

# **SEXUAL AND REPRODUCTIVE HEALTH FOR UNDOCUMENTED WOMEN IN THE NETHERLANDS**

*An exploration of knowledge, needs, barriers, and  
wishes regarding SRH and the perceived quality  
of primary SRH-care*

**Irma Baltes**  
**The Netherlands**

Master of International Health  
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KIT (ROYAL TROPICAL INSTITUTE)  
Health Education/  
Vrije Universiteit Amsterdam

# **Sexual and reproductive health for undocumented women in the Netherlands – an exploration of knowledge, needs, barriers, and wishes regarding SRH and the perceived quality of primary SRH-care**

A thesis submitted in partial fulfilment of the requirement for the degree of Master of Public Health

By  
Irma Baltes  
The Netherlands

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Signature:



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## Glossary

AIGT	Arts Internationale Geneeskunde en Tropenziekten
EU	European Union
GGD	Gemeentelijke gezondheidsdienst
GP	General Practitioner (Family Doctor)
HCP	Health Care Provider
NGO	Non Governmental Organisation
PHC	Primary health care
SRH	Sexual and reproductive health
SRHR	Sexual and reproductive health and rights
STD	Sexually Transmitted Disease
UM	Undocumented Migrants
UW	Undocumented Women

Dokters van de Wereld	Dutch delegation of the international Médecins du Monde. Aim to help vulnerable people
Kruispost	NGO providing medical aid to uninsured people in Amsterdam
Pharos	Dutch centre of expertise on health disparities
PICUM	Platform for international cooperation on undocumented migrants
Lampion	Platform, which is a formal co-operation between several organisations. Lampion aims to improve the access to care for undocumented migrants.
Nivel	Netherlands institute for health services research
LARC	Long-acting Reversible Contraceptives
IUD	Intra Uterine Device Two types are used; both belong to LARC <ul style="list-style-type: none"><li>- Copper containing device</li><li>- Levonorgestrel releasing device</li></ul>
Implanon®	Etonogestrel implant, inserted subdermal and belongs to LARC

## Abstract

Background: Undocumented women (UW) are one of the most excluded and vulnerable groups in Dutch society, with a high prevalence of sexual and reproductive health (SRH) problems. In the Netherlands the general practitioner (GP) plays an important role in providing SRH care. However, there are barriers for UW to access a GP. This study explored how UW perceive the quality of care by looking at their needs, wishes, barriers, and expectations. It also includes the views of experienced health care providers (HCP).

Methods: A qualitative study was performed involving 12 UW and 8 HCP in the Amsterdam area. Semi-structured in-depth interviews based on an analytical framework were held.

Results: UW considered SRH-problems, in particular contraceptives, as a health care need, but experienced barriers to access a GP, including knowledge, finances, and entitlement as a result of being undocumented. Strikingly, the SRH services provided by GPs were rated positively, marked by communication skills, shared-decision making, and empathy. UW and HCP both recognized contraceptives should be discussed more easily.

Discussion: Although SRH-problems were common among UW, barriers to access and obtain health care still existed. Financial restraints and lack of knowledge about entitlements and health all played an important role. In addition, GPs had little knowledge of national policies regarding health care for UW and didn't actively engage to discuss SRH-problems.

Conclusion: GPs should more actively discuss SRH-problems with UW, and the government should consider contraceptives as a basic need and make them more accessible for this vulnerable group.

**Keywords:**

**Undocumented women, Sexual and reproductive health, General Practitioner, Perceived quality of care, the Netherlands**

Word count: 12,961

## Introduction

In 2011 I became a 'Tropical Doctor', and I worked for some years as medical doctor in low-income countries in East Africa.

In the meantime, the term 'Tropical Doctor' had been replaced by AIGT (medical doctor in international health and tropical medicine), which not only resulted in another name, but also in an adjusted training curriculum and extended function possibilities. In addition to the medical specialisation to work in low- en middle-income countries, attention for international (migrant) health in the Netherlands increased. I think this transition is a very valuable contribution. By following the Master course International Health I hope to add my obtained knowledge and experiences to both low-income countries and the Netherlands.

In the Netherlands, migrants are a substantial part of the total population. Migrants came to the Netherlands for many different reasons and many subcultures were established. Particularly last years the influx of migrants had been under attention. The latter is a big issue on governmental and population level how to deal with these aliens. However, the group of undocumented migrants are most disadvantaged when it comes to health and rights.

Nowadays, during my work as General Practitioner in training in the Netherlands, I noticed that many migrants were consulting the primary health care services. That made me even more aware of the different and sometimes difficult situations migrants were confronted with. Especially (undocumented) migrant women have drawn my attention.

I hope to achieve several goals by writing this thesis. It reflects the development of AIGT, my final assessment for the Masters course and the area of interest I would like to work in. After gaining more knowledge of International Health, I hope to use the skills also in my current position. But most of all, I hope it will give undocumented women a voice.

## 1. Background information

In the European Union (EU), about 2 to 8 million people are so-called 'undocumented migrants'. They are migrants who don't have legal documents to reside in the EU (1). The Netherlands is a high income country and EU member state in Western Europe with a population of 17 million inhabitants (2). According to a recent report by van der Heijden et al. the estimated number of undocumented migrants (UM) in the Netherlands ranges from 23 to 48 thousand (3). However, this official calculation is based on assumptions, which might not represent the actual situation as appears from a report of the Clandestino project (1).

Between 6,600 and 13,300 female UM live in the Netherlands (3). This is approximately 29% of all UM living in the country. This number has diminished since the last decade as a result of the expansion of the number of EU countries where a substantial number of former undocumented women (UW) came from. Still, the current number might be an underestimation. It is not known how large the group of UW is, possibly many women live very isolated (4). It is assumed that the majority of UM live in large cities in the West of the Netherlands. UW come from South-America, Sub Saharan Africa, Eastern Europe and Asia (1,5). A substantial number of UW are refugees whose plea for asylum has been declined; another large group consists of victims of human trafficking who end up working in the sex-industry (5). The third group of UW consists of women overstaying the duration of their visa (5,6). A large group of these women joined legal immigrants from Turkey, Morocco, and Surinam for personal reasons such as marriage. After divorcing their husbands, they now live in the Netherlands illegally (4). Of Brazilian immigrants 68% is female. Van Meeteren (5) stated that key informants reported that at least 15% of all Brazilians living in the Netherlands are undocumented. This amounts to 2,040-13,600 women.

UW are one of the most excluded and vulnerable groups in Dutch society. They hide because of fear for deportation and are neglected in health care policies. UW are often dependent on others, mainly men. They have no legal protection, and quite often their housing conditions and hygiene are substandard. In addition, there is no protection of work, and a constant lack of money.

In addition to insecurity, UW often have to deal with the aftermath of abuse and violence (7). Research shows that in general, immigrant women are more at risk of sexual and physical violence (8,9). The majority of trafficked women suffers from physical and sexual abuse and have physical and mental problems (10). Twenty eight of a group of 100 UW in the Netherlands who were interviewed in 2009 mentioned they had experienced sexual violence and 43% of them reported physical violence (11).



In addition, UW also may have to take care of their children and pregnancies.

Overall, Dutch health care is known as the best in Europe, measured by healthcare system indicators and patients' opinions about the performance of healthcare provision (12).

In the Dutch health care system, the General Practitioner (GP) is the 'gatekeeper', the first physician to approach in case of illness. GPs can treat, refer for further diagnostic tests or refer to a medical specialist. Hospital care, with the exception of emergency care, is not accessible without referral by the GP. Some public health services (provided by municipal GGDs) and prenatal care by midwives can be approached directly.

All Dutch residents are obliged to have health insurance and are subsequently entitled to necessary health care. This is according to the 'Zorgverzekeringswet' (13), which is one of the four laws concerning health care.

UM are not allowed to sign up for a health insurance policy; they have to pay directly for their health care (14). If they are not able to finance this, the Dutch government (partially) reimburses health care providers for services rendered. Article 122a of the 'Zorgverzekeringswet' is a contribution arrangement for non-collectable costs of health care providers, which aims to make health care more accessible for UM. However, only hospitals and pharmacies that are appointed by the government are eligible for 100% reimbursement, as is maternity care. GPs and hospital emergency departments only receive 80% reimbursement. Special arrangements exist for mental health care services, leading to 95% reimbursement. Dental care for UM over 18 years of age, physiotherapy, care in case of an induced abortion, IVF, and gender operations are not eligible for reimbursement. For each prescription UM have to pay 5 euros out of pocket; contraceptives and other medication that is not covered by the Dutch healthcare insurance also have to be paid by UM themselves (6,15,16).

Given the Right to Health, which is declared in the Universal Declaration of Human Rights, the states parties to the present covenant 'recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health' (17). According to an article by Biswas et al. the right to health care for UM in the Netherlands is largely acknowledged (13,18). Nevertheless, access to health care, adequate living conditions, and health outcomes amongst UM are still worse compared to the general Dutch population and to documented migrants (19–21).

Besides language and general cultural barriers, a limited continuity of care was noticed because often UM don't live at the same place for longer periods or give false names. GPs often see a delay in health care seeking behaviour, what could be caused by factors such as shame, fear for

deportation, lack of knowledge of the Dutch health care system and the right to access healthcare, and trust in GPs (22). In addition, health care providers are still not aware of the UM's right to medically necessary care and sometimes refuse care or demand direct payment of bills.

### *1.1 Problem statement*

As UW are an invisible and heterogeneous group with problems of insecurity, this group is prone to health problems.

According to a study by Schoevers UW rated their own health as very poor (11).

In terms of sexual and reproductive health and rights (SRHR) in EU countries, SRH-services for UW are scarcely provided. This also applies to implementation of SRH-policies based on the overall Right to Health (23,24).

In the Netherlands, adverse effects for UW are seen in different SRHR-aspects. Research showed that among immigrants there are more serious complications during pregnancy and delivery (25), partly due to delayed access to care (21,26), with adverse perinatal outcomes and inadequate care (27). For UW, these adverse outcomes could be even worse.

Use of contraceptives among UW was low: only 3.1-8.9% of UW between 18-49 years of age used contraceptives, compared to 41% of the general Dutch population (28). Consequently, 29% of UW have an unmet need for contraceptives (29). GPs discussed contraceptives significantly less often with migrants compared to native Dutch women (30). In Switzerland, more unintended pregnancies were registered amongst UW (31) and in the Netherlands the abortion rate is higher than average amongst UW (64.9/1000 women, compared to an average abortion rate in the Netherlands of 8.6/1000 women)(29).

Abortion without a medical indication nor contraceptives for women older than 21 years are included in the healthcare insurance act, so these costs will not be reimbursed for anybody (15). This means that without charity organisations, UW have to pay for these services themselves. Not having access to abortion care interferes with the right to health and has great implications.

A study among 100 UW showed that screening rates on sexually transmitted diseases (STD) and Pap smears were low (29). In addition, seventy per cent of UW had at least one sexual or gynaecological problem. Most frequently lower abdominal pain was reported, followed by vaginal discharge or itching, urine incontinence, and menstruation problems (29).

### *1.2 Justification*

In the Netherlands, the general practitioner is the key person for primary health care (PHC). Screening for and treatment of most sexual and reproductive health problems are carried out by them, and if necessary they refer to specialist care (7). The accessibility of GPs for UW could be limited due to fear for bills, fear for reporting and deportation, because of a lack of knowledge of the entitled right to health, or refusal of services (32). UW are explicitly vulnerable in terms of their background and

current situation. It has been shown that UM in the Netherlands are less likely to visit a GP compared to documented migrants (33,34). It is suspected that problems with SRH are common, but women do often not mention them spontaneously. This can result in health-seeking behaviour at a later or even too late stage, which could cause serious health problems (35). There are several guidelines available for GPs regarding SRH-issues ([www.NHG.org](http://www.NHG.org)), however, there is none dealing with active detection and discussion of SRH-problems. The combination of vulnerability of UW and the limited access to primary health care could result in a double burden for these women. Though accessibility of health care for UW and reproductive health problems have been studied, the UW's perceptions of quality of SRH-services are still unknown. Therefore, the aim of this qualitative study was to analyse what UW want, need, expect, and experience in SRH-care at GPs. This hopefully leads to practical recommendations for GPs and other HCPs to discuss SRHR with UW in their practice.

### *1.3 Objectives*

#### 1.3.1 Overall goal of the research

To identify and analyse factors of the perceived quality of care of sexual and reproductive health services provided by general practitioners to undocumented women in the Netherlands.

#### 1.3.2 Specific objectives of the research

1. To explore the needs, wishes, barriers, knowledge, and expectations in relation to SRH of UW living in the Netherlands.
2. To explore the experiences of UW while using SRH services in the Netherlands.

## 2 Methodology

### *2.1 Study design*

To explore the current health care situation for SRH of undocumented women in the Netherlands, qualitative research was conducted using semi-structured in-depth interviews, between April and July in 2017.

### *2.2 Study area*

This study took place in the Netherlands, predominantly in and around Amsterdam.

### *2.3 Study population*

The study population consisted of UW in the Netherlands between the age of 18 and 49 years. Although the female reproductive age is considered 15 to 49 years, females under the age of 18 were not approached because of ethical regulations regarding the inclusion of minors in Health Research. We also included a group of health care providers (HCP): GPs, a gynaecologist, a midwife, and a nurse working with UW and SRH.

### *2.4 Sampling and recruitment*

UW were recruited through purposeful sampling by using different medical aid providers for undocumented migrants. NGOs the *Kruispost*<sup>\*</sup> and *Doctors of the World*<sup>†</sup>, and GPs were approached to participate. Physicians working at the *Kruispost* were informed about the study purpose and flyers (see Annex 1) in Dutch or English were provided to UW of reproductive age. The interviewer was present at the location three times a week during consultation sessions for 6 weeks. Via *Doctors of the World*, the interviewer visited locations of their mobile health care providers two times per week during 4 weeks. This mobile practice was situated at a market in the south-east of Amsterdam. In addition she visited a shelter home for rejected asylum seekers four times. One GP informed and asked permission of UW registered at the practice and asked their permission to be contacted by the interviewer, after assuring the UW that the information obtained would be confidential, also to the GP.

UW were selected based on age (18-49 years) and sufficient language proficiency in English or Dutch. Other criteria such as education, country of origin, number of years in the Netherlands, profession and number of children could not be included as a result of the limited number of respondents.

HCPs were recruited through existing networks, aiming at a sample consisting of male and female HCPs. Two GPs working at the *Kruispost* were directly approached; others were recruited through the database of *Doctors of the World* and were known to have many UM in their practice.

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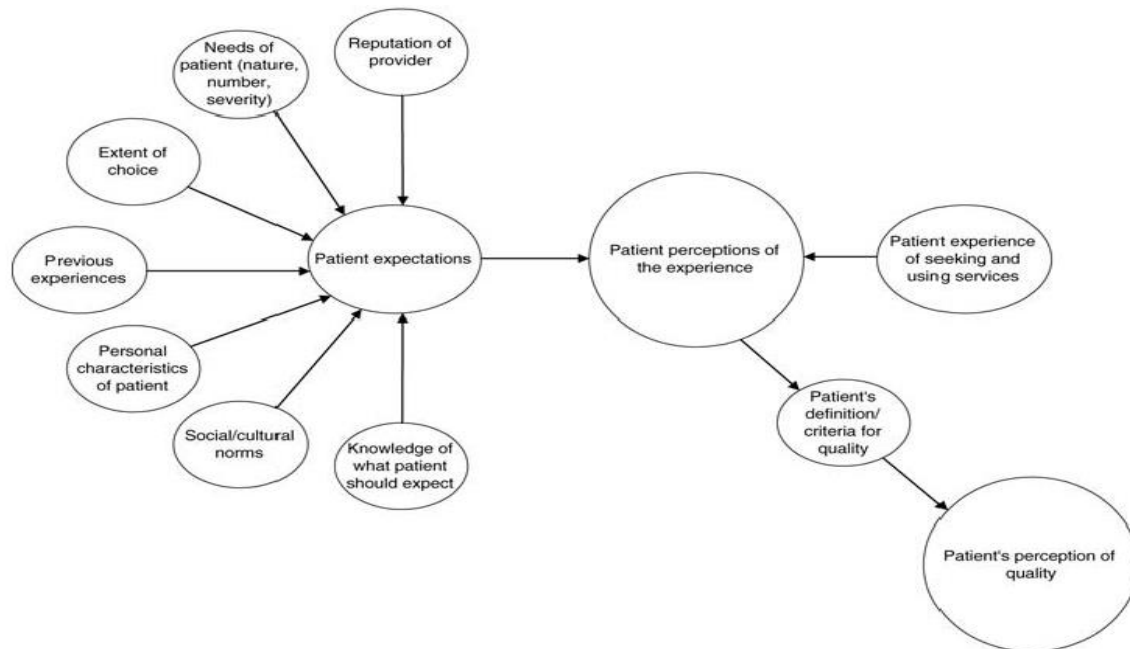
<sup>\*</sup> Kruispost offers medical and psychosocial help to those who are uninsured.

<sup>†</sup> Doctors of the World provides basic medical care and mediates between undocumented migrants and general practitioners.

A fifth GP signed up voluntarily following a request at a platform for safe motherhood. A gynaecologist working in an academic hospital contracted for health care provision to UM, and a midwife known to take care of many UM, were approached and agreed to participate.

### 2.5 Analytical Framework

For this study, a conceptual framework developed by Sofaer et al. (36) was used in order to explore the perceived quality of care in a structured way.



**Picture 1 Conceptual framework developing patients' perceptions of quality of care (36)**

This framework explains patients' perception of quality by assessment of experiences and expectations concerning this topic.

The patient's perceptions of quality are important. Sofaer et al. explained two perspectives why: "it is inherently meaningful and should be a primary focus of attention within the health care system, and patients are powerful drivers of outcomes important to various other stakeholders".

The authors stated that "satisfaction is determined by the difference between a patient's standard of expectancies, ideals, or norms and the same patient's perception of their experiences of care". The model identifies several factors that influence patient's expectations, which are drawn in the model.

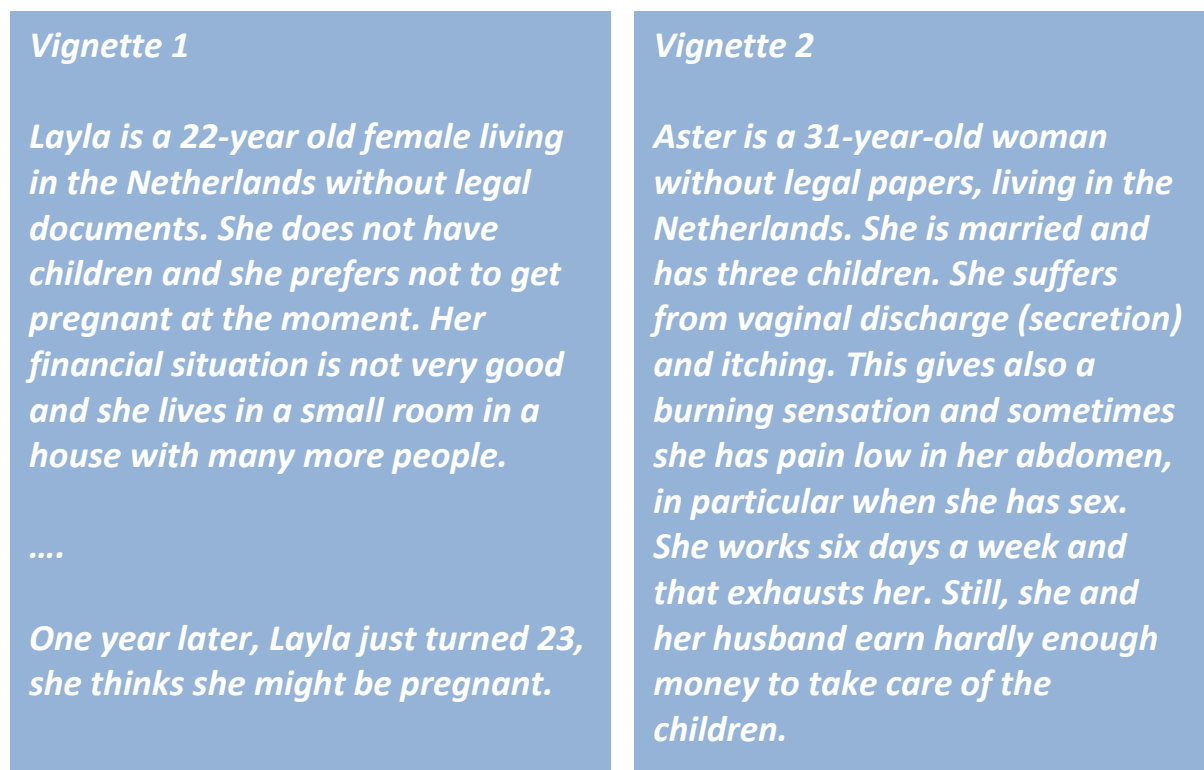
According to this article, patients' definition of experienced quality of care consisted of multiple categories, such as 'patient centred care', 'access', 'communication and information', 'courtesy and emotional support', 'efficiency of care/effective organization', 'technical quality', and 'structure and facilities'.

## *2.6 Data collection*

The topic guide for both the interviews with women and with HCP was based on the Sofaer's framework, relevant literature and expert opinions (see Annexes 2 and 3).

The topic guide did not contain explicit questions about SRH-problems of participants. These were instead explored by using two vignettes about SRH-issues, and gave us the chance to discuss expectations, beliefs, and experiences of peers. Respondents were also asked to share their experience of care of visits to a GP for SRH-issues.

Studies of quality of care (36–38), research of SRHR (9) and determinants of health (studied among migrants in the Netherlands) (39) were used for topics and vignettes.



**Figure 2, vignettes**

We could not actively obtain demographic information, because the first two eligible women declined further participation after asking demographic data. They feared being traceable in the future.

Semi-structured in-depth interviews were conducted. Interviews were held in English or Dutch because the use of phone interpreter services or direct professional interpreter services were not possible. All respondents gave their permission to tape-record the interview.

Interviews took place at a venue of the participant's choice and convenience. There was no financial compensation offered to participants, only drinks and food were provided during the interview.

## *2.7 Data analysis*

The interviewer tape-recorded the interviews and transcribed notes in English. The transcripts were coded and analysed in MAXQDA 12, coding

was subsequently open and axially processed. Double coding was executed by a peer student and took place in three of the interviews. The researcher analysed the information on a weekly basis, and discussed her analysis once every two weeks with the supervisor. In line with the iterative process in this type of study, analysis led to adaptation of the topic-list. Ownership of data is of Pharos and KIT.

Based on the results of this qualitative study and existing literature, recommendations are given for professionals regarding SRH in undocumented women.

### *2.8 Quality assurance*

The topic lists and vignettes were discussed with the supervisor of this study, a peer student and a senior researcher from KIT. An experienced qualitative research professional and the supervisor advised the main researcher prior to interviewing.

Since the sample of UW is small and heterogeneous and member checking was not feasible, the information provided by the HCPs was used to triangulate and enrich the information collected.

### *2.9 Ethical considerations*

This study was approved by the KIT ethical committee, Amsterdam, The Netherlands. All participants verbally gave their informed consent, which was tape-recorded (see Annexes 4,5, and 6).

Afterwards, the participants were given the possibility to ask questions about the topics discussed and were offered help again to register at a GP practice if they wanted to.

### *2.9 Dissemination*

This study is a thesis project for the course of Master in International Health. Concerning dissemination, the aim is to write an article and to publish this in a Dutch medical journal. At the same time, the recommendations will be disseminated online (through [www.huisarts-migrant.nl](http://www.huisarts-migrant.nl)) and will be spread via the Pharos network, e.g. in the working party on Diversity and Global Health (DIGH) of the NHG (The Dutch college of General Practitioners).

### 3 Study results

#### 3.1 General demographics of UW

Twelve undocumented women were interviewed, and all twelve women had lived in the Netherlands for more than five years. Eleven women were living in Amsterdam and one woman near Amsterdam.

<b>Age</b>	Range (years)	23 - 47
	Mean (years)	36,1
	Median (years)	36,5
<b>Country of origin</b>	Brazil	5
	The Philippines	3
	Nepal	1
	Morocco	1
	Nigeria	1
	Uganda	1
<b>Women having children</b>	None	4
	Child(ren) in the Netherlands	5
	Child(ren) in country of origin	3

**Table 1. Demographics of interviewed undocumented women.**

#### 3.2 General demographics of HCPs

*"UW in their fertile age, that is a world of its own."*

- HCP 2 -

No.	Health care provider	Characteristics	Gender	most experiences with UW from:
1	General practitioner	Retired GP, voluntary work with UW	Male	Brazil, the Philippines, Indonesia,
2	General practitioner	Retired GP, voluntary work with UW	Male	East Europe, Ivory Coast, Morocco
3	General practitioner	Many UW in practice	Male	Ghana, Nigeria,
4	General practitioner	Many UW in practice	Female	Uganda, Sri Lanka,
5	Midwife	Many UW in practice	Female	Indonesia, Romania and Bulgaria
6	Gynaecologist		Female	No specific ethnicity



				known of UW
7	General Practitioner	Retired GP, works in asylum centre	Male	East Europe, Morocco
8	Nurse	Specialised nurse for health female genital mutilated women	Female	Ethiopia, Eritrea, Ghana

**Table 2. Characteristics of interviewed health care providers**

The following part of the results will be described in two different sections. In the first section, objective 1 will be outlined following the framework of Sofaer. The second section reflects objective 2: the experienced SRH-services. This section is subdivided in six categories, which according to Sofaer are contributors to the perception of quality of care. In Annex 7 a 'health care providers map' for undocumented women in Amsterdam is drawn, as explored during this study. This map reflects the different stakeholders mediating and providing health care.

### *3.3 Expectations of UW regarding SRH services.*

This section represents the seven different factors constituting expectations, as shown in Figure 1. Seven themes contributing to expectations (drawn at the left side of the framework) will be represented in six subheadings.

#### 3.3.1 Personal Circumstances

Under this section, living circumstances and its influence on health will be outlined.

#### *Living conditions*

Living conditions were generally considered as tough. Also housing conditions were considered suboptimal and were seen as health risks. Many women said they recognized themselves in one of the conditions outlined in the vignettes. Three women used to live in a small room with people they did not know.

*"You always need to be aware with who you are roommate, because if housemates were only women of good, her health will be okay. But if her roommates have different kinds of weird jobs it can have bigger chances her health will be affected"*

*- 30-year-old woman from the Philippines -*

#### *Having no status*

Living here without papers is difficult according to three women. Another three respondents have neither work nor money and said they are dependent on others. One has a small child she has to raise alone. She cannot go back to her country of origin. She stays with acquaintances, but cannot stay there permanently.

*"No money, no papers, nothing. It is so difficult for me, so difficult" [...]  
"sometimes I want to talk with people, I want to cry with people,  
sometimes I would like to eat together or let my daughter play with  
others...it is so difficult.."*

*- 42-year-old woman from Morocco -*

One respondent was pointing out that when you don't have anything you can't stay healthy, it is surviving. Another woman strongly believed that being undocumented could lead to a worse health situation: a friend of her, also undocumented, died of cervical cancer after she had had abdominal complaints already for a longer time. Another woman is worried she would have to spend all her money on medical bills when getting severely ill.

Two women said that it is hard when there is no family to lean on when having medical issues.

At the time of the interview three women had physical complaints and were worried about their own health.

*"I know infection is very dangerous. And in my case if had something  
more, what will I do?"*

*I don't have insurance, I'm not really go there."*

*- 37-year-old woman from Brazil -*

Respondents mentioned that it would be very difficult to survive when getting pregnant or having a baby while being undocumented, especially at a young age. One respondent had experienced being alone with her son and got pregnant in the Netherlands, which was a very difficult situation. Another woman pointed out that there is attention for the woman and the baby during pregnancy and a couple of months after delivery, but after that period she had to manage everything on her own.

### *Language*

Many respondents considered language as barrier.

Respondents pointed out that friends were also important to act as translators when necessary, although daytime working hours would sometimes make this difficult.

*I know of other undocumented migrants who don't speak English or Dutch  
that they feel a barrier to go to the GP because of the language. There is  
no one to accompany them all the time; they often need to work.*

*- 35-year-old woman from Brazil -*

### *Working all hours*

Having work is important in order to survive. But working too many hours, as experienced by many, could cause medical complaints. Although health is important, it is expensive and difficult to visit a GP.

*"Because with us, okay we are sick, but we have to work.  
So sometimes you work all day when you feel no, I need to go to the  
doctor."*

*- 25-year-old woman from Brazil -*

Six women told that they worked hard, making long hours as a cleaner, but earned little. One woman was not able to work anymore because of health problems. Two women mentioned that they came to the Netherlands to work and support their family in their home countries, the same goes for many people they know.

### 3.3.2 Knowledge of rights and health care of UW

This subsection describes the knowledge of UW about their entitlements, and what the respondents knew about health care provision in their situation. The paragraph also includes an explanation of how the UW had acquired this knowledge.

The UW's network is important for mutual help: the women give each other information about the Dutch health care system, point out which GPs provide contraceptives, explain the role of the GGD for STD checks, or searching for midwifery care. Churches play an important role in this network. Most women knew other undocumented persons living in their environment. Also HCPs confirmed that many women had a network through the church, where they were advised to get health care.

Seven women had heard from other UW that they could visit the *Kruispost* for medical help.

One woman explained that during the first year in the Netherlands, when she hardly knew anyone, she didn't know where she could find medical help.

*"I don't know nothing. Like I never go to find why, how I can do, no.  
My first interest with Dutch health care was when I was pregnant."*

*- 35-year-old woman from Brazil -*

Two women were told about a GP practice with many registered UM. Five women knew about the existence of GP practices, but thought they would have to pay consultation fees, which they thought would be very expensive. From the 12 interviewed women, 7 knew the *Kruispost*, where no fees are charged. Two women had experienced care by *Doctors of the World* and another woman had heard of them.

In case of emergency (4 out of 6) women didn't know where to go to and thought they would need to wait until the next available consultation

session at the NGO. Only one woman was convinced that all people would be helped in case of emergency, either *legal or illegal*. Half of the women (6 out of 12) thought they could not go to a doctor because they didn't have money or insurance. Two other women were saving money to be able to consult a GP and gave priority to this.

#### *SRH-specific expectations of approaching health care services*

Many women (8) mentioned they assumed or experienced that they can go to a GP for contraceptives. Most women would use a support organisation such as the Kruispost, but two women also mentioned they went to the 'regular' GP or would approach Doctors of the World. One woman didn't know any place where to get contraceptives. For pregnancy care, 8 women knew or assumed they could consult a GP in the first trimester. Three women would go directly to a midwife, but if they needed to pay they would go to the Kruispost. Only one woman would go back to her home country when she would find out she is pregnant, and another one thought she would go to the hospital in the third trimester. The knowledge of options for abortion care varied. Two respondents did not have any idea where to go when someone is having this wish, one would go to a GP to get a referral for an abortion clinic, and the remaining four women thought they can ask for help at the Kruispost. Four women thought that in case of infection risk one should go to a gynaecologist, but cannot go there because of illegal status, one woman would go directly to the GGD.

#### 3.3.3 Needs for SRH of UW

This subsection describes the extent of needs of UW regarding SRH services. Also the knowledge, opinions, and beliefs of SRH-issues will be outlined in this paragraph.

#### *Contraceptives*

Generally, contraceptives were considered as a need for UW in reproductive age. Eleven women mentioned that it is very important to be able to protect against pregnancies when living in poor circumstances, and especially in young age.

*"In Brazil a lot of young girls got pregnant, 15, 16, 20 years old. In Brazil it is normal, but not for me."*

*- 31-year-old Brazilian woman -*

*"She needs to protect herself, because when she got pregnant, how is she going to cook?"*

*- 47-year-old woman from Nigeria -*

The knowledge, opinions and beliefs about contraceptives were diverse (table 3). Everyone knew the concept of contraceptives.

All twelve interviewed women had at least heard about the option of oral contraceptives. Eight women also mentioned condom use as an option to protect against pregnancy. Intra uterine devices were known among 7 women (hormonal or copper). Six women knew Progesterone injections. Two women mentioned withdrawal as an option, and one person mentioned the morning after pill. Implanon and contraceptive plasters were both only mentioned once. Seven women mentioned the option for an abortion in case an unplanned pregnancy occurred.

Contraceptive	Positive	Number of UW	Negative	Number of UW
<b>Pill</b>	Woman is in control	2	Easy to forget and therefore not safe	2
			Increase of body weight	2
	Relatively cheap	3	Causes foetal deformities	1
			Causes permanent infertility	1
			Not safe	1
<b>Injections (progesterone)</b>			Caused gastritis	1
			Caused madness	1
			Expensive	1
<b>Condoms</b>	Convenient for occasional sex	2		
<b>IUD</b>	Long lasting	3	Causes uterine abnormalities (cancer)	1
	Relatively cheap	2	Insertion lot of effort	1
	Safe	1	Insertion is painful	2
<b>(Hormone containing)</b>	Also effective for menstruation disorders	1	Expensive	3

**Table 3. Positive and Negative Opinions about Contraceptives**

Two HCPs explicitly mentioned that there is poor knowledge about contraceptives; furthermore, HCPs added that many women prefer to have a monthly menstruation and some dislike having a foreign object inserted, such as an IUD or Implanon in their body.

HCPs added to opinions of contraceptives that many women prefer to have a monthly menstruation and some dislike having a foreign object inserted, such as an IUD or Implanon in their body.

Regarding discussing different options of contraceptives, 3 women explicitly said they preferred to get information about all available options. This information is important, because when you don't know you don't ask about it. One woman made clear that if she did not want to receive information about other options when asking for one particular type of contraceptives.

In addition to the need for contraceptives and information, affordability was also discussed. Having financial resources had an influence on the choice. Few women (2) said they would only choose the cheapest option available, one of them explained that women she knew would do the same. Three women thought oral contraceptives in the Netherlands were relatively cheap and affordable. Condoms are expensive according to one woman, but another said she made use of the available free condoms. One woman was surprised by the price of a copper IUD; she considered it to be low, especially because it can last for 5 years. Two respondents considered themselves in a reasonably good financial position and expressed importance of health.

*"But for myself, I always try to do the best for me. Also for me it is really expensive but it is to care for myself"*  
-30 year-old women from the Philippines -

*"I need to take care of my life, the price is not a problem."*  
- 35-year-old woman from Brazil -

#### *Vaginal infections and screening*

Regarding vaginal infections, ten (out of ten) women thought that complaints of vaginal discharge and pain are serious and need to be checked.

Although the need of health care was acknowledged, the knowledge about vaginal complaints and infections could be considered as poor.

Four women knew of STDs such as gonorrhoea and syphilis, and two of candida infection. Besides sexual transmission, one thought that also toilet visits are a source of contamination.

While two women thought that vaginal infections are getting worse when waiting longer, one woman would first start with self-medication, such as Clotrimazole, which is an Over The Counter drug, before consulting a doctor. That would be a good option, provided that someone would consult a doctor if complaints were not dissolved in a few days.

Three respondents were aware of the Pap smear for screening purposes, and one woman said she was afraid for cervical cancer. She thought she couldn't test because she is undocumented.

All HCP noticed that many UW had poor knowledge of their body. But some said there was no difference with documented migrants.

*"You have to talk with them to find out what understandings, knowledge and insights there are."*

- HCP 6 -

According to HCPs, most common SRH-issues to seek health care for were: (unintended) pregnancies, menstruation problems, myomas, and abdominal pain. At the NGO, women also asked about contraceptives (mostly Brazilian women), vaginal discharge, or risk of STDs. Requests for abortion were not uncommon. The gynaecologist gave examples of UWs who had arranged tablets and had used them in an uncontrolled setting. But none of the providers had heard of any unauthorized curettages being done.

Though all HCPs asked about living circumstances of UW, a couple of them also asked about ideas of diseases, or history of (sexual) violence. HCPs mentioned that many UW had experienced sexual violence or sexual transactions. One HCP estimated that a third to half of her UW patients had a history of sexual abuse. One HCP noticed that UW had a more risky sexual behaviour compared to his regular patient population. Three HCPs heard that some UW had sex in change of money or goods. Three HCPs thought that it would be important to ask all UW of reproductive age about their history of abuse and contraceptive use as part of general intake.

#### 3.3.4 Social and cultural norms

Social and cultural norms can be both general and health specific. These norms include, amongst many others, involvement of the partner, expectations based on experiences in country or origin, and personal feelings about (communication about) SRH-issues.

##### *Role of partner*

The opinions about the role or influence of partners were different and depended on the situation. One of the women mentioned it is normal and accepted to discuss contraceptives with her boyfriend.

According to six women, it is important to involve the husband/partner when someone is having symptoms such as abnormal vaginal discharge.

*"Sometimes you might be in a very bad condition that you don't want to go without partner, then he has to be aware of the situation"*

- 36 year-old women from Uganda -

Three women think that when a woman has discharge symptoms, the husband also needs to be treated.

*" The disease is sexual, 100% she has a problem with her husband."  
- 46-year-old woman from Brazil -*

One woman thought that having these complaints can lead to less frequent sex, and the partner might then cheat on her. Few women (2) said they would not involve their partners if this would happen, one because she talked about it with her female friends, and one because she doesn't feel comfortable at all to talk about intimate issues with her partner. Only one woman pointed out the partners' influence on choice of contraceptive, her husband didn't want her to take hormonal contraceptives and used condoms as a preventive measure.

#### *Different health care in country of origin*

Three Brazilian women mentioned that they had been used to a more frequent preventive care in their country of origin. In SRH-terms this means an STD check every 6 months and a Pap smear every year, but that depended on the insurance situation as well.

One woman wanted to have a Pap smear but the GP refused because the interval with the previous one was too short.

*"So in my case I always in my mind you need preventive. Because I am in Europe, it is the first world you know? In Brazil is poor country, and then there they used to do it every year, it is strange.... So I was sad. When you go in my experience I always been sad, sad. Cause you try and you can't and you go and nothing happened."*

*- 37-year-old Brazilian woman -*

#### *Discussion of SRH-issues*

Not many women used to talk about contraceptives before, but surprisingly most women did think this would be important to do. Three women mentioned that in their country of origin it is not accepted to talk about contraceptives before marriage. They noticed a difference with a more open culture in the Netherlands. All three women were in favour of disclosure of this topic at younger ages and one had the intention to be open about it with her daughter. One woman mentioned explicitly that she could only discuss contraceptives when a GP is very trustful.

*"I think the majority of women that know (contraceptives) are the ones who are married. But for the people who were single, they are always avoiding. Some of them like trying to use but it is always hiding. Because some like the dignity... we are not really open."*

*- 30-year-old woman from the Philippines -*

Five women were asked what their opinion is when a GP starts the topic of contraception without this being the reason for consultation. All



respondents had a positive opinion about it. Four of them reasoned that they think there was a lack of information about contraceptives and it is an important topic. One of them suggested to approach churches for that, another one advised to start with the question whether someone is using contraceptives and subsequently ask if the person would like to have information about this. All five women said they trusted the good intention of doctors and it would be good to obtain information. However, one woman first wanted to understand why the doctor would ask her something about her contraceptive status.

*"I think it is okay because like here we don't know. I am still 23 and don't know these kinds of things and like when I had a boyfriend...if you get sick or pregnant, you need to protect yourself, so you need to take pills like that because in our country we are not doing that. And that is important."*  
- 23-year-old woman from the Philippines -

The topic of abortion is a sensitive one. Three women had advised women with an unwanted pregnancy to go back to their parents. The majority of the interviewed women explained that abortion is not allowed in their country of origin and had religious concerns. One woman mentioned spontaneously it would be a good idea that a GP discusses all the options when someone is pregnant. Because if her network disapproves the idea of abortion, she might feel desperate and a GP can help her making decisions for her current situation.

For some women talking about specific vaginal complaints with a GP was expected to be difficult.

One woman said she could imagine that talking about her problems would feel a bit difficult to explain and shameful.

*"She might feel dirty and it is somehow private."*  
- 36-year-old woman from Uganda -

Two other women said that if they would have vaginal pain and discharge, they would tell everything but would be a bit hesitant. It would depend on how comfortable the doctor would make her feel. On the other hand they want the problem to be solved, so they thought it would be stupid if they didn't tell and ask everything. Six women thought it wouldn't be a problem at all to discuss these problems with a doctor. Two of them said they wouldn't be ashamed at all, others mentioned that the doctor is a professional and is there to help people so she shouldn't be afraid.

### 3.3.5 Extent of choice and reputation of GP

This is a merged subsection. In this subsection the (expected) extent of choice available for UW will be outlined. Also the reputation or opinion about GPs in different settings will be discussed.

#### *Perceived extent of choice*

Ten out of twelve women knew the *Kruispost* and used it for primary care. Seven women said they could only go to the *Kruispost*, of which 3 women did not know other medical instances, whereas for others the financial situation played an important part in choosing for the *Kruispost*. Two women had also been to the *Kruispost*, but are registered at their 'own' GP practice as well. They are more content about consultations at the latter. These two women said that there are only few GPs in Amsterdam known to treat undocumented people. The opening hours of *Kruispost* are however more convenient in a working situation. Four women had visited a GP once, but had to pay, and did not return. Two women didn't know other places to go to with a medical problem, and would only go to the *Kruispost*. Two women heard of GPs but thought they had to pay the bill themselves. They were also anxious to be reported to the police.

*"Well in my case, I don't have paper like that, I heard before, you can pay at the private doctor (GP), you can go here, and when I heard of the Kruispost. So that they can also help illegal person like me so you need to pay may be 5 euros."*

*- 37-year-old woman from the Philippines -*

#### *Reputation*

One woman thought that a regular GP is taking medical issues more serious than doctors at support organisations, She felt that a GP in a regular practice would perform a more thorough physical examination by own experience. She also heard this from others. But another woman's opinion was that GPs in general don't request additional tests, they only perform physical examination and give treatment.

*"I don't know, may be because we are immigrants the treatment is not good.*

*For me it was not good. I felt I [mis]spent my time."*

*- 37-year-old Brazilian woman -*

Four women thought GPs only prescribed medication in a late stage of the disease and thought it should be done earlier. One woman heard of a friend that doctors in the Netherlands don't like to prescribe medication because they receive money if they don't prescribe.

*"The doctor knew I want the prescription here the first time. And then she gave me on the third time. I thought in the first time she give I was good, and then I didn't need to go there again."*

*- 37-year-old Brazilian woman -*

Three women were very pleased, generally speaking, said health care providers here are very 'sweet', they are trying to do their best and the help is very good.

### 3.3.6 Previous experiences with health care

For this subsection, previous experiences with GP health care, not related to SRH issues, are described. This has an overlap with the previous section. In general, the previous consultations had been experienced negatively. The reasons for this were unsafe feeling to register, too expensive, and unwillingness of the GP-assistant to register.

A woman said she GP-assistant only asked whether she was insured or not and did not accept her to register.

One felt discriminated when visiting for her son.

*"The doctor told me: 'can I say something to you? May be you go to Brazil with him because you have a good problem with him here'. I said: 'Why do you say that?' But I feel he don't like immigrants, illegal people. We know we are not Dutch people but he didn't take good care of my son."*  
- 35-year-old Brazilian woman -

Three other women mentioned GPs only give painkillers and no other interventions were done and three women said GPs would tell you that all the experienced physical complaints were normal without any tests such as x-rays or lab-tests.

*"They just tell you, go take Paracetamol. That is the only thing."*  
- 36-year-old woman from Uganda -

One woman mentioned that she trusted Brazilian doctors more, after a Dutch GP missed her diagnosis.

Three women said that they had been examined properly before they received medication, which was uncommon in their country of origin, where they got medication right away. They also valued the examination and referral.

Two women who had multiple contacts with the same GP felt treated equally as any other patient who is visiting the practice, a very respectful approach.

### *3.4 Experience of using services and patient's criteria for quality*

In this section, the experienced SRH services and value judgements of different aspects will be described. Nine women had experiences with SRH services provided by GP. Four women consulted the GP for pregnancy-related care, two for contraceptive purposes, two women for vaginal infection (risks), one for cervix screening, and one woman for menstruation problems. In the previous section regarding objective 1, previous non-SRH experiences were outlined, as well as previous knowledge, needs, beliefs and expectations. In this section, experienced SRH-services will be described.

#### 3.4.1 Patient centred care

In general, women appreciated the open-minded and respectful attitude of GPs and the showed interest in their personal situation. They experienced shared-decision making and also valued the possibility to ask and discuss.

*"Because here they are open-minded, and not as in other countries. Like in my country a lot of young girls they get pregnant because they are not using pills like that"*

*- 23-year-old woman from the Philippines -*

One woman explained that for her it felt easier to talk about SRH issues with doctors in the Netherlands. In her case, she had experience with her early pregnancy, which was unplanned and made her desperate at that moment. She mentioned she had the idea that doctors are balancing between respecting the cultural background on one hand and their own culture and medical interventions on the other hand. She didn't feel any cultural barriers. She appreciated that her doctor was informing about her current situation and feelings. The GP gave her support and advises. About being asked intimate questions, such as vaginal problems or about their sex life, six women told they didn't feel uncomfortable.

*"They asked me if I was with another man, my boyfriend was with another woman, they ask if I use condom, about sex, about sex, about sex. For me it is all okay."*

*- 23-year-old woman from the Philippines -*

Two women trusted that the questions asked served a purpose and therefore were right.

*"No because you want to get an answer, you want to get better. So your only hope is to say out what is going on, then you can be helped. Otherwise, when they don't know you cannot be helped."*

*- 36-year-old woman from Uganda -*

One woman experienced that when she was pregnant the GP explored her situation and opinion. She explained the health care system in the Netherlands, also the legal possibility to abort. The woman said, despite

wanting to keep the pregnancy, she appreciated the open attitude very much. Especially because the people in her network would have different (cultural) opinions. Her opinion was that all undocumented people should go to GPs.

*"Because when you have people in this situation, she wants to see the light of the end. I think, you (GP) know you are a person, you have the things of your day, but if you receive someone in your practice, maybe she will only need one...how can I call it...you need to help her to decide. And try to feel what she have. Try to put in the place of her. And maybe you understood good, how you can do for the people."*

*- 35-year-old woman from Brazil -*

All HCPs said that creating a confidential bond is crucial to obtain information, to open up new, possibly sensitive topics and to win the patient's trust. Showing interest and accepting cultural differences in beliefs and treatment resulted in better shared-decision making and better outcomes. Three HCPs said they only asked UW about their background if there were clinical symptoms that could be related to their ethnicity, or had received a clear signal that the UW was willing to talk about her background. One HCP confirmed that many GPs didn't know the background of a referred UW.

In general, HCPs thought most UW were satisfied after consultation. Two HCPs noticed that women were surprised that she/he had put that much of effort into helping them. Also two HCPs noticed that UW tried to return to them. However, that could be difficult in their situation.

Two women complained about the limited time available for a consultation.

Women mentioned that they were unsure if the doctor took her financial situation into consideration.

#### 3.4.2 Communication and information

This section includes characteristics such as open communication, listening carefully and attentively, and adequate and clear provision on information.

In general, women thought the communication was very good: the GP really tried to understand the women and listened very well. Also GPs explained the diagnosis and told what women needed to do.

One woman mentioned how she appreciated that the GP said her diagnosis was common for women. That reassured her.

UW experienced that GPs asked intimate questions to UW, when necessary.

Three women explicitly said that there is neither a language nor cultural barrier, though, on the contrary, it was difficult to understand everything precisely. Some women wouldn't appreciate a third person for these kinds of problems, and preferred a professional translator by phone. Only a few

times the GP explicitly asked an UW if she would like to make use of a professional translator.

In cases women experienced discussion of contraceptives, most of the times only one type of contraceptive was discussed. UW couldn't explain the reason for that. They said they didn't ask for more information either.

HCP's experienced that communication is often a challenge with UW. Three HCPs frequently used an official interpreter. In addition, half of HCPs used Google translate or asked to bring a companion. Often images were used to support their explanation.

Only three HCPs said they asked women to explain what he/she had told them, to check if the UW had understood the information (teach-back).

There is more openness to communicate about SRH issues with HCP among African and Brazilian women compared to women from Asian or Arabic origin. According to the HCP the ethnic background is an important factor in how open a woman would be in explaining her problems and knowledge of SRH-issues. In general, Brazilian and Sub-Saharan African women are more open about sexual and reproductive health. Arabic and Asian women tend to be more closed and ashamed.

All HCP underlined the importance of discussing contraceptives with UW of reproductive age, however, the way to introduce this topic could be difficult when there is no relating question of problem.

#### 3.4.3 Courtesy and emotional support

Most women experienced a friendly and supportive doctor.

Two women said they appreciated that the doctor showed his concerns.

Five women called their GP nice or friendly and helpful. Two women explained that the doctor showed respect and empathy, and was interested in their living circumstances. The GP made them feel comfortable and took time to introduce himself. They trusted the GP.

*"She has a good energy, you feel when people like to help you. You can feel that you can talk about everything with her."*

*- 35-year-old Brazilian woman -*

Characteristics of a good doctor were given, such as: being polite, friendly, to show that you are there to help, to put at ease, and by saying that some other women also suffer from these diseases. That was supportive.

#### 3.4.4 Access

All HCPs thought UW would eventually come to them, but there is a clear delay, especially for the first visit. Women don't visit them with minor complaints and HCPs thought many of them hesitated to go to a clinical practice. They suspected a threshold because many women don't know what to expect. Some HCPs thought women feared to be reported as

undocumented, and feared bills. This experienced barriers in access is in line with the previously stated barriers mentioned by UW in section 3.1.

Three women were neutral about the gender of the doctor; one mentioned that in her country of origin most gynaecologists are men. Six women said they would prefer a female doctor, because they would be shy otherwise. But four of them said that if the doctor were a male they would still go, 'because that is the only way of surviving'.

Concerning gender concordance, HCPs mentioned that Muslim women preferred female doctors. For women with other backgrounds, there were no differences experienced compared to documented migrants or even the native Dutch population.

HCPs confirmed the earlier opinion of UW that they could not afford most types of contraceptives. Besides, problems with compliance and existed beliefs about contraceptives were barriers.

#### 3.4.5 Efficiency of care

This topic means coordination between individuals and organisations, such as referrals and communication between HCPs.

Seven women experienced a smooth referral process to the hospital, GGD, or midwife, though one was not aware she had to pay a large amount of money to the midwife. One woman said that she never experienced a mismatch in her expectation and treatment plan given by the GP. She also said that she trusted that the doctor always finds a way to refer if necessary.

#### 3.4.6 Perceptions of technical quality

The perceived quality of skills provided by GPs was more divided.

Three women felt that the GP examined them thoroughly for their SRH issues and they were treated right. Also two women trusted that the knowledge of GPs is good. Furthermore, one had the idea that for GPs it can be difficult to have the right knowledge about diseases or health beliefs of migrants. One woman thought that the GP was competent, but that he waited too long with treatment options and she couldn't understand why she got a Pap smear only every 5 years.

Two women experienced that the doctor very easily said that everything was normal, without checking by additional tests, such as ultrasounds. One of them said that her problems were still there and she wouldn't go back. She lost hope; she thought she would get Paracetamol again instead of being referred to a specialist.

One woman thought that if she would pay more she got better examinations.

All HCPs mentioned that being undocumented didn't lead to other treatment decisions compared to insured people, with the exception of infertility problems. In contrast, diagnostic tests, such as pap smears and

STD tests were performed earlier, considering the higher chances of finding abnormalities. Not all HCPs were discussing different types of contraceptives with their patients. The extensiveness of explanation depended on the questions of the UW. Sometimes women used already a contraceptive, which was started in their country of origin. So, in case of an extension request, GPs only evaluated the use instead of given all other opportunities.

There were some differences in how or where to give treatment, but this depended on factors such as housing, support system, and ability to call for help.



## 4 Discussion

This study was performed to understand how undocumented women think about sexual and reproductive health and the quality of SRH-care provision in the Netherlands.

The framework of Sofaer et al. served to explore the perceived quality of care, which can be determined by experiences of care in view of previous expectations.

### *4.1 Answering objective 1: Discussion of needs, wishes, barriers, and expectations*

UW considered contraceptives and SRH related problems, such as vaginal infections as needs to go the GP.

Access to primary health care (PHC) seemed to be problematic, as was expected: most interviewed women knew their way to an NGO for PHC, but only few women knew they could go to a regular GP practice. Financial aspects, being uninsured, no admittance to register at GP practice, being unaware of how to approach a GP practice for the first time, and fear for being reported were reasons for not using regular GP care. Although the majority of interviewed women only assumed (one of) the previously stated barriers, some of UW had actually experienced them. In Amsterdam, UW knew of only a small number of GP practices that admitted undocumented migrants. The health care providers confirmed this. In addition, in 2012 an NGO also reported that they struggled to find GP practices in Amsterdam that admit UM (40).

The living circumstances of undocumented migrants had clear health impacts. Some interviewed women said they worried about their health, didn't have a family to lean on, or knew people with advanced stage illnesses because of their undocumented status. Lack of social support and family among ethnic minorities was found as one of the possible barriers to health care according to Scheppers et al.(43)

In addition, Kuehne et al. showed that in Germany, living without legal papers has a negative impact on health (44).

All the respondents emphasized the importance of social networks and health care utilization. People living in comparable circumstances helped and informed each other. Churches and support organisations played an important part here. Also HCPs emphasized the role of word of mouth recommendations and the influence of churches. According to a study of Devillanova performed in Milan, Italy, strong networks significantly promote PHC utilization (41). Our study was conducted in Amsterdam, where relatively high concentrations of UM live, and where support organisations were established. This probably contributes to stronger networks.

Interviewed UW stated that being in vulnerable situations such as not having documents nor work nor money could result in high dependency on

others. On the one hand, networks of UM such as 'We Are Here'<sup>‡</sup> empowered themselves and provided shelter homes and food. On the other hand, UM, especially women, were more prone exploitation or sexual abuse (8,29,42). HCPs indeed noticed a large percentage of UW who had been or still were sexually abused or needed to prostitute themselves in order to obtain goods.

All interviewed UW had at least some knowledge of contraceptives and believed it important for women to be able to protect themselves against pregnancies. The majority of women only knew one or two types of contraceptives and some (false) side effects. Although the importance of contraceptives was acknowledged, not many UW actually used them. Lack of information and mismatch between the ideal form of contraception and its affordability were the major arguments given by UW. According to HCPs some women explicitly prefer regular vaginal blood loss or do not want a foreign object, such as IUCD or implanon in their body. Together with financial restraints and knowledge these factors determined the decision about use or type of contraceptive.

HCPs had the impression that knowledge of health and body among UW was poor. This is supported by an international review by Scheppers et al. about potential barriers among ethnic minorities and the use of health services. The authors stated that cultural perception, language skills, health beliefs and attitudes, and lack of knowledge about disease and physiology all could act as a barrier and led to ineffective communication and understanding (43). Also results of our study showed that HCP noticed poor knowledge of contraceptives in UW, and UW mentioned that they were eager getting more information about contraceptives. Meanwhile, there are signs UW do not spontaneously mention SRH issues easily(29).

The quality of conversations would improve by using an professional interpreter (43). Taken all this into account, it is still unsure whether understanding was achieved between UW and HCP, also in our study. Brink et al. showed that there was a discrepancy between self rated knowledge about contraceptives and effective contraceptive use among Curacao women (47).

Education and information both are important for effective contraceptive use.

HCPs, especially those in one particular part of Amsterdam, noticed that not many UW used their services to obtain a prescription for contraception. According to Raben et al, contraceptives were less often discussed with refugees and migrants compared to native Dutch people (30). It can be assumed that the same applies to UW.

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<sup>‡</sup> 'We Are Here is a group of refugees in Amsterdam. The group decided to make the inhumane situation that they have to live in visible, by no longer hiding, but showing the situation of refugees whose asylum requests are rejected in The Netherlands.' [www.wijzijnhier.org](http://www.wijzijnhier.org)

Surprisingly, both UW and HCPs supported the suggestion of the researcher to discuss contraceptives with all UW of fertile age. There were, however, some critical remarks on how to implement this.

In our study, there was a high percentage of Brazilians. It seemed that these women had more knowledge about SRH-issues than the UW coming from other parts of the world, and were used to regular check-ups for STD and cervix screening in Brazil. They also had the wish for periodic screenings in the Netherlands.

In general, the UW considered it necessary to visit a GP or gynaecologist in case of vaginal complaints. All UW knew these were associated with sexual transmission. Subsequently, women thought their partners should be involved for having a better understanding and getting treatment.

#### *4.2 Discussion of objective 2: experienced health care*

Generally, women who had experiences with SRH-services were satisfied with them. Most women considered communication about gynaecological symptoms and sexual behaviour related to symptoms or infection risks as positive. Some women did however mention feeling shy or ashamed to talk about it. Women said that talking about these problems was necessary to receive help and were of the opinion that doctors were there to help them. Open-mindedness, a respectful approach towards cultural differences, and exploring the current circumstances of women were all mentioned as positive characteristics of GPs. Furthermore, it was appreciated that GPs showed empathy, were friendly and put women at ease.

HCPs said they saw ethnical differences in how women communicate about SRH-issues. In general, Arabic and Asian women tend to talk less openly about intimate problems than.

Schoevers et al showed that SRH problems were common among UW, but rarely mentioned spontaneously (11). This is an interesting finding, however, this was not explored in our study.

UW rated the quality of information provided by their GP as satisfactory, meaning explanation was generally sufficient; there was often room for asking questions. Especially the shared-decision making process was appreciated. Nevertheless, some women said the GP should know what was best for them.

A negative comment concerned time pressure during consultations.

As stated before, women had experienced information and explanation as sufficient, nevertheless during the interviews some of them realised that not all available information had been given. E.g. not all available contraceptive methods had been discussed with women who had requested a prescription for one specific form of contraception. Nevertheless, the openness in discussing especially vaginal infections, pregnancy and abortion was very much appreciated.

Language problems, which are often seen in literature as a major barrier for access of UW to PHC (22,34,43), were not found to be problematic in this study. However, since the interviewed UW were selected on their ability of speaking Dutch or English sufficiently, our results may be biased and the UW in this study may not be representative for common clinical practice. To overcome language barriers, GP explained that they used pictures, but few HCP used phone interpreters to achieve better understanding. The phone service for translation was used only by HCP who could get reimbursement.

HCPs noticed delayed first visits. The UW came with pregnancies, vaginal infections, and menstruation disorders (mainly due to myomas) at more advanced stages compared to documented migrants and native Dutch people. This occurrence was also presented in a report of Nivel (21). It was unclear if UW noticed that they had a delay causing adverse effects.

It was remarkable that none of the interviewed women considered male GPs as a reason not utilising care for SRH issues. However, a substantial number of women preferred female doctors if they could choose. One of the explanations was that most gynaecologists in their country of origin were male.

HCPs had different opinions about the role of the HCPs' sex and other barriers to discuss SRH-related topics. Cultural and religious backgrounds played a role in situations where (undocumented) female migrants refused to be seen by a male GP. But in the opinion of HCPs, for most UW there was no difference between male and female GPs. Having a confidential bond was more important to open up problems according to both UW and HCP. However, it is important to realize this outcome might be closely related to this particular study sample.

The assessment by UW of the quality of knowledge and performance of GP showed that most UW trusted the medical skills of GPs, but were aware of cultural differences in the health system. According to UW, these differences caused a delay in treatment ('let's wait to see what happens') or resulted in another treatment than expected (or wanted) ('please take a paracetamol'), or less diagnostic screening options. In addition, the knowledge of GPs about diseases that are more specific to certain ethnicities was called into question.

UW acknowledged the existence of a confidential bond between GP and patient. Opinions about GPs as not being a 'real' doctor, which was described in a 2009 report by NIVEL (22), were not uttered by the UW in this study. The reason for not considering GPs as full doctors was, according to the NIVEL report, due to having a poor knowledge of the Dutch health care system. Undocumented migrants thought that specialist care was inaccessible because of their status.

Also in our study some individuals thought they could not directly visit the hospital and were forced to rely on GPs at voluntary medical support organisations because of their entitlement. Our study provided little information on the assessment of physical performance, such as physical examination or treatments.

#### *4.3 Experienced SRH services for UW and the current policy*

Every person, irrespective of his legal status, is entitled to the Right to Health. This Right to Health is not merely right to access of health care, but also includes safe drinking water and food, adequate nutrition and housing, healthy work and environmental conditions, health-related education and information and gender equality. Entitlements belonging to the Right of Health are:

- "The right to a system of health protection providing equality of opportunity for everyone to enjoy the highest attainable level of health;"
- "The right to prevention, treatment and control of diseases;"
- "Access to essential medicines;"
- "Maternal, child and reproductive health;"
- "Equal and timely access to basic health services;"
- "The provision of health-related education and information;"
- "Participation of the population in health-related decision- making at the national and community levels. (17)"

The Netherlands implemented article 122a in the national health insurance law 'De zorgverzekeringswet'. This stated that all uninsured people should get medically necessary care. Medical doctors determine the necessity of care. According to Biswas et al. (18) the Netherlands is theoretically meeting its obligations.

However, access to health care is still problematic, as also found in our study. NIVEL stated in its report of 2009, that access to primary health care services had improved compared to ten years ago. The main reasons for this improvement consisted of a higher concentration of UM in few GP practices and the increased awareness of reimbursement for care for UM among GPs (22). This phenomenon was also seen in our study. Both UW and GPs mentioned there were only a few regular GP in the Amsterdam area with relatively high concentrations of UM. Many other practices refused to register UM because of several reasons. Bakker et al. confirmed that 'although the Dutch health care legislation should facilitate accessibility in principle, it does not guarantee access to health care in all cases'(45).

In this study, the interviewed HCP, who see and treat UM, mentioned that they made the same decisions about treatment, diagnostic investigations or referral for UM as for insured patients.

When coming back to entitlements of the Right to Health, the principles of 'the right to prevention, treatment and control of diseases' and 'the

provision of health-related education and information' should be discussed in relation to the current situation of SRH services should be discussed. Induced abortion on social grounds is an intervention that is under law Termination of Pregnancy, and not seen as basic health care. This means that the government will only pay costs of abortion for women with a legal status, leaving out one of the most vulnerable groups for unwanted pregnancies, namely UW.

In addition, in our country, everyone of 21 years and above has to pay for contraceptives. Regarding the need of women to be able to prevent pregnancies and the high (unmet) need of contraceptives amongst UW(29), contraceptives should be considered as basic health care.

Not surprisingly, abortion rates are much higher among UW (29,46) compared to the general Dutch population. Considering the living circumstances of many UW and the high risk of being victimised of sexual abuse, and the high abortion rate, this is an urgent call to policy makers to make contraceptives (freely) available for them.

Preventive cervical screening is another issue what is not considered as basic need, although national screening programs for documented women do exist and are free of costs. UW cannot be notified by letter, but health related education and information should be in place.

Cervical screening is a cost-effective prevention method, however, quality adjusted life years (QALY) used for calculations cannot be measured for UW. And as in the study of Schoevers (29), also in this study several women mentioned spontaneously being concerned of developing cervical cancer.

A number of recommendations and motivational factors to improve contraceptive uptake among vulnerable women in the Netherlands had already been explored. In a qualitative study of Rijlaarsdam et al. about vulnerable women in the Netherlands and contraceptive use, five (motivational) factors resulted in adequate contraception use, namely money, knowledge, responsibility of discussing contraceptives, talking about sexuality, and emotions of rational suitability of raising a child against intrinsic desire of having children (48). Also PICUM wrote a report on how to improve and promote SRHR for UW in European countries, among others on the level of policy makers and training for service providers (24). These tools would be helpful for the future purpose to improve the accessibility of contraceptives and other SRH-issues.

#### *4.4 Strengths and limitations of the study*

There are only a few studies about undocumented women and their perception of the quality of health care. Discussing sexual and reproductive health and rights can be sensitive, therefore it is important to have a better understanding of health care seekers. This study has tried to fill that gap.

However, there are several limitations. The UW studied were limited to only one geographical area, Amsterdam. It is therefore uncertain if results are representative for other parts of the Netherlands. The selection of UW

was based on age and the ability to communicate sufficiently in Dutch or English. Since neither English nor Dutch was the mother tongue of any of the interviewee, difficulties in expression and bias in interpreting of the answers could have occurred. Besides, interpreter services were not available and translation by family or friends was not allowed, which could lead to selection bias, such as inclusion of only higher educated women or women already living in the Netherlands for a longer time. It is assumed that these women have different expectations of the health care system compared to women with a lower educational status or shorter stay in the Netherlands. The demographic data was collected summarily, because the first two UW declined to continue with the interview during questions about general demographic characteristics such as employment status, housing, household composition, and reasons to come to the Netherlands. They explained that, in spite of their willingness to help, fear for leakage of information or being reported predominated. After this, only age and country of origin was asked specifically. If other demographic information was mentioned spontaneously during interviews, it was noted. No further withdrawals occurred during the in-depth phase of the interviews.

Many topics did not reach saturation of information. This is probably due to the low number of interviewed women compared to the heterogeneity of the studied group. The majority of interviewed women were recruited at an NGO and came from Brazil or the Philippines. Other sites to recruit women, such as shelter homes for UW, were visited multiple times. With a number of women who lived in shelter homes a confidential bond arose. Due to time constraints, interviews could however not be conducted and included for this master thesis. The perhaps more invisible group of UW who never utilized health care services was not approached at all. Again, due to time constraints, (better) investments in networks such as churches or NGOs to recruit UW who were not related to health care providers could not be carried out.

Another limitation is that no male participants were involved in this study for objectives 1 en 2, while they could have played an important role in influencing expectations and the health care-seeking behaviour of women.

Participation of additional health care providers of an abortion clinic and the GGD did not succeed because of time constraints. Although the same number of male and female HCP participated in this study, only one female GP was interviewed. Since GP is the key person for primary health care, it would be interesting to explore whether female GPs do have other experiences compared to male GPs.

Despite prior training and reviewing and discussing of 'pilot phase' interviews, the main researcher is relatively inexperienced. This could possibly affect the quality of obtained data.

#### *4.5 Discussion of framework*

Although the used framework is a tool to explore the perceived quality of care, in our study it became clear that many aspects were largely interrelated. Another difficulty what was experienced, was an overlap of topics for objective 1 and 2. An example is language barrier. There is the expectation of language barriers prior to seek health care, the experienced barrier of language in the **previous** experienced health care utilisation, the experienced language barriers during SRH-services and the experienced language barriers by health care providers. In addition, the different subjects that influenced the expectations (the seven balloons around expectations) were inseparable, though the gathered information could be accommodated in more subheadings. Also the subheading 'access', headed under experienced care confuses. It could suggest that other topics such as knowledge, barriers, and beliefs are not parts of access. Moreover, it is unsure if the framework is suitable for a group of people, because comparing expectations and experiences and defines these as quality of care is difficult to apply when the studied group is very heterogeneous. The 'structure and facilities' of experienced SRH services were not discussed during the interviews. Given the already extended topic list, this aspect for evaluating the experience was seen as less important for the overall impression of UW and their perceived quality of care.

## Conclusion and recommendations



In this study the quality of SRH services in the Netherlands as perceived by UW and provided by general practitioners has been explored. Knowledge of the perceptions of quality is crucial to determine strong and weak aspects of health care provision and health care seeking behavior. This is important because UW have considerably more problems regarding SRH than the general population. In addition, UW are one of the most vulnerable groups of women in Dutch society. To determine the perceived quality of care, Sofaer's framework was used. The two main categories were the expectations of health care and the actually experienced services. In addition to UW, health care providers who worked with UW and SRH were interviewed as well.

The first main category was the expectations of the UW: knowledge of the health system and of SRH, barriers, needs and wishes.

### *Knowledge*

Our study showed, as expected, that UW lacked information about access to health care facilities, the fundamental rights everyone is entitled to, and specific SRH knowledge.

Contraceptives were a focus point in this study. UW found being able to use contraceptives important and they were eager to obtain more information about them.

GPs lacked information too. They were often not aware of their (moral) obligation to give health care regardless of someone's legal status. In addition, many GP were poorly informed about article 122a of the health insurance law, which states that 80% of consultation costs would be reimbursed if the financial status of undocumented migrants doesn't allow payment.

Social networks, such as churches and support organisations, had a positive influence on health. Being involved in a network enhanced the knowledge of how to access health care and diminished delays in seeking health care.

### *Barriers*

A barrier to achieve optimal sexual and reproductive health is money. Contraceptives are not included in the basic package of the health insurance and therefore everyone of 21 years and above has to pay these costs. Another law applies for induced abortion care; women without Dutch documents are excluded from financial support and have to pay themselves, in contrast to documented women.

UW often have a poor financial status, which means many UW cannot afford contraceptives or abortion.

### *Needs*

Although several barriers to access health care for SRH services exists,

there is a strong need for (better) health care utilization. Also having a social network is considered as need. This improves both knowledge about health and health care provision, and mutually helps undocumented women.

### *Wishes*

SRH-issues should be discussed more easily according to UW and HCPs. Not only contraceptives should be discussed pro-actively; also UW do not always mention other SRH-problems spontaneously.

Besides, there is a wish for screening on STDs and Pap smear.

Involvement of partners was considered as important. Not only for understanding of UW, also for treatments.

The second main category explored in our study was the experienced SRH-care. These experiences were mainly evaluated positively. Communication skills, open-mindedness, and providing emotional support, were characteristics assigned to GPs. Being able to create a confidential bond and reaching shared decisions for treatment between UW and GP were other positive values appreciated by the UW. Nevertheless, the knowledge and skills of GPs in general were only rated as moderately good. This could be caused by previous experiences in the countries of origin, where medical specialists instead of GPs provide health care, and additional tests and treatments used to be requested and prescribed at an earlier stage. Also the so-called watchful waiting approach of GPs is unknown by migrants who are relatively new in the Netherlands or new in the Dutch health care system.

### *Recommendations*

Key points of recommendations:

- Increase awareness and knowledge of UW about SRH services using existing networks.
- Increase knowledge of GPs of Dutch policy for providing health care for UM.
- Stimulate an open and pro-active attitude of GPs towards discussing SRH problems, in particular contraceptives.
- Create awareness among GPs for vulnerability of UW and high prevalence of SRH problems.
- To create a guideline for SRH services and care for UW.
- Call to the Dutch Ministry of Health: make contraceptives and abortion free of charge for UW.

Considering the current problematic situation for UW in the Netherlands, the researchers think that campaigns and new policies should be

developed and implemented. We recommend making better use of the established social networks to increase knowledge of SRH and the Dutch health care system and raise awareness of the current entitlements. The role of the GP as a key person in providing primary health care, easily accessible, and as a counsellor of patients, should also become common knowledge.

Promotion of health care-education in existing networks, public areas, and PHC facilities should be increased. Videos in different languages, using key persons to pass on information and using church meetings to spread information are achievable by mapping networks and designate suitable key informants.

GPs should be aware of the vulnerability of UW and the heightened risks of SRH-problems. An open attitude, and even a pro-active attitude to discuss SRH-issues, and contraceptives in particular, is recommended. Regarding the positively valued communication skills of GPs and the eagerness of UW to obtain information, chances to improve SRH of UW are huge. GPs should be aware of pre-existing beliefs, opinions, and possible barriers around SRH and should explore them carefully in order to find the most suitable and safe entry point for discussion. To support GPs guidelines are urgently needed. Recommendations could be spread through national medical journals and websites.

At the policy level of the Dutch Ministry of Health, we strongly recommend to make contraceptives and abortion free of charge, or at least low cost, for UW.

#### *Further research*

First of all the study population should be enlarged to make the group of UW more representative of the Dutch situation. Especially the situation of UW who are more 'invisible' in the society is of interest. It would also be important to explore their knowledge, beliefs, barriers, and needs.

Next, a greater diversity of background, such as country of origin and reason to stay in the Netherlands, could be assessed.

The results shown in this paper are interim results. During the execution of this study, the research group (main researcher/student and Pharos) thought it would be interesting and feasible to enrich the obtained data by recruiting UW via other entry points and to include focus group discussions. This would, however, take significantly more time. Another suggestion for further research is a pilot study for the evaluation of implemented recommendations coming from this stud

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## Acknowledgements

I would like to start to thank my supervisors and back stopper. You supported the subject and the idea of performing a qualitative study, knowing that this would be quite a challenge. Your knowledge, optimism, and help with writing this thesis were very valuable to me.

In addition, I would like to thank the participants of this study. The women who dared to discuss their opinion and shared their experiences, and the health care providers who were so enthusiastic and helpful. It was very special to me talking to you. Not only for the purpose of this study, but also to have a broader and perhaps better view of the life of undocumented women.

Also without help from *Dokters van de Wereld*, the *Kruispost*, and general practitioner van Wijngaarden I wouldn't have been able to perform this study, many thanks! You gave me the possibility to getting introduced in established supportive networks and facilitated all options to recruit and interview women. All coordinators and volunteers I met were very enthusiastic and encouraging. Their stories and experiences were very inspiring.

Pieter Willem, thank you for all the mental support. Even though your scientific interest is in completely different areas, I noticed that the topic of this thesis and (undocumented) migrants in general became more interesting to you as well. You shared your view and made my 'evening and weekend shifts' as much comfortable as possible.

Unfortunately, most people I would like to thank had to be mentioned anonymously. Nevertheless, I appreciated all the help and inspiration I got from you.

## Annex 1: invitation letter

### Research about the health of undocumented women in the Netherlands

My name is Irma Baltes. I am a medical doctor and researcher. In cooperation with Pharos I am conducting a study and I am asking for your help. Together with other doctors we would like to know how we could help you as good as possible.

Many women go to the general practitioner because they do have questions about pregnancy. Or just to prevent of getting a baby. Other questions of women can be related to abdominal pain. Or about testing on sexually transmitted diseases. Some women do have problems with their menstrual period or do have an itchy vagina. Or suffer from pain during sex.

For many women, these problems are difficult to discuss with the general practitioner. Perhaps many women will not go to the general practitioner.

Therefore, we would like to talk to you. You do not have to tell us whether you have problems yourself. But we would like to know if you think **other women** without legal documents will go to the general practitioner or not. And why they will do it or they will not do it.

In case you have been to the general practitioner for a women's problem, we only would like to know of how you think the doctor was helping you.

In this way we can help you and other undocumented women better in the future.

Everything what you will tell will stay confidential (secret). Also when you did visit the general practitioner. We will not contact your general practitioner to ask about you.

You can always decide you do not want to be involved anymore. Also when you first said yes.

If you would like to go to a general practitioner but you do not know if you are allowed to go to the general practitioner, we will support you to come in contact with a general practitioner who can help you. We will also help you if you no longer wish to participate.

If you are thinking of helping us in our study, I will kindly ask you to contact me. Firstly, I will give more explanation about the research and you can always decide whether or not you want to participate, at all times. You also may ask other women if they are willing to join in this research.

You can call me at **06 45872700** or send me an email: [i.baltes@pharos.nl](mailto:i.baltes@pharos.nl)  
If I am allowed to call you, please put your number or email address on this form.

Thank you for reading this and thank you for your help.

Kind regards,

Mrs. Irma Baltes, medical doctor and researcher

Dr. Maria van den Muijsenbergh, general practitioner and researcher at Pharos

## Annex 2 Topic guide Undocumented Women

### Semi-structured interview Undocumented Women

Date  
Time interview started:  
Name of interviewer:

Code:  
Time ended:

General comments:

Age:  
Country of origin:  
Current living place:  
Duration of stay in the Netherlands:  
Housing condition:  
Social support/ composition:  
Occupation:  
Education:

1. What do you know about the Dutch health care system?

#### 2. HEALTH DETERMINANTS INFLUENCING HEALTH AND HEALTH CARE SEEKING BEHAVIOUR

- If you were Layla/ Aster, what do you think you would do in her situation?
- Would she seek medical care for these issues/ complaints? And to whom?
- What do you think of her situation or do you feel about the situation she is currently in?
- How do her current living circumstances affect whether she will go to a doctor or not? Why? And does it influence her health? (Financial/ housing /children/ other members in household, working condition).
- In case she is married, will her husband influence her decision/ ability of going to a doctor? And do you think her husband will/ should be involved with her health care?

#### EXPECTATIONS OF GOING TO GP

*Depends on participant whether to use 'vignette person' or own previous experience.*

- What do you know about a general practitioner?
- Do you think Layla/Aster or other undocumented women you know will go to an alternative doctor/healer in case in they are having health problems?
- What do you think of the complaints of Layla/ Aster?
  - Is it serious? What can it be?

- Do you think Layla/ Aster is allowed to go to a GP for these issues/ medical problems?
- Will there be obstacles for Layla/ Aster to go to a general practitioner?
- Would it be important for her if the doctor were male or a female?
- What do you think a good doctor should be? (cultural differences?)
- What could possibly happen with Layla/ Aster in her situation if she does not visit a general practitioner?

#### EXPERIENCE OF VISIT TO GP

- Patient centred care
  - Do you think the GP showed respect? Do you think the GP explored how you were thinking about your problem and what your expectations were? Do you think the GP listened to you? Do you think you were involved in making decisions about your health?
- Access
  - Do you think the GP was gender concordant? Convenient place? Do you think there was an appropriate interpreter service if necessary?
- Communication and information
  - Do you feel the GP was complete and accurate in explaining? Do you feel you were given space to ask questions and decide about the proposed treatment?
- Do you expect technical quality will be adequate at the practice of the GP?
  - Interpersonal communication skills? Knowledge of the doctor? Experienced doctor? Diagnoses accurately and provide effective treatment?
- Courtesy and emotional support
  - Do you think the GP and supporting staff is friendly? Support you? Showed compassion?
- Efficiency of care
  - Do you think GP and supporting staff or medical specialists are working together efficiently? (Referral)
- Technical quality
  - Do you think the GP had enough knowledge? Provides effective treatment? Diagnoses accurately? Had a professional presentation?

## Annex 3: Topic guide Health Care Professionals

### Vragen voor interview met huisartsen/ andere zorgverleners:

Medische onderwerpen: anticonceptie, abortus, fluorklachten/SOA, misbruik

Wat zijn je eigen ervaringen met ongedocumenteerde vrouwen? (waar komen ze voor? Specifieke SRHR problematiek?)

Wat is het gang van zaken hier als het om ongedocumenteerden gaat? Hoe komen ze hier terecht? (aanmelden, afspraken, financieel)

Hoe verloopt het contact? Wat maakt het makkelijker en moeilijker? (taal –tolk?, religie, cultuur man-vrouwelijke arts?, kennis)

Wat is de ervaring van de kennis en percepties/belevingen van UW over de klacht wat speelt? Voorbeelden van diverse anticonceptie bijvoorbeeld? Klachten?

Heeft het ongedocumenteerd zijn invloed op het consult? Hoe? (te denken aan doorverwijzen, diagnostische tests wel of niet aanvragen, anticonceptie advies). (meer open vraag bedenken, minder sturend)

Kunt u wat zeggen over verwachtingen van de vrouw over een consult?

Heb je het gevoel dat vrouwen (en evt. degenen die begeleiden) tevreden zijn over de zorg? Waar wordt dat uit afgeleid? Vragen ze er naar?

Begrijpen wat er aan de hand is na bezoek? Teach-back toegepast?

Zijn er verhalen bekend over alternatieve trajecten, illegale abortus bijvoorbeeld? Goed doorvragen, is het hear say of eigen ervaringen of dingen die UW hebben verteld?

Is er wat bekend over de achtergrond (gezondheidsdeterminanten) van de vrouw en of dat de zorg beïnvloedt? Vragen ze daar naar tijdens een consult?

Denkt u dat de situatie waar deze vrouwen inzitten de gezondheid beïnvloedt? Hoe? Voorbeelden?

Wordt er actief naar misbruik of ander ongewenst gedrag jegens de vrouwen gevraagd? Hoe?

Worden vrouwen verder voorgelicht betreft anticonceptie? Hoe? Op initiatief van wie? Zelf voorkeur voor anticonceptiemiddel bij deze groep?

Zou actieve benadering met anticonceptie wenselijk zijn?

Soa testen of uitstrijkjes, is daar vraag na? En hoe wordt daarmee omgegaan? Zou u juist meer of minder willen zien? Kan tevens een vraag over ongedocumenteerd zijn en invloed op consult.

Adviezen aan huisartsen die hier niet of nauwelijks mee in aanraking komen.

# Annex 4: informed consent form Undocumented Women

## **Informed consent form for undocumented women**

### **Project ‘General Practitioners and Undocumented Women in the Netherlands- How to deal with their sexual and reproductive health and rights?’**

#### **Introduction**

Hello, my name is Irma Baltés and I work with Pharos and KIT on a study for better understanding what undocumented women think of going to the general practitioner for typically women’s problems, also called female sexual and reproductive health. I will provide you information and will invite you to be part of this study. Please, before you decide, do not hesitate to ask me for explanation if any words or concepts are not clear to you. I will go through the information with you and I will take time to explain.

#### **Purpose of the research**

The aim of the study is to have a better understanding of reasons what undocumented women in the Netherlands think of going to the general practitioner if they have problems on sexual and reproductive health. This means fertility, family planning, health care during pregnancy, wish to abortion, pain or itching in the vagina or problems during sex or menstruation problems. With this information, we think we can improve the primary health care to undocumented women in the Netherlands.

#### **Type of research Intervention**

The research involves your participation in a private interview that will take about one hour.

#### **Participant selection**

You are being invited because might have heard about this research or you might read the information poster we distributed, and because you have no legal documents. Be aware that we never will report your illegal status to anyone else, regardless of participation.

#### **Voluntary Participation**

Your participation in this research is entirely voluntary. It is your choice whether to participate or not. You do not have to decide directly and again, if anything is not clear to you, do feel free to ask or talk with someone of our study group.

#### **Procedures**

I am asking you to help us to learn more about undocumented women and their health seeking behaviour and experiences with general practitioners. This will mainly go about the health topic of sexual and reproductive health and rights. If you accept, you will be asked to participate in a private semi-structured interview.

In this interview you do not have to talk about your problems with sexual and reproductive health in case you ever experienced them. Instead, we will give you some examples of stories of other women, and I will ask you what you think this woman will think or do if you were this woman. If you have experience with going to the general practitioner for sexual and reproductive health problems, we will not ask you about the problem itself, but on how you think the general practitioner was helping you, what was good and what could be better. Also we like to know a bit more of your background, but not your private details like name, address or telephone number.

#### **Duration**

The total time of all interviews will take place over two months. This particular interview with you will be held once and have a duration of one hour.

### **Risks**

The discussed issues can be very sensitive. For many women, these issues are difficult to talk about. You may feel uncomfortable talking about some of the topics, even when you do not have to talk about your own situation. You can always tell me when you do not wish to answer the question, without giving a reason why.

In case any of these questions made you sad or afraid during or after the interview, we can always offer you support to talk with you together with health professionals.

### **Benefits**

There will be no direct benefits for you, but your participation is likely to help us to improve general practitioners helping you or other undocumented women in the future. If you would like to be registered at a practice and you do not know how you can access, we can help you registering at one.

### **Reimbursement**

You will not be provided any incentive to take part to the research. However, we will give you money for your time and travel expense.

### **Confidentiality**

We will not be sharing information about you to anyone outside the research team. The information that we collect from the study will be kept private. Any information about you will have a number on it instead of your name. Only the researchers will know what your number is and we will lock that information up. It will not be shared with or given to anyone except our research team. So also not the community where you are staying, nor health care workers or the government will get information about you.

### **Sharing the results**

The results that we collect from this study will be shared with you if you are willing to. With the results we will try to make recommendations to general practitioners. It is important for us to know if you think these recommendations will help undocumented women receiving better health care.

### **Right to refuse or withdraw**

You do not have to take part in this research if you do not wish to do so. You may stop participating at any time. You may also withdraw after the interview has been held.

### **Who to contact**

The proposal of this study has been reviewed and approved by Research Ethical Committee of the Royal Tropical Institute (KIT), Amsterdam, which is a committee to make sure that study participants are protected from harm. Contact details KIT Health, Mauritskade 63 in Amsterdam. Telefoon: 020 5688514

### **Certificate of consent**

**I have read the foregoing information, or it has been read to me. I have had the opportunity to ask questions about it and any questions I have been asked have been answered to my satisfaction. I consent voluntarily to be a participant in this study.**



# Annex 5: Informed consent form Health Care Professionals

## **Toestemmingsverklaring gezondheidsmedewerkers**

Project 'General Practitioners and Undocumented Women in the Netherlands- How to deal with their sexual and reproductive health and rights?'

### **Introductie**

Hallo, mijn naam is Irma Baltés en ik werk met Pharos, het AMC en Koninklijk Instituut voor de Tropen (KIT) aan een kwalitatief onderzoek naar ongedocumenteerde vrouwen. We willen met name bekijken wat de factoren zijn waarom deze vrouwen bij seksuele en reproductieve gezondheidsproblemen wel, of juist niet naar de huisarts gaan.

Van degenen die wel eens een huisarts heeft bezocht voor een seksuele of gynaecologische klacht willen we graag uitzoeken hoe ze het bezoek aan de huisarts ervaren hebben.

We vragen u om ons te helpen aan informatie, omdat ook u ons belangrijke informatie kan geven over dit onderwerp. Voordat u besluit om wel of niet deel te nemen verzoeken we u dit document goed door te nemen en als u vragen hebt dit graag laagdrempelig aan ons te stellen.

### **Doel van het onderzoek**

Ongedocumenteerde vrouwen zijn een kwetsbare en onzichtbare groep in de Nederlandse samenleving, welke vaak te maken krijgt met seksuele of gynaecologische klachten.

We willen graag beter begrijpen wat de factoren zijn waarom ongedocumenteerde vrouwen wel of juist niet naar de huisarts gaan bij gynaecologische en seksuele problemen. En als ze wel naar de huisarts gaan, wat dan hun ervaring was. Daarnaast zouden we ook graag informatie van u verzamelen om een nog beter beeld te krijgen van de ervaringen. Dit hoeven niet alleen huisartsen te zijn. Met de verzamelde gegevens willen we kijken wat factoren zijn en hoe we daarmee aanbevelingen kunnen geven en een leidraad kunnen opstellen voor huisartsen. We hopen zo dat de gezondheid van ongedocumenteerde vrouwen verbetert.

### **Soort onderzoek**

Bij dit onderzoek zouden we u graag willen laten deelnemen aan een semigestructureerd interview. Dit zal ongeveer een half uur in beslag nemen.

### **Selectie deelnemers**

U bent uitgenodigd voor deze studie omdat u te maken krijgt met de zorg voor vrouwen met seksuele en/of gynaecologische problemen.

### **Vrijwillige deelname**

Voorop staat dat uw deelname geheel vrijwillig moet zijn. U mag zelf kiezen of u wel of niet deel wil nemen en ook mag u altijd later besluiten of u wil deelnemen of niet.

### **Procedure**

We zullen u vragen over uw ervaringen met ongedocumenteerde vrouwen en gynaecologische en seksuele klachten aan de hand van enkele open vragen.

### **Tijdsduur**

De individuele interviews zullen ongeveer een half uur in beslag nemen. De totale tijdsduur van het afnemen van alle interviews zal twee tot drie maanden bestrijken.

**Risico's**

Het praten over deze onderwerpen kan gevoelig liggen. U kunt bijvoorbeeld schrijnende verhalen van deze groep vrouwen hebben meegemaakt, of achteraf ervaren dat u liever bij nader inzien iets op een andere manier zou hebben benaderd of behandeld.

**Voordelen**

Er zijn geen directe voordelen voor u tijdens het onderzoek. We hopen echter wel dat mede door uw informatie er een leidraad of aanbevelingen kan worden geschreven en verspreid zodat de zorg en de gezondheid voor ongedocumenteerde vrouwen wat beter zal worden.

**Onkostenvergoeding**

Behalve onkostenvergoeding als reiskosten of drinken zullen er geen andere kosten vergoed worden.

**Vertrouwelijk**

Uw informatie zal vertrouwelijk worden behandeld. Buiten het onderzoeksteam zullen we uw gegeven informatie wat naar u herleidbaar kan zijn niet naar buiten brengen. De verzamelde informatie zal zes maanden bewaard blijven, daarna wordt deze vernietigd.

**Delen van de resultaten**

De kennis wat we met deze studie vergaren zullen we in een rapport en/of artikel uitbrengen. Daarnaast zullen we een leidraad schrijven bedoeld voor huisartsen in Nederland. Voordat dit uitgebracht wordt willen we graag uw mening hierover peilen. We zullen u vragen of u de geanalyseerde resultaten met ons wil bekijken voor commentaar. Als u dat wenst zullen we het rapport van dit onderzoek opsturen per post of per email.

**Recht om te weigeren of terug te trekken**

U mag ten aller tijden stoppen als u betrokken bent in dit onderzoek, zonder opgave van reden.

**Contact**

Het onderzoeksvoorstel is gezien en goedgekeurd door de ethische commissie van het KIT. Deze commissie zorgt ervoor dat deelnemers aan deze studie worden beschermd tegen schade welke veroorzaakt zou kunnen worden door dit onderzoek. Mocht u daar meer vragen of details over willen weten, kunt u contact opnemen met afdeling KIT Health, Mauritskade 63 in Amsterdam. Telefoon: 020 5688514

**Toestemmingsverklaring**

**Ik heb de bovenstaande tekst gelezen en heb de kans gekregen om vragen te stellen over dit onderzoek en daarop antwoorden gekregen welke voldeden aan de vraag.**

**Ik verklaar dat ik vrijwillig deelneem aan dit onderzoek.**

Datum

Naam

Handtekening

## Annex 6: Ethical approval



KIT | Health

Contact

Meta Willems

Telephone +31 (0)20 568 8514

[m.willems@kit.nl](mailto:m.willems@kit.nl)

KIT Health | P.O. Box 95001, 1090 HA Amsterdam, The Netherlands

BY E-MAIL:

[irmabaltes826@hotmail.com](mailto:irmabaltes826@hotmail.com)

Our reference KIT Health

Amsterdam, 15 May 2017

Subject Decision Research Ethics Committee on Proposal S80

Dear Irma,

The Research Ethics Committee of the Royal Tropical Institute (REC) has reviewed the proposal entitled "Family Practitioners and Undocumented Women in the Netherlands- How to deal with their sexual and reproductive health and rights?"

The decision of the Committee is as follows:

The Committee has reviewed the revised protocol and has taken note of your changes and clarification, and is pleased to see that you have addressed our concerns and questions to our full satisfaction.

The Committee is of the opinion that the proposal meets the required ethical standards for research and herewith grants you ethical approval to implement the study as planned in the afore mentioned protocol.

Kind regards,

P. Baatsen,  
Chair Research Ethics Committee, KIT

Mauritskade 63  
1092 AD Amsterdam  
P.O. Box 95001  
1090 HA Amsterdam  
The Netherlands

[www.kit.nl/health](http://www.kit.nl/health)

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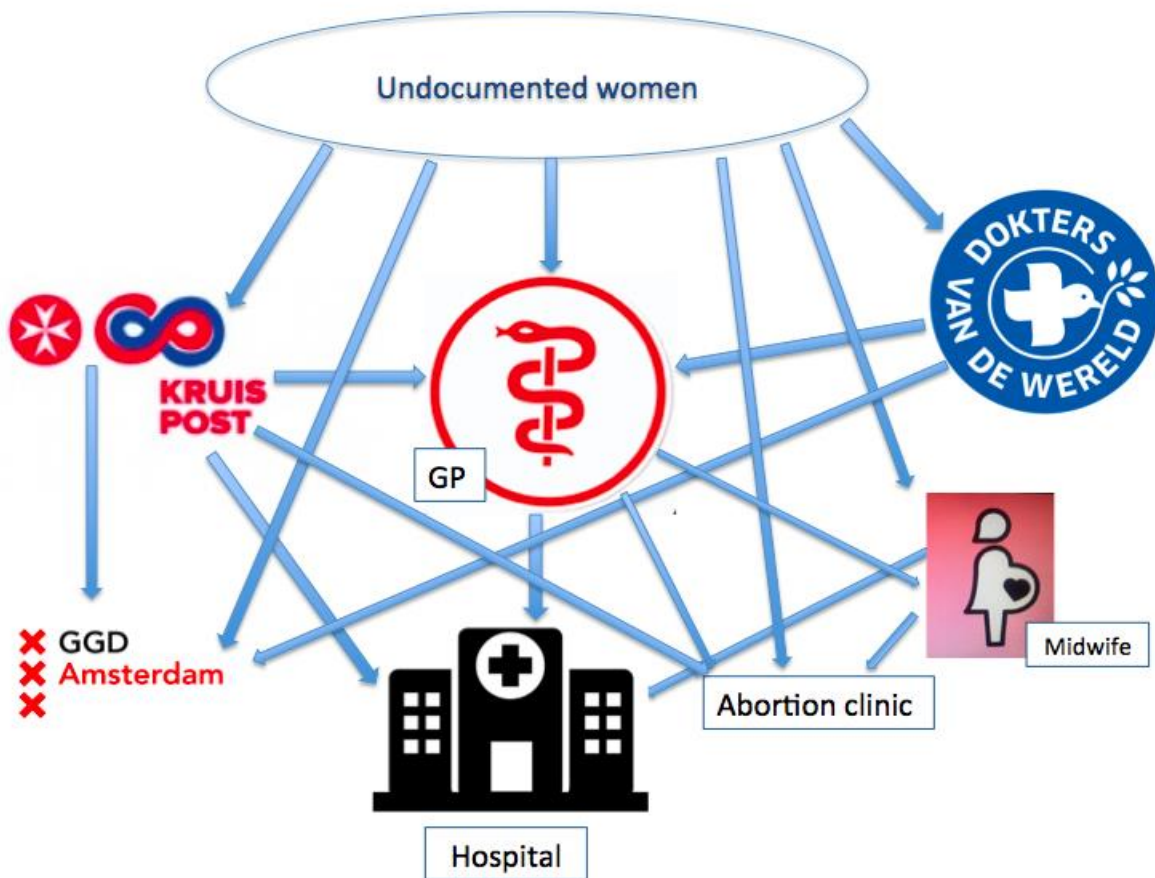
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*Royal Tropical Institute*

## Annex 7: Medical map

### Medical map

A summary of key services available for undocumented women in Amsterdam used for this study.



The number of arrows also indicates the 'labyrinth' that UW and HCP do encounter sometimes.

The Kruispost is an NGO offering medical and psychosocial care to uninsured people. For medical help people can go there on morning and evening hours from Monday until Friday. Doctors, mainly GPs, work there voluntarily. Consultations are 5 euros, or for free if one cannot afford it. There are a large number of doctors working at the Kruispost, some work on fixed days. They can, like 'normal' GPs, request for tests and refer for other specialist care.

Doctors of the World (Dokters van de Wereld) do have mobile clinics and visit shelter homes for undocumented migrants. Shelter homes can be squatted buildings or basic need supports organized by the municipality. They also visit a market place in an area of Amsterdam that is well known for many undocumented citizens. Doctors of the World offers basic care and health promotion. Besides, the voluntary health care providers triage if someone needs medical help and arrange an appointment at a GP practice. Health care providers don't have the ability to diagnose and treat on GP-level.