly) disagreed that mortality of vulnerable pregnant women (VPW) is an important political topic.
- 71% (n=25) of respondents (strongly) agreed that interventions are in place to prevent maternal mortality of VPW. Remarkably, 3 out of 4 respondents from Romania, Hungary and Latvia also agreed, deapite MMR being higher there.

GENERAL BY REGION



GOVERNMENT PERIODICALLY REVIEWS EARLY ACCESS TO AC FOR VPW

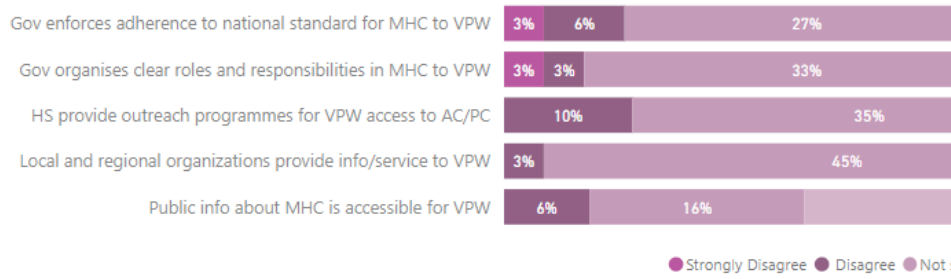


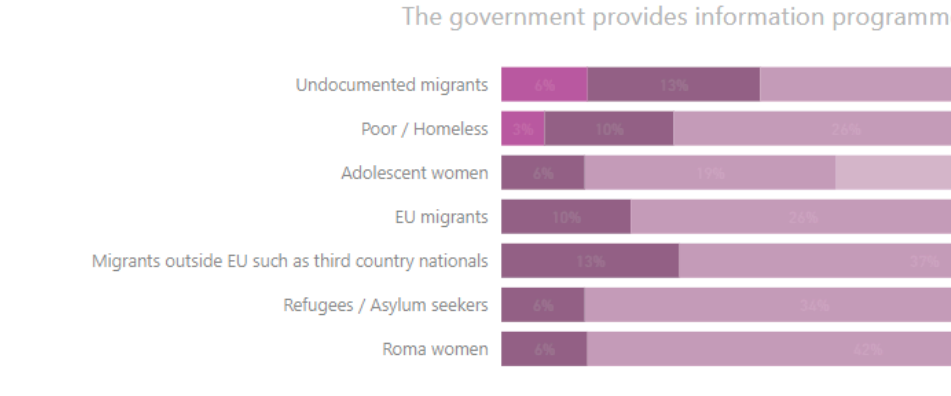
- 21% of respondents in the eastern region (n=18) as well as the western region (n=11) (strongly) disagreed on general aspects of maternal healthcare, in particular:
  - Mortality of VPW being an important political topic (n=10)
  - Media actively following developments on maternal healthcare for VPW (n=7)
  - Collection of information about adverse pregnancy outcomes (n=6)
- Notably, 50% of respondents from the eastern region (strongly) disagreed to mortality of VPW being an important political topic.
- On the contrary, 79% of the respondents in the northern region (strongly) agreed with the aformentioned general questions.

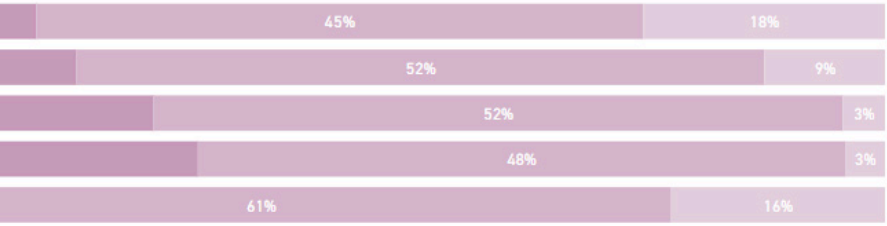
Other findings:

- In the eastern region about 79% (n=11) of the respondents (strongly) agreed to having interventions in place to prevent mortality of VPW, compared to 71% across all regions.
- 71% of the respondents in the southern region strongly agreed on mortality of VPW being an important political topic, compared to 48% across all regions.
- 36% of the respondents in the eastern region disagreed that the government carried out a periodic cost-effectiveness analysis on providing early access to antenatal care (AC) for VPW.
- These figures are more positive in the northern region, where none of the respondents disagreed. (The number of responses from this region was limited compared to the other regions.)

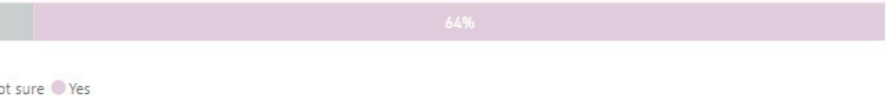
APPROACHABILITY





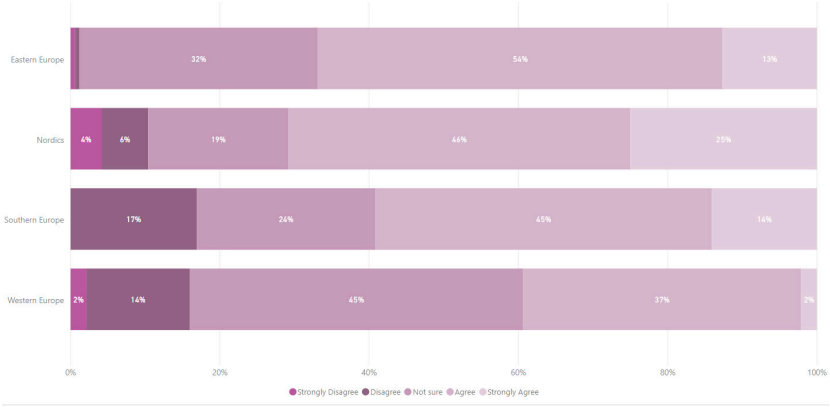


es on how to access the maternal health services to:

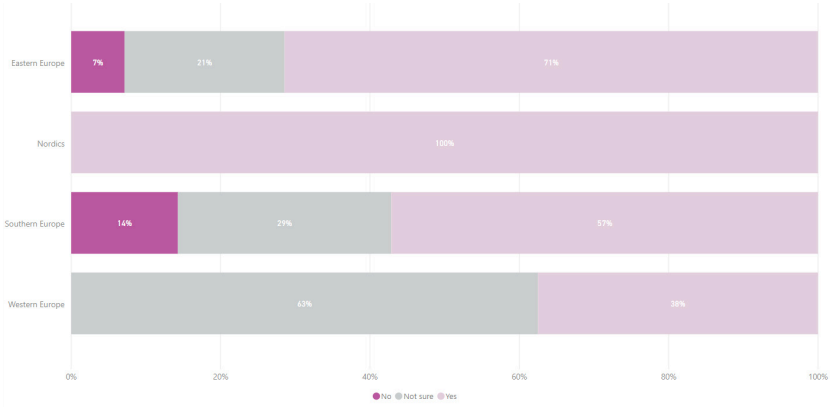


- According to roughly 75% (n=24) of respondents, public info about maternal healthcare is accessible for VPW.
- Moreover, the majority of respondents (63%) state that their government demands adherence to a national standard care to VPW.
- Within the vulnerable groups, undocumentend migrants and the poor/homeless are least exposed to information programmes on accessing maternal health services: respectively 19% and 13% (strongly) disagree with the statement.
- Adolescent women fare better, with 75% of the respondents stating that the government provides information programmes.
- Generally, public information about maternal health care services and professionals is readily available in at least one non-native language (21 out of 33 respondents indicated 'Yes').

APPROACHABILITY BY REGION

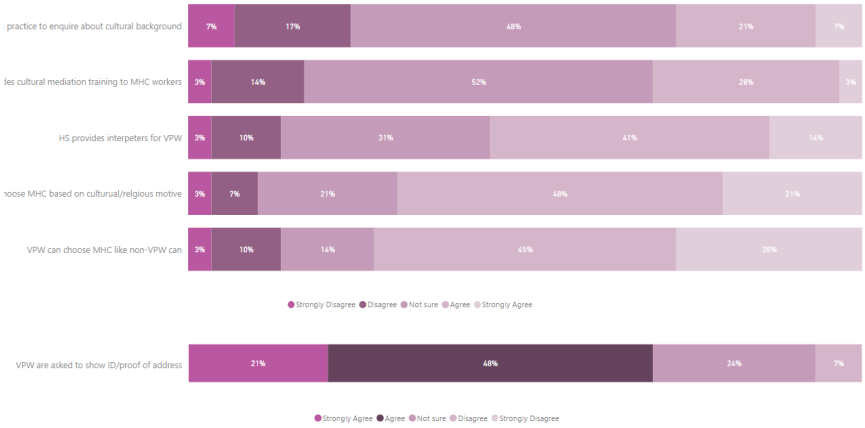


PUBLIC MHC INFO AVAILABLE IN ≥ NON-NATIVE LANGUAGE



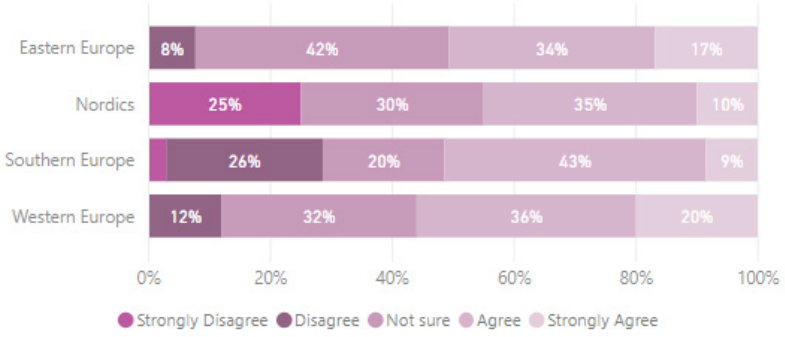
- Among the regions, the eastern region and the northern region lead in terms of the accessibility of public information by VPW (none of the respondents disagreed and for both regions, nearly 30% of respondents strongly agreed with the statement.
- Also, about 79% (n=11) of respondents from the eastern region (strongly) agreed that the government enforces adherence to a national standard for MHC to VPW, compared to 63% overall.
- In contrast, in both Western and the southern region, approximately 16% disagreed with the statement about accessibility of public information.
- Additionally, in the eastern region, reportedly all the vulnerable groups are targeted with information programmes, except for undocumented migrants, where only 7% of respondents (strongly) disagreed that the government provided such programmes.
- This is in stark contrast to the western region, where 25% (n=13) of the responses were '(strongly) disagree' across all vulnerable groups.
- In the southern region, information programs are mostly targeted at Roma women and refugees/asylum seekers, with nearly 75% (strongly) agreeing and nobody disagreeing.
- In the Nordic region, all respondents agreed that public information about maternal healthcare services and professionals is readily available in at least one non-native language. 7% and 14% of the respondents in the eastern region and the southern region respectively, disagreed on the availability of such information in at least one non-native language.

ACCEPTABILITY

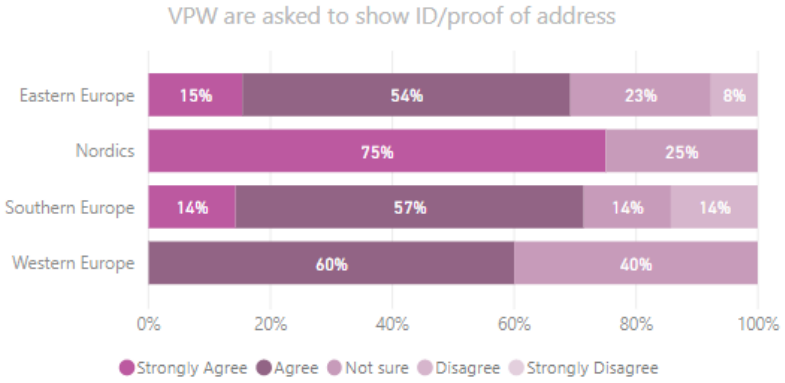


- 24% of respondents (strongly) disagreed that it is common practice to enquire about cultural background of patients with the aim to deliver a tailored care.
- Uncertainity looms over the statement if health system provides cultural mediation training to MHC workers (with over half of the respondents being not sure).
- Around 70% of respondents (strongly) agreed that VPW can choose MHC to the same extent as non-VPW, and they can make choices in the care received, based on cultural or religious motives (e.g. choosing a female doctor).

ACCEPTABILITY BY REGION

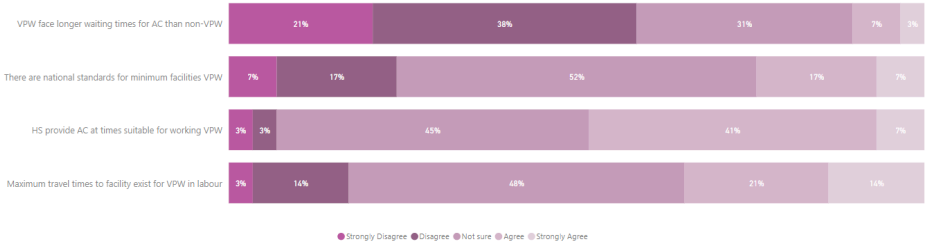


- Both the northern region and the southern region show a high (strong) disagreement rate on acceptability parameters (25% and 29% respectively).
- Over 75% of the respondents in Western and the eastern region (strongly) agreed that VPW can make choices about their care based on cultural/ religious motives.
- In the northern region and the southern region, VPW can choose their health services in the same way as non-VPW can, as (strongly) agreed by about 75% of respondents.
- Among all regions, the western region and the northern region garnered the highest (strong) agreement rate regarding health services offering interpreters for VPW (60% and 75% respectively).



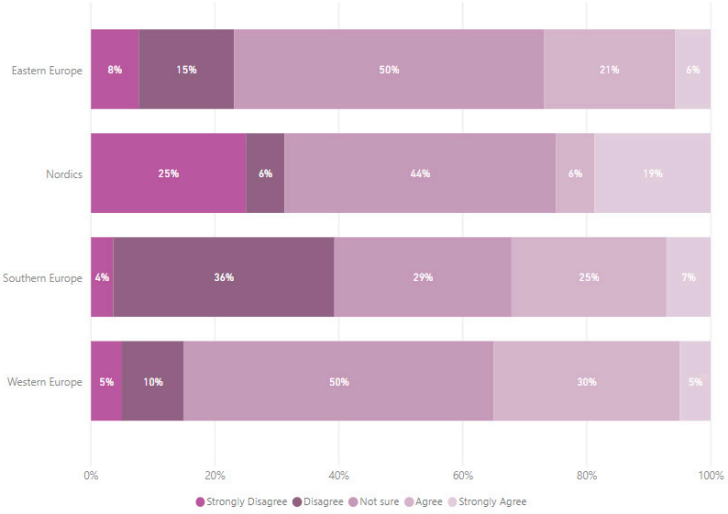
- In all regions, VPW are generally asked to show ID/proof of address when accessing health services (around 70% (strongly) agrees).

AVAILABILITY AND FACILITIES



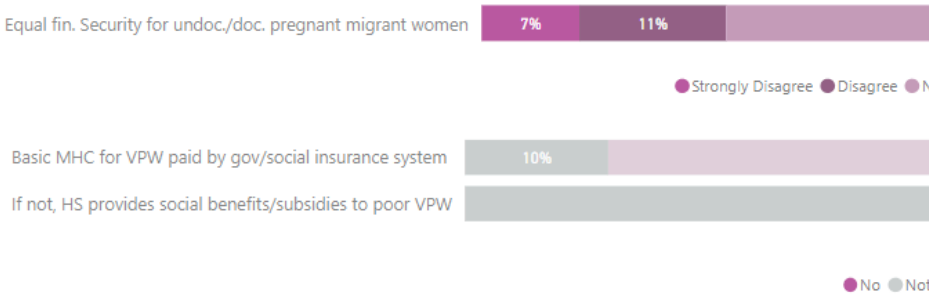
- About 59% (n=17) of respondents (strongly) disagreed that VPW face longer waiting times for antenatal appointments as compared to non-VPW. The health services provide antenatal appointments at times suitable for working VPW who are unable to take leave, a statement (strongly) agreed to by 48% (n=14) of respondents.
- 35% (strongly) agreed that minimum requirements exist on travel time towards a healthcare facility for VPW in labour.

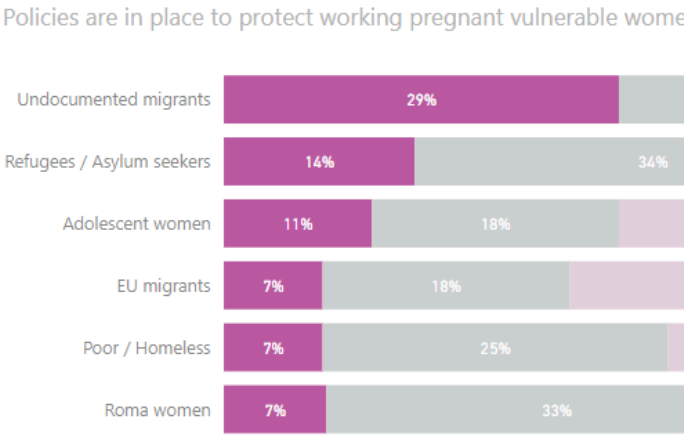
AVAILABILITY AND FACILITIES BY REGION



- The southern region and the northern region show the highest disagreement rate (between 31-40% of respondents (strongly) disagreeing) on aspects of availability and facilities.
- This is in particular the case on whether VPW face longer waiting times than non-VPW (61-85% (strongly) disagrees).

AFFORDABILITY

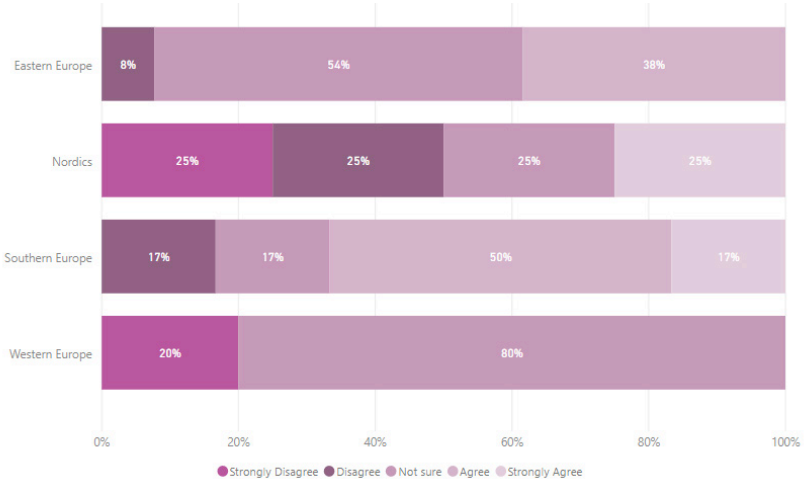





46%
29%
7%
lot sure
Agree
Strongly Agree
90%
71%
29%
sure
Yes
n from losing their job or receiving a pay-cut from employers
50%
21%
52%
71%
75%
68%
59%
No
Not sure
Yes

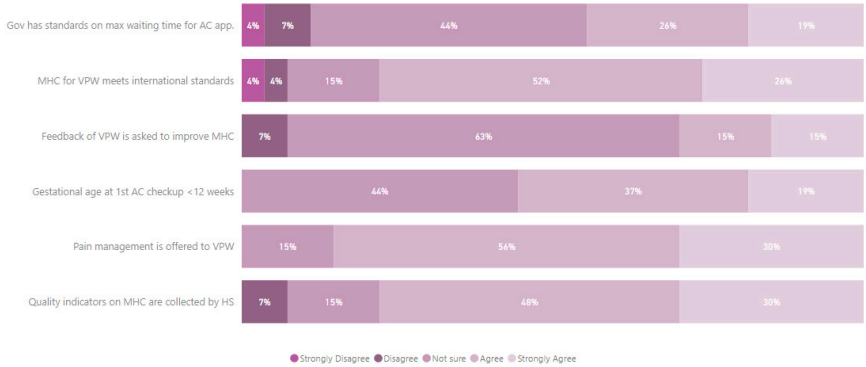
- About 36% of respondents (strongly) agree that undocumented pregnant migrant women receive the same financial security for accessing MHC as documented pregnant migrant women.
- Notably, 90% of respondents (strongly) agreed that basic MHC for VPW is paid through government/ social insurance systems.
- Of all the working VPW groups, adolescent women and EU migrants are best protected from losing their job or receiving a pay-cut (more than 70% answered 'Yes' for these groups).

AFFORDABILITY BY REGION



- In the northern region, about half of the respondents (strongly) disagreed that undocumented pregnant migrant women receive the same financial security for accessing MHC as documented pregnant migrant women.
- In the western region, the majority of respondents (80%) were uncertain regarding equal financial security for VPW.
- Among all regions, the southern region has over 67% of respondents in (strong) agreement of equal financial security between undocumented and documented pregnant migrant women.

APPROPRIATENESS



- 56% of respondents (strongly) agreed that gestational age at 1st antenatal care checkup is <12 weeks, with the remainder not being sure.
- Regarding offering pain management, about 86% of the respondents (strongly) agreed that pain management is offered to VPW, with the remainder being uncertain.
- In the northern region and the southern region, 100% of respondents (strongly) agreed that pain management is offered.
- However, in the western region and the eastern region, some of the respondents were uncertain (40% in the western region and 17% in the eastern region).


Eastern Europe
28%
47%
22%
Nordics
8%
21%
38%
33%
Southern Europe
8%
25%
39%
28%
Western Europe
7%
63%
20%
10%
0%
20%
40%
60%
80%
100%
Strongly Disagree
Disagree
Not sure
Agree
Strongly Agree

ASSESSMENT OF RESULTS: INTERVIEWS

Question 1: Where do you think Europe stands currently in terms of providing access to maternal healthcare for vulnerable pregnant women (VPW)?

"Despite multiple steps taken to bring a positive change, we are not nearly close to an acceptable level. We know what works, what is necessary for good basic healthcare for every woman, so we should act on it. The EU countries should be aware of this responsibility for both women in the EU and outside EU."

- While many European countries have the lowest rates of maternal death in the world and average EU performance is fairly good, serious disparities remain in access to maternal healthcare:
  - Roma women have twice as high a complication rate during pregnancy as non-vulnerable women. Particularly in Bulgaria, their abortion rate is 50% higher than non-vulnerable women.
  - Migrants are at twice a higher risk than average women in the western region.
- What is problematic is that member states often have country-specific policies on social protection, health, and vulnerable groups. EU directives do set out a goal that must be achieved by all members but it is up to each country to devise their own laws and policies to reach these goals.
- Moreover, migration is a hot topic in its link to the fight against terrorism but not specifically in terms of maternal health. As such, migrants' perceived association with terrorism has led to narrowmindedness and differential treatments towards migrants by healthcare practitioners.
- Currently, health systems are usually more migrant-friendly in countries strongly committed to equal rights and opportunities,

but are rarely inclusive or responsive in countries with restrictive integration policies.

- Where the number of migrants is low, little to nothing may be done to adapt service delivery to their needs.
- Due to lack of knowledge/awareness, cultural differences and language barriers, VPW are unable to express themselves, unwilling to be honest about disparities in the care-rooms and uncomfortable in asking for help.

Coherence:

All respondents agreed that access to healthcare for vulnerable women must be improved.

COUNTRY-SPECIFIC INFORMATION

1. The national law in **Cyprus, Finland, Lithuania, Luxemburg,** and **Poland** make no entitlements to maternity care
2. In **Belgium,** access for **vulnerable pregnant women is well regulated**. There are different systems to provide access even for women who don't have any health insurance and to ensure that the treatment is paid for by the government
3. In **Poland**, **refugees/migrants** receive the care they need for free, including translators and free choice of doctor
4. In **Malta**, undocumented pregnant women (UPW) can apply to "core health benefits" which is an **exemption to pay**
5. In **France**, UPW have increasing **difficulties to access free antenatal care clinics**
6. In **Switzerland**, UPW who cannot afford the cheapest health insurance (€300/month) **have to pay themselves**
7. In the **UK, antenatal care, delivery and postnatal care are not free for UPW.** are billed for the full course of care throughout pregnancy, which is around €7,000 (without complications)
8. In the **Netherlands, UPW are often urged to pay straight away in cash** for antenatal, delivery and postnatal care and are pursued by debt collectors

Question 2: Despite most EU countries having the lowest maternal mortality rates in the world, VPW have low access rates to maternal healthcare, meaning their care is inadequate. How do we work on improving that?

- To overcome challenges and barriers of access, you need legislation and investment. With regard to the latter, that means a long-term investment that is not only about money but also about raising awareness and promoting well-being in the community.
- There should be a much more forceful lobby to solve injustice and inequality issues.
- Share best practices and guidance within the EU.
- Conduct outreach activities to reach vulnerable women in their own communities and address barriers. Vulnerable women must be actively engaged to increase their understanding of the services available.

COUNTRY-SPECIFIC INFORMATION	
Greece	**Belgium**
- It is very important that all the people in the community, not only women, have access to information and education regarding maternity related matters. - Social services are needed to overcome language and income barriers in accessing maternal care. It is very difficult for someone who is not from Greece to contact or communicate with the local authorities and doctor without an interpreter.	- A project will be launched to ensure that all partners (potentially) dealing with VPW meet on a regular basis and develop a standard procedure on treating VPW: 1. Establish one point of information for VPW 2. Appropriate care path for VPW

Question 3: There is a variation in the maternal mortality rates seen for vulnerable women across European countries. Why is that?

Uneven access to adequate healthcare

The differences in maternal mortality rates of vulnerable women in the EU are most probably the result of unbalanced access to adequate healthcare and uneven accessibility of information (e.g. access and information regarding Sexual and Reproductive Health and Rights (SRH)).

Correlation with variation in health systems in general

There is a strong correlation between the overall status of healthcare systems and maternal healthcare. For instance, poor primary care and poorly trained health professionals are associated with higher Maternal Mortality Rate (e.g. in Bulgaria and Romania).

Diversity in both health policies and population

In the EU, countries often have their own specific health policies. In addition, the EU population is comprised of many different groups, and there is a high degree of migration within member states as well as an influx from countries outside the EU. This combination makes it challenging to organise public health in a manner that ensures proper access for everybody.

Deviations in data reliability

Differences in MMR could arise due to deviations in data reliability. Data provided by the general vital statistics are not considered sufficient to gauge MMR. The monitoring of maternal mortality requires collection of information on individual cases, which is not consistently done in the EU.

Political attendance and sensitivity

"If you don't think that the vulnerable groups are important (such as Roma or migrants), they don't get any specific attention and are not considered in the topic of maternal healthcare." Discrimination and xenophobia play a very important role here.

Ability to afford expenditure on public health

Richer countries may be able to spend more on public health, leading to lower mortality rates. On the other hand, each EU member is sufficiently resourced to establish access to maternal healthcare for all women.

Question 4: Name one policy change that would have the most impact on improving access to maternal healthcare for VPW

- Governments should implement a basic benefits package that includes free access to contraception, information on birth planning, antenatal and postnatal care for vulnerable pregnant women at all public health facilities.
- Teach women and adolescent girls their rights, focusing not only on women but also on men, boys, and families so everybody understands the values and rights
- Launch antipoverty and social programmes to improve empowerment of specific vulnerable groups
- Mandatory training for healthcare professionals on culturally sensitive care
- Give patients free choice of doctor
- Member states should offer systematic prenatal follow-up for all pregnant women, and for their unborn children, in accordance with WHO recommendations
- Launch EU-wide educational campaign on immigrant health and inclusive society, which will help change the mentality and perception that public servants have about vulnerable groups.
- Policy measures that support a lifelong approach to maternal health, thus focusing on a healthy start to life and targeting the needs of people at critical periods throughout their lifetime – not only at the time when they are pregnant or at delivery.

Coherence:

- All answers mentioned providing free maternal healthcare as an essential policy.
- 4 out of 12 responded around the theme of non-discrimination and promoting a more inclusive society.

Question 5: Name the biggest challenge we face in bringing about policy change to improve access to maternal healthcare for VPW

Most of the responses are related to the political sphere in the EU:

- Political ownership
  - Without political will, access to maternal healthcare will not improve, even with EU directives and the appropriate legal frameworks.
  - Governments must simply honour their obligations in regards to treaties they have signed.
- Negative political/societal sentiment towards (new arrivals of) migrants and refugees
  - Improved access to maternal healthcare for VPW may be prevented by the generally negative opinion about migrants and refugees.
  - For example, the rise of right-wing populists could influence governments' and societies' stance on protecting vulnerable groups and may dismantle solidarity schemes.
- Alignment between parties
  - Failing to align all parties in the EU, given also the disparity in health policy among member states.

Other challenges that were mentioned are:

- Lack of awareness among vulnerable groups about the services that are available, in particular due to the distance to the healthcare system.
- Lack of adequate data about the number of migrants and refugees.

Coherence:

5 out of 10 responses referred to political factors as the biggest challenge

Remarkable insight

- The major challenge is that maternal health is looked at very narrowly in terms of antenatal and postnatal care.
- Instead, maternal health should be looked at from the Sexual and Reproductive Health and rights (SRH) perspective, including all aspects of female health throughout all stages of life.

"Good SRH is a state of complete physical, mental and social well-being in all matters relating to the reproductive system. They must be informed and empowered to protect themselves from sexually transmitted infections. And when they decide to have children, women must have access to services that can help them have a fit pregnancy, safe delivery and healthy baby. Every [woman] has the right to make their own choices about their sexual and reproductive health." - United Nations Population Fund (UNFPA)[9]

Question 6: Where do you see Europe in 5 years regarding access to maternal healthcare for vulnerable pregnant women?

Positive scenario

- In five years, Europe will have made maternal health care a policy priority, have further increased the access to maternal healthcare for all pregnant women, with lower maternal mortality rates as a consequence.
- Member states will have translated the body of international and European legislation into concrete national rights. Access and accessibility will have been improved significantly with monitoring or observatory mechanisms.
- There will be free access to sexual and reproductive healthcare as well as a firewall for undocumented women will be enshrined into national laws. With a significant push in the next legislature, real SRH can be achieved within 8 years.
- The tone in Europe regarding immigrants will have changed and, by means of a proper integration strategy, vulnerable groups will be included in policy planning.
- Investments will have been made with the aim of a healthy future in which not just MMR but also maternal morbidity and SRH are improved. Oversight boards are in place that hold governments accountable with continuous advocacy and reporting.

Negative scenario

- SRH face conservative sentiment and Euroscepticism, overall restricting fundamental sexual and reproductive healthcare rights (such as in Poland).
- VPW will have limited access to maternal health due to the ramping populism, xenophobia, and retrograde pressure on women rights.

Overall, with the approaching end of Europe's 2020 strategy, it is important to advocate and reach out for the next steps to ensure the implementation of the Sustainable Development Goals (SDGs), in which migration and migrant health are included.

Coherence:

3 out of 9 responses (respondents representing Belgium, European region and Iceland) were completely positive and optimistic.
6 responses were positive with advice/recommendations (Belgium [1 response], Greece [1 response] and European region [4 responses]).

2017, Iceland, WPL Annual Global Summit, Caroline Hickson, Regional Director IPPF; Xavier Prats Monné, Director General of DG Santé; Marie-Louise Colerio Preca, President of Malta; Mary-Ann Etiebet, Lead and Executive Director, MSD for Mothers; Katja Iverson, CEO WomenDeliver

2018, Lithuania, WPL Annual Global Summit, Marian Knight, Professor of Maternal and Child Population Health University of Oxford; Gabi Grom, MSD for Mothers; Marie-Louise Colerio Preca, President of Malta; Oana Mioara Bizgan Gayral, Member of Parliament, Romania; Xavier Prats Monné, Director General of DG Santé

INTERPRETATION OF RESULTS
GENERAL

Disparity in MMR

- Both the mapping and interviews showed that a disparity in MMR between EU countries exists, with the highest rates in the eastern region being more than tenfold the lowest rate. We have no reason to suspect that mortality will be lower amongst VPW in particular and, as such, it is likely that this pattern at least equally applies to VPW.
- The disparity in MMR may be explained by several factors, including unbalanced access to adequate care, discriminatory/ xenophobic attitudes towards vulnerable groups in certain regions and differences in the reliability of reported MMR.

MMR and overall health system

- In addition, MMR seems to follow the overall performance of healthcare systems, with e.g. poor primary care and training of health professionals being associated with higher MMR.

Mortality of VPW not a concern

- Moreover, the EU28 and particularly the eastern region, do not seem to be concerned with the mortality of VPW and the health of migrants in general.

Effectiveness of interventions

- Although the survey results suggest, particularly in the eastern region, that interventions are in place to prevent mortality of VPW, the mapping indicates otherwise (i.e. higher MMR in this region).

The EU28: a challenging environment

- There is a large variety of policies on social protection, health and vulnerable groups in the EU. In combination with high degree

of migration and influx from countries outside the EU, this makes it challenging to organize maternal healthcare in a way that ensures equal/balanced access for everybody. At the same time, the interviews show a full consensus on the urgent need for better access to maternal healthcare for VPW.

ACCEPTABILITY

Cultural sensitivity of care:

- Although VPW can usually make choices in the care they receive based on cultural or religious motives, the EU28 performs poorly on the cultural sensitivity of maternal healthcare. This counts both for VPW and non-VPW.

Proof of identification upon accessing healthcare

- Across the EU28, VPW are usually asked for identification and/or a proof of address upon accessing health services, which could affect the degree to which they seek care.

MMR and undesired pregnancies

- A higher MMR is often accompanied with a relatively high number of undesired pregnancies, as witnessed by higher postpartum depression and adolescent birth rates.

APPROACHABILITY

Information and Awareness about maternal healthcare:

- Both the survey and mapping demonstrate that public information about entitlements and the use of maternal healthcare is accessible for VPW, especially in the eastern and northern regions.
- However, VPW seem to be neither aware of nor knowledgeable on the use maternal health services, which is also underlined in the HEN Synthesis Report 45[10], showing that both provider and receiver are often not sure about entitlements to health services.
- In addition, undocumented migrants and the poor/homeless seem much less exposed to information about maternal healthcare than the other vulnerable groups.

AVAILABILITY AND FACILITIES

Results are inconclusive regarding waiting times for antenatal appointments for VPW, the existence of suitable appointment mechanisms for working VPW and standards that monitor maximum waiting times for antenatal appointments and access to labour rooms.

AFFORDABILITY

Insurance coverage:

- The mapping shows that, in most countries, approximately 100% of the overall population* is covered by social health insurance. This is confirmed in the survey for VPW in particular.
- Notwithstanding, undocumented migrant VPW likely experience much less financial security than other vulnerable groups.

A free basic benefits package for VPW

- When asked about the one policy change that would have the most impact on improving maternal healthcare for VPW, all interviewees mentioned that VPW must obtain access to a free basic benefits package that includes 1) Information/advice on family planning, 2) Access to contraception, 3) Antenatal and delivery care and 4) Postnatal care.
- Such a package would be particularly beneficial for undocumented pregnant women, who are required to pay for maternal healthcare in many EU nations.

MMR and the wealth of young women

- A high MMR is often accompanied by a poor score on the wealth of young women, whereas countries with a low MMR score well on the wealth of young women.

*vulnerable groups, particularly undocumented VPW, are potentially omitted in these statistics

APPROPRIATENESS

Adherence to national standards:

- The survey suggests that most governments enforce adherence to a national standard in the care that is delivered to VPW, especially in the eastern region.

Results are inconclusive in regards to the extent to which the gestational age at first antenatal checkups is less than 12 weeks.

CONCLUSIONS AND RECOMMENDATIONS

GENERAL

Conclusions:

- Based on publicly available data, it remains difficult to accurately and objectively assess the status of maternal healthcare for VPW. Several key outcome and process indicators were not represented at all, for instance gestational age at first antenatal care visit and health literacy.
- Both the mapping and interviews showed that a disparity in MMR between EU countries exists, with the highest rates in the eastern region being more than tenfold the lowest rate. In the eastern region, there seems to be a lack of awareness about the fate of many VPW, as witnessed by the fact that MMR is higher here and political leaders from this region simultaneously believe that interventions are in place to prevent maternal mortality of VPW.
- The heterogeneity in the EU with regard to policies on social protection, health and vulnerable groups poses a challenge to access to maternal healthcare.

Recommendations:

- Develop specific indicators to measure maternal health and pregnancy outcomes for VPW.
- Launch an educational campaign in each Member State that expresses how every woman – regardless of citizenship status, ethnicity and cultural background – should have adequate access to maternal healthcare. This is particularly important as a defense against ramping populism, xenophobia and retrograde pressure on

women and sexual and reproductive healthcare and rights (SRH).

- Member states should develop concrete national rights which include access to maternal healthcare for vulnerable women

ACCEPTABILITY

Conclusions:

- While EU countries do well on some elements of culturally sensitive care (i.e. VPW can often make cultural or religion-based choices in the care they receive, similarly to the way non-VPW can), the delivery of maternal healthcare is often not tailored to the cultural background of patients.
- VPW are likely not seeking maternal care because it threatens their ability to stay in the country, regardless of whether the care is free and how knowledgeable they are on the use of such services.

Recommendations:

- Design and implement mandatory training of health professionals in delivering culturally sensitive care.
- Involve people from the same background, religion, ethnicity to reach out to vulnerable pregnant women to inform them about services available and make them more comfortable in approaching the healthcare system.
- Ensure and make clear that using maternal healthcare services does not pose the threat of having to leave the country due to one's immigration status.

APPROACHABILITY

Conclusions:

- Although information on maternal health services is generally available to VPW through various media and in at least one non-native language, it does not always reach them.
- As such, information about maternal healthcare services currently do not seem to support VPW in seeking and receiving maternal healthcare.

Recommendations:

- Conduct outreach activities which more effectively reach VPW in their own communities, paying attention especially to undocumented migrants and the poor/homeless. Technology could play an important role here (e.g. smartphone app with an intelligent chatbot that speaks all languages and advises on when and where to seek care and knows answers to frequently asked questions).
- Ascertain that social services are available to overcome language and income barriers.
- Educate the entire community about the rights of VPW, not just the women and adolescent girls but also the men, family members and rest of the community. Pay explicit attention to information on how to use contraceptives.
- Actively monitor the use of information programmes for VPW (who, what, where and how often).
- Aim for one go-to point of information for VPW.

AVAILABILITY AND FACILITIES

Conclusion:

- Evidence regarding availability and facilities is inconclusive.

Recommendations:

- Investigate the typical waiting times for antenatal appointments for VPW and the appointment mechanisms/systems in place for working VPW.
- Ensure that standards on maximum waiting times for antenatal appointments and access to labour rooms for VPW are in place and monitored.

AFFORDABILITY

Conclusions:

- There is consensus on the necessity of a basic benefits package for VPW that covers maternal healthcare, but results were inconclusive as to the extent to which such maternal healthcare is currently already covered.
- Undocumented migrants are particularly vulnerable as they are least financially protected.

Recommendations:

- Further investigation should be conducted to assess the degree to which VPW are covered under basic maternal healthcare.
- At the very least, ensure that contraceptives are available for all VPW in the EU and that they know how to use them (in particular in refugee camps).
- Design and implement a basic maternal healthcare benefits package that covers 1) Information/advice on family planning, 2) Access to contraception and 3) Antenatal, delivery, neonatal and postnatal care.
- The benefits package should support a lifelong approach to maternal health, thus focusing on a healthy start to life and targeting the needs of people at critical periods throughout their lifetime – not only at the time when they are pregnant or at delivery.
- Launch antipoverty and social programmes to improve empowerment of VPW, especially undocumented migrants.

APPROPRIATENESS

Conclusion:

- Although the survey results suggest that standards are enforced in the delivery of maternal healthcare to VPW, their effectiveness remains uncertain.

Recommendations:

- Further investigate how effective the standards of maternal healthcare for VPW are. For instance, assess whether these standards require and monitor when first antenatal checkups must be conducted.
- As recommended by the WHO, member states should offer systematic prenatal follow-up for all VPW.
- Ensure that there are oversight boards in place to hold governments accountable, with continuous advocacy and reporting.

INITIATIVES AND LESSONS LEARNED ACROSS EUROPE

ADVERSE EVENTS INITIATIVE & THIRD PARTY PAYMENT RULE

Belgium is planning to launch the adverse events initiative.
With this initiative, each maternal death is investigated and documented. Subsequently, a committee of experts guide health professionals on how to prevent that death in the next situation. Continuously doing so at the EU level may significantly improve maternal healthcare

In addition, Belgium has the so-called third party payment rule.
People with limited financial resources can visit the doctor for €1, with the remainder being paid for by the government (third party).

PRENATAL TRAINING COURSES

Kaiser-Franz-Josef-Spital in Vienna, Austria designed courses for the Turkish community, which accounts for 35%–40% of their obstetric clients. The courses were free of charge and conducted in co-operation with a Turkish midwife who worked as interpreter

Guastalla Hospital, Reggio Emilia, Italy developed courses for women from Indian and Pakistani ethnic groups. A taxi service for women and a baby-sitting service were offered to provide easy access. Intercultural-linguistic mediators for Arabic and Punjabi languages facilitated communication

ARDENNES CROSS-BORDER COLLABORATION

This is an arrangement at the French–Belgian border which allows French patients to cross the border, mainly for obstetrical care and to give birth in a Belgian hospital as it is their closest health facility

Benefits of crossing the border for French mothers include geographical proximity, perceived better quality of care, reduced waiting time and efficient obstetrical services. Attention to communication between providers in terms of discharge summaries and assigned contact persons ensured continuity of care

PRENATAL TRAINING COURSES

ORAMMA is a two year project funded through the European Union's Health Programme to develop an approach to maternal healthcare for migrant and refugee women.

It assesses the current state of women's health provision for migrants and refugees in project countries.

The project is developing a pathway to help multidisciplinary teams of health workers provide quality perinatal care to pregnant migrants and refugees entering Greece, the Netherlands and the UK.

"The migrants are vulnerable particularly when they are pregnant as their healthcare has not been properly managed. If you look at sheer numbers, complications at birth and pregnancies are the first cause of hospitalisation among undocumented and documented women (refugees) in Europe, which is not the case for EU citizens." - Professor Vanessa Grotti, EU Border Care Project

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ANNEXES

- Description of mapping indicators
- Mapping sources
- Survey questions
- List of interviewees
- Advisory panel of WPL Maternal Healthcare project

ANNEX 1. DESCRIPTION OF MAPPING INDICATORS

		Additional indicato
Nr.	Indicator	Description
	General information | Demographics	
1	Population	Number of people living in a particular geographical are
2	Urban population %	Number of inhabitants of a city/town including metropoli
3	Ethnic groups	A community or population made up of people who shar
4	Women as a percentage of immigrants	Percentage of women migrants among all immigrants
5	Languages	Listing of languages spoken in each country and specifi population)
6	Religions	Details of the religion of the country, starting with the lar
7	Dependency ratio	The total dependency ratio is the ratio of combined yout
8	Birth rate	Average annual number of births per 1.000 people in th
9	Death rate	Average annual number of deaths per 1.000 population
10	Population growth rate	The average annual percent change in the population, r a country
11	Net migration rate	This includes the figure for the difference between the n population. An excess of persons entering the country is
12	% female	This indicator includes percentage of females out of the
13	% female (16-45)	Percentage of females in the age group of 16-49 years
14	Life expectancy at birth (female)	Average number of years to be lived by a group of peop
	General information| Availability and expenditure	
15	Physician density	Number of medical doctors (physicians), including gene

or information
a
tan areas and suburban areas expressed as a percentage of total population
re a common cultural background or descent
es any that are official national or regional languages (the data is available as a percentage of the total
rgest group, as a percentage of the total population
th population (ages 0-14) and elderly population (ages 65+) per 100 people of working age (ages 15-64)
e population
esulting from a surplus (or deficit) of births over deaths and the balance of migrants entering and leaving
umber of persons entering and leaving a country during the year per 1,000 persons based on midyear s referred to as net immigration; an excess of persons leaving the country as net emigration.
total population in the year 2017
as compared to the total female population
le born in the same year, if mortality at each age remains constant in the future
ralist and specialist medical practitioners, per 1.000 population

ANNEX 1. DESCRIPTION OF MAPPING INDICATORS

		Additional indicato
16	Hospital bed density	Number of hospital beds available per 10.000 inhabitan
17	Curative care beds in hospitals	Hospital beds provide information on health care capac care) beds in hospitals are beds that are a subgroup of immediately available for the care of admitted patients;
18	Out-of-pocket expenditure as a percentage of total expenditure on health	Level of out-of-pocket expenditure (refers to the expend of total expenditure on health
19	Population coverage	Percentage of total population covered by social health
20	Health expenditure	Total expenditure on health
21	General government expenditure on health as a percentage of total expenditure on health	Level of general government expenditure on health (GG General government expenditure on health -The sum o Health, other ministries, parastatal organisations or soc extrabudgetary funds). It includes all expenditure made includes transfer payments to households to offset med capital expenditure.
22	Private expenditure on health as a percentage of total expenditure on health	Level of private expenditure on health expressed as a p Private expenditure on health - The sum of outlays for institutions serving households, resident corporations a all sources, so includes any donor funding passing thro
23	Social security expenditure on health as a percentage of general government expenditure on health	Level of social security funds expressed as a percentag Social security funds - The expenditure on health by so controlled by government units for the purpose of provic community. They include payments to medical care pro outlays on supply of services in kind to the enrollees. It institutions are included.

or information
ts in a population
ities, i.e. on the maximum number of patients who can be treated by hospitals. Curative care (or acute total hospital beds which are defined as all hospital beds which are regularly maintained and staffed and both occupied and unoccupied beds are covered.
iture on health by households as direct payments to health care providers) expressed as a percentage
insurance
GHE) expressed as a percentage of total expenditure on health f health outlays paid for in cash or supplied in kind by government entities, such as the Ministry of ial security agencies (without double counting government transfers to social security and by these entities, regardless of the source, so includes any donor funding passing through them. It ical care costs and extrabudgetary funds to finance health services and goods. It includes current and
ercentage of total expenditure on health health by private entities, such as households, commercial or mutual health insurance, non-profit nd quasi-corporations with a health services delivery or financing function. It includes expenditures from ugh these "financing agents".
ge of general government expenditure on health cial security institutions. Social security or national health insurance schemes are imposed and ding health services to members of the community as a whole or to particular segments of the oviders and to suppliers of medical goods as well as reimbursements to households and the direct includes current and capital expenditure. Any donor (external) funds channeled through these

ANNEX 1. DESCRIPTION OF MAPPING INDICATORS

		Additional indicat
Nr.	Indicator	Description
	General information | Maternal health	
24	Mother's mean age at first birth	Average age of mothers at the birth of first child.
25	Maternal mortality rate	The maternal mortality rate (MMR) is the annual numb management (excluding accidental or incidental cause pregnancy, irrespective of the duration and site of the
26	Maternal mortality ratio (MMR) from routine systems	Number of maternal deaths per 100,000 live births Routine systems are generally available in each memb data systems, in which deaths are coded according to
27	MMR from enhanced systems	Number of maternal deaths per 100,000 live births Enhanced systems vary by country and may use differ routine systems by linking data sources, for example,
28	Maternal mortality by cause of death	Percentage of maternal deaths by cause of death whic disorders; IV Haemorrhage; V Chorioamnionitis/Sepsis Uterine rupture; X Other direct causes; XI Indirect caus cause/Unknown
29	Maternal morbidity indicator	Number of women experiencing any one of eclamptic an intensive care unit as a percentage of all women wi
30	Fetal mortality	Number of fetal deaths at or after 22 completed weeks
31	Neonatal mortality	The annual neonatal mortality rate is defined as the nu after 22 completed weeks of gestation in 2010, expres neonatal deaths in 2010 or 2011 at or after 22 complet are subdivided by timing of death into early neonatal d

or information
er of female deaths per 100,000 live births from any cause related to or aggravated by pregnancy or its es). The MMR includes deaths during pregnancy, childbirth, or within 42 days of termination of pregnancy, for a specified year.
per state or country; the data is generally extracted from national civil registration and cause-of-death ICD-10
rent inclusion criteria from routine systems and from each other. Some enhanced systems improve on deaths with births, for a more complete ascertainment of deaths associated with pregnancy
ch includes I Ectopic pregnancy; II Pregnancy with abortive outcome (excl. ectopic); III Hypertensive s; VI Other thromboembolic causes;VII Amniotic fluid embolism; VIII Complications of anaesthesia; IX ses: diseases of the circulatory system; XII Indirect causes: other; XIII Unspecified obstetric
seizures, caesarean hysterectomy, embolization, blood transfusion, or a stay of more than 24 hours in th liveborn and stillborn babies.
of gestation in a given year, expressed per 1000 live births and stillbirths that same year
umber of deaths during the neonatal period (up to 28 completed days after birth) after live birth at or sed per 1000 live births that year. The cohort neonatal mortality rate is defined as the number of ed weeks of gestation occurring to babies born in 2010 expressed per 1000 live births. Neonatal deaths eaths (0-6 days after live birth) and late neonatal deaths (7-27 days after live birth)

ANNEX 1. DESCRIPTION OF MAPPING INDICATORS

		Additional indicat
32	Total fertility rate	Average number of children that would be born per wor fertility rate at each age. This indicator shows the poter replacement rate for a population, resulting in relative s whose median age is declining. Higher rates may also enter the labor force. Rates below two children indicate
33	Adolescent birth rate	Annual number of births to women between 15 to 19 ye women aged 15-19.
34	Births by mode of delivery (%)	The percentage distribution of all births, live born and s A: Vaginal total B: Caesarean total
35	Births by type of C-section (%)	See above
36	Place of birth by volume of deliveries	This indicator describes the number of births occurring year at home, and in hospitals that had a total number 4000-4999, or 5000 and over
37	Mode of onset of labour (numbers and percentages of total births)	Mode of onset of labour is described by the numbers of caesarean section, either planned or undertaken before

or information
man if all women lived to the end of their childbearing years and bore children according to a given ntial for population change in the country. A rate of two children per woman is considered the stability in terms of total numbers. Rates above two children indicate populations growing in size and indicate difficulties for families, in some situations, to feed and educate their children and for women to e populations decreasing in size and growing older.
ears of age per 1,000 women in that age group. It is also referred to as the age-specific fertility rate for
stillborn, by method of delivery for all women. It is segregated in two types:
at home or in maternity units of various sizes and is defined by the total number of births in the same of births in 2010 of less than 300, 300-499, 500-999, 1000-1499, 1500-1999, 2000-2999, 3000-3999,
f babies (per 100 live births and stillbirths) born after spontaneous onset of labour, induced labour, and e labour

ANNEX 1. DESCRIPTION OF MAPPING INDICATORS

		Additional indicato
Nr.	Indicator	Description
	A) Approachability	
38	Smoking at the beginning of or during pregnancy	Smoking during pregnancy is defined as the proportion pregnancy
39	Prevalence of anaemia in pregnant women estimates (%)	Percentage of women aged 15–49 years with a haemog
40	Prevention of mother-to-child transmission of HIV	The indicator has been defined as: A. Number of HIV-positive pregnant women who receiv B. Estimated number of pregnant women living with HIV C. Percentage of HIV-positive pregnant women provide
41	Antenatal care attendees who were positive for syphilis	Percentage of antenatal care attendees who tested pos
42	Prevalence of postpartum depression	Estimated number of people with Postpartum depressio
43	Use of intrapartum epidural analgesia in vaginal deliveries	Percentage of women receiving intrapartum epidural ar
44	Information for service providers about migrants' entitlements	A. Service provider organisations receive up-to-date inf B. Organisations pass on up to-date information about t

r information
of women (among those with liveborn or stillborn babies) who smoked during the third trimester of
globin concentration less than 110 g/L for pregnant women, adjusted for altitude and smoking
ed antiretroviral drugs during the past 12 months to reduce mother-to-child transmission / needing antiretrovirals for preventing mother-to-child transmission based on WHO methods d with antiretroviral therapy (ART) to reduce the risk of mother-to-child transmission during pregnancy
itive for syphilis
n at any given time
algesia in vaginal deliveries
formation on migrants' entitlements these entitlements to their employees

ANNEX 1. DESCRIPTION OF MAPPING INDICATORS

		Additional indicato
45	Information for migrants concerning entitlements and use of health services	The indicator involves the following methods of dissemin A. Websites B. Brochures in public places C. One-stop shops D. Classes or individual instruction E. Other
46	Health education and health promotion for migrants	The indicator involves the following methods of dissemin A. Websites B. Brochures in public places C. One-stop shops D. Classes or individual instruction E. Other
47	Involvement of migrants in information provision, service design and delivery	The indicator includes forms of migrants who are explici A. Migrants are involved in service delivery (such as thr B. Migrants are involved in the development and dissem C. Migrants are involved in research (not only as respor D. Migrant patients or ex-patients are involved in the eva E. Migrants in the community are involved in the design

r information
nation:
nation:
tly encouraged by policy measures. These forms are grouped as follows: ough the employment of cultural mediators) nination of information ndents) aluation, planning and running of services of services

ANNEX 1. DESCRIPTION OF MAPPING INDICATORS

		Additional indicat
Nr.	Indicator	Description
	B) Acceptability	
48	Interpretation services	This indicator measures the extent to which health se barriers and improving understanding between migran A: Availability of qualified interpretation services for pa B: Methods used for interpretations which include fac cultural mediators, employment of competent bilingua
49	Interpreters needed vs. Provided (ratio)	Proportion of consultations which required an interpre
50	Obligation to report undocumented migrants	This explains whether health-care professionals or or A: Explicitly forbidden in law and/or professional code B: No relevant legislation or professional codes of cor C: Explicitly required in law
51	Any sanctions against helping undocumented migrants	This explains if there are any legal or organisational s A: No legal sanctions or other pressures on professio B: Only organisational sanctions exist C: Legal sanctions exist against helping undocumente

or information
rvices are adapted to meet the special needs of migrants. This mainly involves tackling linguistic nts and health workers. This is divided into two sections: atients with inadequate proficiency in the official language(s) e-to-face, telephone interpretation, interpretation by video link, credentialed volunteers, employment of l or multilingual staff
eter and got one
ganisations are required to report undocumented migrants to the police or immigration authorities. es of conduct nduct
sanctions against health-care professionals or organisations assisting undocumented migrants. nals to deter them from helping migrants who cannot pay ed migrants

ANNEX 1. DESCRIPTION OF MAPPING INDICATORS

		Additional indicat
52	Self-reported unmet needs for medical examination by sex, age, detailed reason and income quintile	Person's own assessment of whether he or she need The European Statistics of Income and Living Conditi
53	Availability of "culturally competent" or "diversity-sensitive" services	Standards or guidelines require that health services ta beliefs, religion, culture, competence in intercultural c A: Standards or guidelines exist on "culturally compet B: Compliance with these standards or guidelines is r
54	Encouraging diversity in the health service workforce	The indicator examines recruitment measures (such a the health service workforce
55	Migration of doctors - Domestically trained doctors and foreign trained doctors	The indicator includes the following parameters based A. Domestically trained doctors B. Foreign trained doctors (Annual inflow) - The numb receiving a new authorisation in a given year to practi C. Foreign trained doctors (Stock) - The number of do practice in the receiving country

or information
ed examination or treatment for a specific type of health care, but didn't have it or didn't seek for it. on (EU-SILC) collects data on two types of health care services: medical care and dental care.
ake account of individual and family characteristics, experiences and situation, respect for different ommunication. ent" or "diversity-sensitive" services monitored by a relevant authority
as campaigns, incentives, support) to encourage participation of people with a migrant background in
d on availability in the database: ber of doctors who have obtained their first medical qualification (degree) in another country and are ce in the receiving country octors who have obtained their first medical qualification (degree) in another country and are entitled to

ANNEX 1. DESCRIPTION OF MAPPING INDICATORS

		Additional indicato
Nr.	Indicator	Description
56	Migration of nurses - Domestically trained nurses and foreign trained nurses	The indicator includes the following parameters based A. Domestically trained nurses B. Foreign trained nurses (Annual inflow) - The numbe receiving a new authorisation in a given year to practic C. Foreign trained nurses (Stock) - The number of nurs nurse in the receiving country
57	Training and education of health service staff on needs of migrants	The indicator examines policies exist to support trainin professional education and/or in-service professional d
58	Development of capacity and methods for HCW to interact with migrants	A: Development of capacity and methods: Diagnostic p background of patients B: Policies exist to encourage: i) Development of treatments for health problems spec diseases and genetic risk factors) ii) Adaptation of standard treatments for routine health iii) Use of complementary and alternative “non-Wester

r information
on availability in the database:
er of nurses who have obtained a recognised qualification in nursing in another country and are ce in the receiving country ses who have obtained a recognised qualification in nursing in another country and are working as a
g of staff in providing services responsive to the needs of migrants. Training may be part of basic development
procedures and treatment methods are adapted to take more account of variations in the sociocultural
cific to certain migrant communities (such as female genital mutilation, effects of torture, rare import problems in order to better serve migrant communities n" treatments for physical and mental health problems

ANNEX 1. DESCRIPTION OF MAPPING INDICATORS

		Additional indicato
59	Provision of “cultural mediators” or “patient navigators” to facilitate access for migrants	This indicator deals with the use of “cultural mediators”
60	Estimates of contraceptive prevalence (any method and modern methods) among married or in-union women aged 15 to 49, 2015	Contraceptive prevalence is defined as the percentage those aged 15 to 49 years, unless otherwise stated) wh Modern methods of contraception are defined to includ condoms, injectables, the implant (including Norplant), contraception include rhythm (periodic abstinence), wit
61	Abortion rate	The number of abortions per 1,000 women in reproduc
62	Abortion legislation in Europe, 2012	The indicator summarizes laws on abortions in selecte
63	Legally induced abortions by mother's age and number of previous live births	Legally induced abortions are defined as induced expu

or information
' or "patient navigators" to help migrants find the way to health care
e of women currently using any method of contraception among all women of reproductive age (i.e., no are married or in a union. le female and male sterilization, oral hormonal pills, the intra-uterine device (IUD), male and female vaginal barrier methods and emergency contraception. Traditional or natural methods of thdrawal and lactational amenorrhoea method (LAM).
ctive ages in a given year
d European countries
lsion of the foetus during the first part of a pregnancy, permitted by law for health or other reasons

ANNEX 1. DESCRIPTION OF MAPPING INDICATORS

		Additional indicat
Nr.	Indicator	Description
	C) Availability and accommodation	
64	Nursing and midwifery density	Number of nursing and midwifery personnel per 1,00
65	Number of licensed qualified obstetricians actively working	Total number of licensed, qualified physician obstetri
66	Obstetricians and gynaecologists	Density of licensed obstetricians and gynaecologists
67	Very preterm births delivered in maternity units without an on-site neonatal intensive care unit (NICU)	Proportion of all births (live born and stillborn) betwee (NICU)
68	Proportion of patients who visited an emergency department because primary care was not available, 2011-13	This section gives the proportion of patients who visit
69	Doctor consultations in all settings (Number per capita)	This provides the details of the number of consultants
70	Gatekeeping function implemented (yes/no)	Gatekeeping is the term used to describe the role of p care, and diagnostic tests
	D) Affordability	

or information
0 population
cians
per 1,000 population
n 22 and 31 weeks of gestation delivered in units without an on-site Neonatal Intensive Care Unit
ed an emergency department because primary care was not available
/visits with a physician per person per year
primary care physicians or general practitioners (GPs) in authorising access to specialty care, hospital

ANNEX 1. DESCRIPTION OF MAPPING INDICATORS

		Additional indicat
71	Antenatal care coverage (at least one visit)	Percentage of women aged 15-49 with a live birth in a midwife) at least once during pregnancy
72	Antenatal care coverage(at least four visits)	Percentage of women aged 15-49 with a live birth in a
73	Free access to GP	Proportion of patients with free access to GP
74	No coverage for healthcare at all	Proportion of 'vulnerable in health' patients with no co
75	Coverage only for emergency services	Proportion of patients having coverage only for emerg
	E) Appropriateness	
76	Standards of care for health professionals (yes/no)	The existence of national standards of care developed narcologists (medical doctors with specialization in ad psychiatric nurses, nurses not specialized in psychiat for patients with substance abuse disorders and beha community who are chosen by community members workers, working with patients having substance use
77	First antenatal visit data	The indicator shows the distribution of timing of the fi are defined as follows: the first trimester is the period
78	Births attended by skilled health personnel	Proportion of births attended by skilled health personn
79	National perinatal health reports published	Many European countries routinely publish reports ba and child health outcomes as well as useful comment

or information
a given time period that received antenatal care provided by skilled health personnel (doctor, nurse or
a given time period that received antenatal care four or more times
overage for healthcare at all. Refers only to the sample taken for the Doctors of the World survey.
gency services
d for different health professionals, such as psychiatrists, , addiction medicine specialists/ ddiction medicine/narcology), medical doctors not specialized in psychiatry or addiction medicine, try, psychologists, social workers, addiction counsellors (professionals certified to work as counsellors avioural addictions after completion of a formal training), community health workers (members of a or organisations to provide basic health and medical care to their community) or outreach/field disorders
rst antenatal visit by trimester of pregnancy for all women with liveborn or stillborn babies. Trimesters up to 14 weeks, the second trimester 15-27 weeks, and the third from 28 weeks to delivery.
nel (doctors, nurses or midwives)
ased on data from their perinatal health information systems. They include recent data on maternal tary about trends over time and risk factors for poor health.

ANNEX 1. DESCRIPTION OF MAPPING INDICATORS

		Additional indic
Nr.	Indicator	Description
	F) Other	
80	Collection of data on migrant health	All approaches stresses the importance of data colle migrant status, country of origin or ethnicity is includ
81	Extent to which migrants' health is regarded as a concern throughout the health system	Migrant or ethnic minority health is a priority throug has been categorised into three parts: A: Commitment to providing equitable health care fo health agencies B: Concern for migrant or ethnic minority health is r C: No systematic attention is paid to migrant or ethn
82	Has government published an explicit plan for action on migrant health	This examines the extent to which government gives A: Government publishes an explicit plan for action B: Policies are implemented to support these measu

ator information
ection and research in order to strengthen the knowledge base concerning migrant health. Data on ded in medical databases or clinical records.
hout service provider organisations and health agencies (integrated versus categorical approach). It or migrants or ethnic minorities is present in all departments of service provider organisations and egarded as a priority only for specialized departments or organisations nic minority health in any part of the health system. Measures are left to individual initiative
s leadership in achieving change. This has been categorised into two segments: on migrant health ures

ANNEX 1. DESCRIPTION OF MAPPING INDICATORS

		Additional indic
83	Involvement of stakeholders / migrants' contribution to health policymaking	The indicator examines whether stakeholders in ge health. A: Policy to involve stakeholders in the design of mi expertise) or through ad hoc cooperation (such as c B: Migrants' contribution to health policymaking at n or regular review of health legislation, services and outcomes) or through ad hoc cooperation (such as
84	MDG Goal 5: Improve maternal health	The goal includes: A. Reduce maternal mortality by three quarters (Ma B. Access to universal reproductive health (Contrac and Unmet need for family planning - percentage of
85	Females aged 15-29 at risk of poverty or social exclusion	No additional information given
86	Females aged 16-29 who cannot afford to spend a small amount of money each week on themselves	No additional information given
87	Severe housing deprivation rate (females aged 16-29)	No additional information given
88	Heavy episodic drinking among lower educated women aged 15-29	Lower educated women are defined as having ISCE
89	Daily smoking (>20 cigarettes) by lower educated women aged 15-29	Lower educated women are defined as having ISCE

ator information
neral and migrant organisations in particular are involved in consultations and policymaking on migrant grant health policies - Either through structural cooperation (such as via advisory body or centre of during consultations on new health strategy or law or through projects) national or regional level - Either through structural cooperation (such as involvement in advisory body during consultations on new health strategy or law or through projects)
ternal mortality ratio - maternal deaths per 100,000 live births) eptive prevalence rate - percentage of women aged 15-49, married or in union, using contraception, f women aged 15-49, married or in union, with unmet need for family planning)
ED level 0, 1 or 2.
ED level 0, 1 or 2.

ANNEX 2: MAPPING SOURCES

- Doctors of the World
- IOM (International organisation for Migration)
- Alliance for Maternal Healthcare Equality
- EC (European Commission Communication)
- WHO (World Health Organisation)
- OECD (Organisation for Economic Co-operation and Development)
- PICUM (Platform for International Collaboration on Undocumented Migrants)
- IPPF (International Planned Parenthood Federation)
- EPF (European Parliamentary Forum on Population and Development)
- White Ribbon Alliance
- CIA (Central Intelligence Agency)
- Euro-Peristat
- Mipex Health Strand (of IOM)
- UN data
- The Commonwealth Fund

ANNEX 3. SURVEY QUESTIONS

A. General Questions

1. The country/government you represent:
2. The health system has specific policies in place for vulnerable pregnant women requiring access to maternal healthcare. (Strongly Agree – Disagree – Not sure – Agree – Strongly Agree)
3. The national or local media actively follow developments on maternal healthcare of vulnerable pregnant women. (Strongly Agree – Disagree – Not sure – Agree – Strongly Agree)
4. The government ensures regular and affordable access to maternal healthcare for all vulnerable pregnant women. (Strongly Agree – Disagree – Not sure – Agree – Strongly Agree)
5. The government carries out a periodic cost-effectiveness analysis on providing early access to antenatal care for vulnerable pregnant women. (Yes – No - Not sure)
6. Mortality of vulnerable pregnant and postnatal women is an important topic widely discussed on a national political level. (Strongly Agree – Disagree – Not sure – Agree – Strongly Agree)
7. Information is collected on adverse pregnancy outcomes faced by vulnerable pregnant women. (Strongly Agree – Disagree – Not sure – Agree – Strongly Agree)
8. Specific interventions have been implemented to prevent maternal mortality of all vulnerable pregnant and postnatal women. (Strongly Agree – Disagree – Not sure – Agree – Strongly Agree)

B. Approachability

1. Public information about maternal health care services and professionals is readily available in at least one non-native language. (Yes – No - Not sure)

2. Public information about maternal health care services and professionals is readily accessible by vulnerable pregnant women. (Strongly Agree – Disagree – Not sure – Agree – Strongly Agree)

3. The government provides information programmes on how to access the maternal health services in your country specifically for (Strongly Agree – Disagree – Not sure – Agree – Strongly Agree)
   - Undocumented migrants
   - Refugees and asylum seekers
   - Roma women
   - Poor and homeless women
   - Migrants from outside the EU such as third country nationals
   - Adolescent women
   - EU migrants

4. Health services perform outreach programmes targeting vulnerable pregnant women to ensure that they have regular access and information on ante- and post-natal care. (Strongly Agree – Disagree – Not sure – Agree – Strongly Agree)

5. Organisations at local and regional level provide information and services such as interpretation or administrative simplification to vulnerable pregnant women. (Strongly Agree – Disagree – Not sure – Agree – Strongly Agree)

6. The government has organised clear roles and responsibilities between involved healthcare professionals in the delivery of maternal healthcare to vulnerable pregnant women. For example: The role of midwives and obstetricians/gynaecologists. (Strongly Agree – Disagree – Not sure – Agree – Strongly Agree)

7. The government enforces adherence to a national standard for the maternal healthcare services provided to vulnerable pregnant women. (Strongly Agree – Disagree – Not sure – Agree – Strongly Agree)

C. Acceptability

1. Vulnerable pregnant women can choose their health services to the same extent that non-vulnerable pregnant women can. (Strongly Agree – Disagree – Not sure – Agree – Strongly Agree)
2. Vulnerable pregnant women are asked to show ID/proof of address when accessing the health services. (Strongly Agree – Disagree – Not sure – Agree – Strongly Agree)
3. It is common practice to enquire about the cultural background of patients, with the aim of delivering more tailored care. (Strongly Agree – Disagree – Not sure – Agree – Strongly Agree)
4. The health system provides cultural mediation trainings for healthcare professionals to overcome cultural and linguistic barriers when treating vulnerable pregnant women. (Strongly Agree – Disagree – Not sure – Agree – Strongly Agree)
5. Vulnerable pregnant women can make choices regarding the care they receive, based on cultural or religious sensitivities (For example: choosing a female health professional instead of a male health professional). (Strongly Agree – Disagree – Not sure – Agree – Strongly Agree)
6. Health services provide interpreters for vulnerable pregnant women who cannot speak the native language. (Strongly Agree – Disagree – Not sure – Agree – Strongly Agree)

D. Availability and accommodation

1. National standards are implemented for the minimum number of

health care facilities for vulnerable pregnant women per 1000 citizens. (Strongly Agree – Disagree – Not sure – Agree – Strongly Agree)

2. Minimum requirements are implemented on maximum travel time towards a health care facility for vulnerable pregnant women in labour. (Strongly Agree – Disagree – Not sure – Agree – Strongly Agree)

3. Vulnerable pregnant women face longer waiting times for antenatal appointments compared to non-vulnerable pregnant women. (Strongly Agree – Disagree – Not sure – Agree – Strongly Agree)

4. The health services provide antenatal appointments at times suitable for working vulnerable pregnant women who are unable to take leave. (Strongly Agree – Disagree – Not sure – Agree – Strongly Agree)

E. Affordability

1. Basic maternal healthcare for vulnerable pregnant women is paid for through the government/social insurance system. If Yes, please continue to Question 3 (Yes – No - Not sure)

2. If not, the health system provides social benefits/ subsidies for vulnerable pregnant women who cannot afford access to the system. (Yes – No - Not sure)

3. Undocumented pregnant migrant women receive the same financial security for accessing maternal healthcare as documented pregnant migrant women. (Strongly Agree – Disagree – Not sure – Agree – Strongly Agree)

4. Policies are in place to protect working pregnant vulnerable women from losing their job or receiving a pay-cut from employers. (Please rate for each vulnerable group) (Strongly Agree – Disagree – Not sure – Agree – Strongly Agree)
   - Undocumented migrants
   - Refugees and asylum seekers
   - Roma women
   - Poor and homeless women

- Migrants from outside the EU such as third country nationals
- Adolescent women
- EU migrants

5. The government provides information programmes on how to access the maternal health services in your country specifically for (Strongly Agree – Disagree – Not sure – Agree – Strongly Agree)
    - Undocumented migrants
    - Refugees and asylum seekers
    - Roma women
    - Poor and homeless women
    - Migrants from outside the EU such as third country nationals
    - Adolescent women
    - EU migrants

F. Appropriateness

1. The average gestational age at the first antenatal check-up for vulnerable pregnant women is before 12 weeks. (Strongly Agree – Disagree – Not sure – Agree – Strongly Agree)

2. The government has standards on maximum waiting times for regular antenatal appointments. (Strongly Agree – Disagree – Not sure – Agree – Strongly Agree)

3. Maternal healthcare for vulnerable pregnant women meets international standards for quality. For example: A minimum of 8 antenatal appointments (WHO Standards). (Strongly Agree – Disagree – Not sure – Agree – Strongly Agree)

4. Indicators of quality of maternal healthcare are collected by the national health system. (Strongly Agree – Disagree – Not sure – Agree – Strongly Agree)

5. Pain management (E.g. epidural, water-birth) is being offered to vulnerable pregnant women. (Strongly Agree – Disagree – Not sure – Agree – Strongly Agree)

6. 6.Vulnerable pregnant women are asked to provide feedback which is used to improve the delivery of maternal healthcare. (Strongly Agree – Disagree – Not sure – Agree – Strongly Agree)

G.Other

1.What is the one area where legislation/policy could help to improve access and provide early, regular, and affordable maternal healthcare for vulnerable pregnant women?
2.What improvements would you suggest at a European level to provide early, regular, and affordable maternal healthcare for vulnerable pregnant women?
3.Do you have any additional comments?
4.Age:
5.Gender:

ANNEX 4. LIST OF INTERVIEWEES

Name	Position	Organization name	Country
Xavier Prats-Monné	Director-General for Health and Food Safety	European Comission	European Comission
Milojka Kolar Celarc	Minister of Health	Ministry of Health	Slovenia
Mieke Walraevens	Deputy Director of Health	Ministry of Health	Belgium
Christine Defraigne	President of the Senate	Senate of Belgium	Belgium
An Capoen	Member of Parliament	Foreign Affairs Ministry	Belgium
Sander Loones	Member of European Parliament	European Parliament	Belgium
Katja Iverson	President CEO	Women Deliver	EU Union
Francois Fille	European Programs Builder	Medecins du Monde	EU Union
Anastasios Yfantis	Operations Director	Doctors of the World	Greece
Irene Donadio	Senior Advocacy Officer	International Planned Parenthood Federation European Network	EU union
Elena Val	Migration Health Officer	Institute of Migration	EU Union
Edythe Mangindin	Midwife student		Iceland
Polish Delegate at WPL Annual Summit, 2017			Poland

ADVISORY PANEL

France Donnay
Women's Health Consultant, Coach and Connector
Member of the Advisory Board of Merck for Mothers

Marian Knight
Professor of Maternal and Child Population Health at University of Oxford

Elena Ateva
Maternal and Newborn Health Policy and Advocacy Advisor at White Ribbon Alliance

Nilsy Desaint
Associate Director EUCAN public policy

Caroline Hickson
Regional Director, International Planned Parenthood Federation (IPPF), European Network

2018

IMPROVING MATERNAL HEALTHCARE FOR VULNERABLE WOMEN IN EU28: WHAT CAN YOU DO?

Assessment of EU Status and Call for Political Action

A report by Women Political Leaders Global Forum (WPL), supported by MSD for Mothers