DOI: https://doi.org/10.2298/GEI1803657L
UDK 39:618.2-083(497.4)
Original research paper

Uršula Lipovec Čebron

Department of Ethnology and Cultural Anthropology, Faculty of Arts – University of Ljubljana
ursula.lipovec@gmail.com

Lea Bombač

Department of Perinatology, Division of Gynecology – University Medical Centre Ljubljana
bombac.lea@gmail.com

Pregnant Women on the Move and the Response of the Slovenian Health System to Their Needs

In the article we present our research on health care provided to female asylum seekers in Slovenia, and more specifically, analysis of some of their experiences when searching for medical help in the field of gynecology and obstetrics. In the introduction we briefly present general aspects of female migrations and discuss the complexity of pregnant migrants/refugees through a broader context, describing some crucial aspects of their health issues related to pregnancy. We then show how in the context of Slovene health care system their vulnerability is emphasized through three main levels of obstacles. Through qualitative research with ten asylum seekers we demonstrate that the first level of obstacles is due to their hindered access to healthcare institutions. Despite that legislation in Slovenia secures equal health rights to the majority of pregnant asylum seekers as to nationals, these women experience many difficulties when searching for health care. In the second level no dissemination of information concerning their entitlements and use of health service is exposed. With the third level we analyse language barriers that are related to language misunderstanding and the lack of professional interpreters/intercultural mediators.

Key words: pregnant women, asylum seekers, healthcare, Slovenia, barriers

Труднице у покрету и одговор словеначког здравственог система на њихове потребе

У овом чланку представљамо наше истраживање о здравственој заштити азиланткиња у Словенији, а посебно анализу појединих њихових искустава приликом тражења медицинске помоћи из области гинекологије и акушерства. У уводном делу кратко говоримо о општим аспектима миграција жена, те разматрамо комплексну ситуацију трудних мигранткиња/избеглица у ширем контексту, уз опис појединих битних аспеката њихових здравствених питања повезаних са трудноћом. Тиме показујемо да је, у контексту словеначког здравственог система, њихова рањивост посебно наглашена на три главна нивоа препрека. На основу квалитативног истраживања са

десет тражилаца азила, показујемо да је први ниво препрека узрокован отежаним приступом здравственим установама. Упркос законодавству у Словенији, које јамчи подједнака здравствена права тражитељима азила као и држављанима Словеније, ове жене су искусиле многе потешкоће када су потраживале здравствену негу. Други ниво препрека настаје услед недостатка дисеминације информација које се тичу њихових права и коришћења здравствене службе. На трећем нивоу, долазимо до анализе језичких препрека повезаних са неспоразумима и до мањка професионалних преводилаца, односно интеркултурних медијатора.

Кључне речи: труднице, тражиоци азила/азиланти, здравствена заштита, Словенија, препреке

Introduction

On a global scale, women and girls make up half of the world's migrants (Mixed migration platform 2016), the share of female migrants/refugees1 is constantly growing also in Europe (International Migration Report 2017, 15), where they account for one third of all asylum seekers in EU countries. However, most studies on migration are gender-neutral and utilize models based on male experiences (Dhar 2007; Chavez and Menjívar 2010): »Gender is still a factor that is not considered enough in research on migration. Women are often presented as passive victims or completely forgotten in academic writings and public discourses. Taking gender into account, understood as social and cultural ideas, performances and practices of femininity and masculinity, is crucial, because it is shaping our life possibilities and opportunities (Cranford and Hondagneu-Sotelo 2006, 106).« (Ivnik 2017, 560).

Pregnancy or even the possibility of conception is one of the factors that makes a woman's migrant experience different (Castañeda 2008, 172). Pregnancy is usually a period of increased vulnerability for migrant/refugee women, which is reflected in their reduced mobility, loss of employment, increased financial needs, all of which affects their autonomy (Castañeda 2008, 2009). Additionally, migration can significantly change women's experience of being pregnant and the outcome of pregnancy. A systematic review of 30 scientific articles showed that migrants/refugees have different perinatal health outcomes compared to nationals (Almeida et al. 2013). Previous research (Castañeda 2008, 2009; Freedman 2016; Recape 2016; Hupp Williamson 2017) has also shown that is important to take into account the complex intersection of vulnerabilities that relate to their gender, pregnancy, legal and socioeconomic status in order to fully understand the relationship between migration and perinatal outcomes:

---

[1] When we speak in general, we use both terms migrant as well as refugee since we do not want to reproduce the problematic dichotomy »economic migrant« vs. »refugee« that has recently been misused in xenophobic and racist anti-immigration political propaganda across Europe. However, when presenting the analysis of our research, we use the term asylum seeker since the experiences of our interlocutors in the Slovene healthcare system were shaped by the fact that they had this legal status.

> "The physicians I interviewed noted that all pregnancies among non-documented migrant women must be considered high-risk, due to socioeconomic marginalization and delays in seeking prenatal care." (Castañeda 2008, 182).

This quotation is in line with research among other categories of migrants/refugees, where several studies emphasize that perinatal, neonatal, and child mortality rates as well as incidence of stillbirth (Almeida et al 2013) have been consistently higher in foreign-born groups than in the rest of the population (Schulpen 1996; Carballo and Nerukar 2001; Almeida et al. 2013). Moreover, the literature states that there are higher levels of maternal mortality (Razum et al. 1999; Almeida et al. 2013) as well as mental health problems, e.g. postpartum depression (Stewart 2008; Almeida et al. 2013; Wittkowski et al. 2017) among pregnant migrants/refugees. Due to the afore mentioned complications, the migrant/refugee pregnancies are considered high risk by obstetricians (Scott 2004). Studies also revealed higher overall caesarean rates and higher emergency rates related to pregnancy for certain groups of migrant/refugee women (Merry et al. 2013).

One of the most important risk factors for pregnant migrants/refugees is the delayed access to antenatal care (Wolff 2008; Almeida et al. 2013). Despite the need for better access to prenatal care, studies show that pregnant migrants/refugees, even those living longer periods in a certain territory without a legalized status, come to the first examination later than other women and that many of them do not seek prenatal care until the third trimester (Castañeda 2008, 182). Similar are the findings of Doctors Without Borders that report a very high percentage (58.4%) of pregnant women across eleven different EU countries that had not accessed antenatal care (Observatory report 2017, 42). The reasons for delayed antenatal care are exclusion from the health system or limited access to health care institutions, poor information on health rights during pregnancy, lack of money for paying health services and fear of contact with administrative authorities due to the possibility of deportation (Castañeda 2008; Almeida 2013; Ivnik 2017; Doctors of the World 2014).

Since the above-mentioned research and international reports identifies limited access to health care institutions as one of the main problems pregnant migrants/refugees face across Europe, we researched some of their experiences when searching for medical help in the field of gynecology and obstetrics in Slovenia. Here previous research has shown that migrants/refugees often face cultural, linguistic, administrative, economic and other types of barriers within the healthcare system, resulting in lower quality healthcare services and unequal treatment (Brovč et al. 2009; Bofulin and Bešter 2010; Lipovec Čebron 2010a, 2010b; Jazbinšek and Lipovec Čebron 2016; Bombač, Lučovnik et al. 2017; Lipovec Čebron and Pistotnik 2018b etc.). However, from this prior scientific research little is known about obstacles to healthcare faced by pregnant migrants/refugees in Slovenia.

This article is based on qualitative research conducted from May 2017 to June 2018 among ten interlocutors, who were pregnant or had recently given birth. Their age ranged from 20 to 30 years. At the time of the interview six interlocutors were asylum seekers and four were refugees with recognized international protec-

tion, and all of them described their experiences with healthcare institutions while being asylum seekers. We conducted four semi-structured interviews in different locations in Ljubljana and one focus group with six women residing in the reception centre (Asylum seeker centre). Since our interlocutors were native speakers of Arabic and Farsi, interviews and the focus group discussion were translated with the help of two interpreters/intercultural mediators. In the paper we are combining research findings with previous scientific work on health aspects of migration (Lipovec Čebron 2010a, 2011a, 2011b; Lipovec Čebron and Pistotnik 2015, 2018a, 2018b; Lipovec Čebron, Pistotnik et al. 2016, 2017; Bombač et al. 2017) and experiences during medical practice in asylum centres in Slovenia2.

We argue that the vulnerability of our interlocutors is emphasized mainly due to three levels of obstacles experienced in the context of the Slovene health care system. The first level presented in the section Hindered access to legally guaranteed health rights we demonstrate that despite that legislation in Slovenia secures the same health rights to the majority of pregnant asylum seekers as to nationals, they experience many difficulties when searching for health care. The second level discussed in the section Insufficient information on health rights addresses inadequate information on asylum seekers reproductive health rights. The last level of obstacles in quality healthcare provision for asylum seekers is described in section Language barriers and is related to language misunderstandings and the lack of professional interpreters/intercultural mediators. For this article we focus only on obstacles experienced by a limited number of female asylum seekers3 in Slovenia, therefore it is important to stress that other asylum seekers and women with different legal statuses (such as undocumented women, women with temporary or permanent residency status in Slovenia, etc.) may encounter diverse obstacles, therefore it is not possible to generalize the experiences presented in the following pages to other refugee/migrant women in Slovenia.

Hindered access to legally guaranteed health rights

> "When we were staying in the asylum seeker home before, I didn't want to become pregnant and when we wanted to go to doctor, everyone [including employees in the Asylum centre] said there if you don't have anything urgent you cannot go because you don't have the possibility. But you know, I have a small baby, I really don't want to be pregnant. Every month I'm scared. I don't want more, I don't want more, but we are Muslim and you can't go to doctor and say 'I don't want the baby'." (interview with Nadia, Ljubljana, 11.9.2017)

[2] Co-author Lea Bombač provided medical treatment and care for asylum seekers as a medical doctor carried out in the EU funded project "8 NGOs for migrants / refugees' health and 11 countries" from August 2016 till April 2017.

[3] In general, numbers of female asylum seekers are much lower to those of men in Slovenia: in the period of last three years (2015-2017) from 3061 persons requested international protection in Slovenia, only 407 (13%) were females (Ministrstvo za notranje zadeve RS 2018).

Researcher: "Do you remember what month of pregnancy you finally visited doctor (gynaecologist, op. a.) for the first time?"

Miriam: "At 6 months. I was asking the nurse [in the Asylum centre] to go to gynaecologist for 2 months." (interview with Miriam, Ljubljana, 16. 9. 2017)

Nadia's and Miriam's experiences in the asylum centre show that they were unable to access legally guaranteed health rights. According to Slovene legislation asylum seekers have the right to "emergency health care"4 which includes antenatal, perinatal, and postnatal care, meaning free access to "contraceptives, abortion and medical care during pregnancy and at birth" (Article 84, International protection law 2017). Besides this, pregnant asylum seekers are regarded as "vulnerable persons with special needs"5 for whom medical or other assistance is guaranteed (Article 21, International protection law 2017).

Previous research (Bofulin and Bešter 2010; Lipovec Čebron and Pistotnik 2015, 2018a, 2018b etc.) has similar findings, showing that legal provisions are not always recognized in the practice – not only in the cases of asylum seekers, but also in cases of other migrants/refugees, especially those with uncertain legal status. Moreover, the country report for Slovenia (MIPEX Health Strand) emphases that legally guaranteed health rights for migrant/refugee women are "generally not known, recognized or respected in practice" (MIPEX 2015, 12). This is also clear from Nadia's experience cited above. Nadia came to Slovenia with her husband and two small children, one of them was born in Turkey on her way toward EU: "When I was pregnant 9 month I go only one time to doctor [in Turkey] and when I had baby [delivery] they don't give me any medicine. I had down this [perineal tear] they don't give me any medicine for pain. I'm really crying and crying. I was really in pain. When you have this without painkiller it's like giving another birth. I stayed in hospital just one day." After her arrival to Slovenia she felt exhausted because of her long and hard journey to the EU, the constant care for two small children, inappropriate living conditions in the asylum centre, and the uncertain future due to unclear result of their asylum application in Slovenia. In the interview she also emphasized that she was highly motivated to enrol in translation studies and to put her interpreting skills to good use in a new setting. In this situation she claimed that she

[4] As defined in the Article 84 of International protection law, emergency treatment include "maintaining vital functions, stopping serious bleeding or preventing bleeding to death; prevention of sudden deterioration of the health condition that could cause permanent damage to individual organs or life functions; treatment of shock; treatment of chronic diseases and conditions, the neglect of which would directly and within a short period of time cause invalidity, other permanent damage to health, or death; treatment of high temperature conditions and preventing the spread of infection that could lead to a septic condition; treating and preventing poisoning; treatment of broken bones or sprains and other damages that require urgent medical attendance; medicines from the positive list in accordance with the list of mutually replaceable medication prescribed for the treatment of certain diseases or conditions" (Article 84, International protection law 2017).

[5] Under the category of "vulnerable persons" the law (International protection law 2017) foresees children, unaccompanied children, the elderly, pregnant woman, single parents with children, and victims of rape, torture or other forms of psychological, physical or sexual violence

desperately needed contraceptives, since she was unwilling to consider the possibility for having another baby. By the previously mentioned law on international protection she was guaranteed contraceptives, however employees and other asylum seekers in asylum centre wrongly interpreted legal provisions saying that her need for contraceptives cannot be regarded as emergency care and therefore she is not entitled to "go to the doctor". As a result, Nadia became pregnant and just recently gave birth to her third child.

Similar obstacles to legally guaranteed health rights are encountered by other asylum seekers for whom the access to healthcare is hindered by employees of asylum centres. In the event of illness and with a valid asylum seeker identity card, the asylum seeker has a right to receive treatment in the nearest health centre. However, research (Palaić and Jazbinšek 2009; MIPEX 2015; Bombač et al. 2017) shows that access to health care depends on arbitrary decision of employees, including persons without medical education, working in asylum centres6 about when and to whom treatment should be given. In this context even legally guaranteed access to an ambulance (or other emergency transportation) in cases of emergency can be difficult to access:

> "Once I had strong pain in my belly before I gave birth and thought I had appendicitis. I was on the floor and I was screaming. Nurse came and gave me Urbana bus card and said I can go to doctor. 10 days after I gave birth I was operated on for appendicitis. When I was 9 months pregnant I was bleeding. My husband started screaming on the corridor, so they called an ambulance but it took them one hour to come! The water was coming out of me; I wanted to give birth." (interview with Lisa, Ljubljana, 16. 9. 2017)

The right to emergency care is often further limited in healthcare institutions. Even though emergency care should by law7 be given to anyone in need, without additional requirements, this universal right is violated by different administrative and structural obstacles8 preventing the possibility for many mi-

---

[6] Besides the Asylum centre in Ljubljana (in Vič and on Kotnikova street) there is also a structure for the accommodation of asylum seekers in the town of Logatec.

[7] As per the Health Care and Health Insurance Act (Zakon o zdravstvenem varstvu in zdravstvenem zavarovanju, ZZVZZ), everyone, regardless of his or her health insurance status, can receive urgent medical treatment. Article No. 7 of this Act provides the possibility of access to urgent treatment for various groups of people (people of unknown residence, foreigners from the states that have not signed a bilateral treaty with Slovenia, as well as all foreigners and citizens of Slovenia with permanent residence abroad, etc.); in addition, it provides that the Republic of Slovenia must assure financial means directly from the state budge intended for urgent treatment of those, who are temporarily staying or travelling through Slovenia and are unable to cover the costs of medical treatment. The Article also mentions other persons who are not included in the compulsory health insurance system and are not insured by a foreign health insurance provider/agency.

[8] It is a common practice in various health institutions to ask migrants/refugees to present a health card (which only those with health insurance have) and/or personal documents. If they do not have such documents, they may be denied treatment, even in urgent cases. The decision as to whether they will receive treatment depends on a clinical judgement by health workers based on

grants/refugees from exercising this right (Bofulin and Bešter 2010; Lipovec Čebron 2010a, 2010b; NIPH2014; MIPEX 2015).

The obstacles described above often have many negative consequences for the migrants'/refugees' health (Palaić and Jazbinšek 2009; MIPEX 2015; Bombač et al. 2017). Moreover, in cases of pregnant women the barriers mentioned above are sometimes the reason for late access to antenatal care, as was Miriam's experience cited at the beginning of this chapter. Similar to Miriam's case, reports show that other pregnant migrants/refugees also come to the first examination later than nationals; many only in the last third trimester (Observatory report 2017: 42; see also Castañeda 2008; Almeida et al 2013). Miriam was already pregnant at the start of her travels from Iran to Slovenia, which took her 3 and a half months. During this entire period she did not have a single gynecological examination:

> Researcher: "Did you see any doctor when you were pregnant?"
>
> Miriam: "When I was on the boat from Turkey to Greece I visited a doctor and he gave me a pill against sickness. It was in the ship from a Greek island to Athens." …
>
> Researcher: "Did any doctor made any tests on the way? "
>
> Miriam: "No. I just told the doctor that I'm pregnant." (interview with Miriam, Ljubljana, 16. 9. 2017)

At the border between Austria and Slovenia she and her husband were stopped by Austrian police and sent back to Slovenia where they decided to apply for asylum. When Miriam arrived at the asylum centre in Ljubljana she was accommodated with three other families

> "in a small room, 12 m2, 3 double beds, just mattresses. At first check-up before applying for asylum I told to doctor I'm pregnant. I was all the time crying, so I went with translator, my friend, to the doctor and I wrote letter and sent it to head of the Asylum home and so we got a separate room."

She was trying to take care of her health by herself:

> "I knew from Iran that a pregnant woman has to take folic acid, I took them from Iran but lost them on the way. I got in contact with N. [volunteer] in 2015. She helped me to get vitamins."

At the same time Miriam tried to get the appointment with the gynaecologist:

> Miriam: "I went to a nurse [employed at the Asylum centre] to tell about the pregnancy, but she said that in Slovenia it's not like this that

their criteria for what constitutes 'urgent'. Since the emergency care is covered by the Ministry of Health budget, medical staff need to provide a range of different documents justifying the costs for services provided. In case treatment is regarded as non-urgent, uninsured patients must pay for the service out of pocket.

> you immediately go to check with gynaecologist and I have to wait because it's too early to go."
>
> Researcher: "But when you asked a nurse to go to the gynaecologist you were 6 months pregnant?"
>
> Miriam: "Five months and half." (interview with Miriam, Ljubljana, 16. 9. 2017)

Insuficient information on health rights

Besides hindered or limited access to health care institutions, poor information on health rights during pregnancy is among the reasons for delayed antenatal care. However, lack of information on healthcare entitlements, organization of the healthcare system, and use of health service can be seen as general problem among migrants/refugees with different legal statuses (Bofulin in Bešter 2010, 272): "Lack of information about entitlements is a serious barrier to exercising them: people who do not know their rights cannot claim them. … This situation is made worse when legislation is complex and changes rapidly. There is no systematic dissemination of information concerning entitlements and use of health service for the migrant population. … However, since the information is difficult to find, access to it depends on personal initiative and motivation." (MIPEX 2015: 17).

Similar conclusions are found in a quantitative research on health of migrant/refugee women with various legal statuses in Slovenia (Kulovec 2012). The research demonstrates that almost one fifth of the surveyed migrants/refugees (18.5% out of 63) did not receive any information about their health rights (Kulovec 2012, 31). Accurate information on the health system is even more difficult to obtain in cases of asylum seekers, as demonstrated by notes from a focus group in the Asylum centre: "They were highly motivated to talk about their experiences with giving birth and had many questions on reproductive rights and how to solve different gynaecological and other medical problems … All women had little or no information on contraception, they did not know how to get it, what forms of contraception are available in Slovenia and what kind of contraception is available free of charge. Most of them were not informed that they can get free condoms from a social worker who works in the asylum centre, in the same department as they were located" (notes from the focus group in the Asylum centre, 18. 10. 2017).

The fact that pregnant asylum seekers were unfamiliar with their reproductive rights could be the result of different factors (social isolation, dissimilarity of healthcare systems in different countries, different legal and social statuses, education etc.) (Bofulin in Bešter 2010 etc.), including linguistic barriers, which numerous migrants/refugees who do not speak the Slovene language experience when searching for information on healthcare.

Language barriers

> "When I arrive [at the maternity hospital] I am … really, really scared, scared. I don't know the language, no translator in the hospital. Yes. The nurse is kind, she smiling, but she talk, talk and I don't understand... nothing! They take my hair, shave [shaving of the pubic hair before delivery]. I am crying. I am in shame and don't know what they are doing. Then they give me this… for the bottom [an enema]. I am crying all the time. Then the baby is born quickly and everything is ok. Yes." (interview with Sonia, Ljubljana, 2. 4. 2018)

Tania gave birth in Slovenia. When asked what her birth experience was like, she answered:

> "Nothing good. … I feel pain, I ask the doctor for caesarean section, doctor said 'No. No.' I do not know why. I say, I want. And doctor: 'No, no.' I do not understand why not. They gave 2 tablets at midnight. At 14 o'clock very painful. Then injection, then with a needle [artificial rupture of membranes]. Then 20 hours, of pain, pain." (interview with Tania, Ljubljana, 18. 10. 2017).

The interview shows that she did not understand the procedure inducing labour and could not get information on why the physician refused to do caesarean section. She felt maltreated as a result, and thought that this was because she was a refugee. Due to language problems, she was deprived of the right to autonomously decide on the course of childbirth, methods of pain relief during labour, and agree or disagree with medical procedures utilized.

Previous research (Gosenca 2017; Kocijančič Pokorn 2018; Milavec Kapun et al. 2017; Rotar Pavlič et al. 2017) has shown that healthcare workers in Slovenia encounter many language barriers which hinder them in providing high quality healthcare for non-Slovene population, while migrants/refugees experience several difficulties when searching for medical help. The consequences of language barriers are multiple: from avoiding or delaying the visit to the doctor, to numerous misunderstandings, unsatisfactory[9] or even traumatic experiences in medical settings as in Sonia's and Tania's case. All of this can lead to inadequate access to quality healthcare services and insufficient healthcare treatment, posing a risk to patients' safety.

A nation-wide survey of healthcare workers in Slovenia (n= 564 healthcare workers, incl. physicians, dentists, nurses) on communication between healthcare workers in the healthcare system and non-Slovene speaking patients has shown that language diversity poses a great challenge to personnel to ensure quality healthcare

[9] The language barriers can also lead to ridiculous misunderstandings. Since the documentation that migrants/refugees must fulfil during their medical procedures are usually available only in Slovene language, one of our interlocutors told us that her friend signed a document that she could not understand because she did not read Slovene. As a consequence, the room where she delivered was – against her will - full of students of medicine (notes from the focus group in Asylum centre, Ljubljana, 18. 10. 2017).

(Kocijančič Pokorn 2018; Mikolič Južnič 2018). The results of this survey have shown that 94% of respondents have contacts with foreign-speaking patients in their work, and that the most challenging encounters are those with Albanian-speaking patients and with patients who speak Arab, Chinese, Russian, Roma, Bulgarian and other languages (ibid). The same survey also shows that communication problems arise in various medical fields, and that they are most common in emergency services, family medicine, paediatrics, gynaecology and obstetrics10. Moreover, health problems or diagnoses that are most frequent among users who do not speak Slovene fell, according to the respondents, in the following categories: first, antenatal, perinatal and post-natal care; second, injuries; third, psychiatric problems; fourth, gastrointestinal problems; fifth, respiratory infections etc. (Mikolič Južnič 2018).

The results of this survey and our qualitative research reveal that healthcare workers as well as patients are left alone to face multiple language misunderstandings. Unlike in some other countries of European Union11, the Slovene healthcare system doesn't have professional interpreting service available in healthcare institutions. Although many professional interpreters exist, they lack the training for interpreting in healthcare setting, are often difficult to reach and their services are too expensive for an average patient (Lipovec Čebron et al. 2018a). This problem was addressed also in the MIPEX Country Report for Slovenia:

> "Even though the Patient Rights Act (ZpacP) includes the patient's right to understand the procedure, to be informed and not to be discriminated against, in practice there is a great lack of systematic solutions (national or regional policy) regarding the availability of interpretation services." (MIPEX 2015, 19).

In the absence of available interpreters, some of our interlocutors decided to solve this problem by themselves: they found a friend or relative who could step in the role of an ad-hoc interpreter or try to resolve their communication problems by enrolling in the courses of Slovene or English. However, as previous research has shown (Kocijančič Pokorn 2018) ad-hoc interpreters and basic language skills are temporary and provisional solution, since they cannot guarantee accurate communication and cannot replace professional interpreter or intercultural mediator.

In conclusion, we present a description of Ana's experience. She outlines several of barriers in searching for healthcare in Slovenia described above, while opening other problems (criminalization of migrants/refugees, illegal conduct and humiliating attitude by authorities) that many women on the move face (Wilson 2011; Freedman 2016; Heidari and García Moreno 2016; Van der Zee, 2016; Amnesty International, 2016). The following fragment from the conversation with her

---

[10] In the survey, the respondents were asked to indicate medical fields where they encounter most problems in communication with non-Slovene-speaking patients. Twelve medical fields were provided on the list and the respondents were able to add additional ones if they wanted. Most respondents (67%) selected emergency services (and 27% emergency transportation related services). The second most frequently selected medical field was family medicine (56%), followed by paediatrics (34%), gynaecology (28%) and obstetrics (24%).

[11] For instance, in Italy, Germany or Switzerland (Gosenca 2017).

show how pregnant refugees'/migrants' experiences are shaped by a complex intersection of vulnerabilities that are related to their legal status, gender, and pregnancy on one hand, and to increasingly restrictive EU immigration policies that are pushing female refugees into situations in which they are at great risk, including health risk:

> "Before her arrival in Slovenia, she stayed in Greece for six months, where she became pregnant, but she suffered a miscarriage. She went to the hospital where no one examined her after the miscarriage and when being discharged from the hospital, the translator interpreted doctor's words as that she could not become pregnant for another 6 months, therefore she relied on this information and did not use any contraception. However, she became pregnant few weeks later. With her husband she headed towards the north and she had to walk through the forests and mountains. When she reached Slovenia she was arrested by the police and taken into prison. The police in the prison said that she had to remove her clothes, the same thing happened to her at the police station where she had to stand completely naked in front of several police women. She had severe abdominal pain and was continuously asking the police in the prison for a doctor. Despite her pregnancy only once a doctor, who wasn't a gynaecologist examined her. She asked for a translator, but was not allowed to get one. She cried every day in the prison, she did not know where her husband was" (notes from the interview with Ana, Ljubljana, 18.10.2017).

Conclusion

Over the 20th century childbirth had little to do with women's autonomy. In maternity hospitals with a traditional orientation, women needed to strictly follow the procedures determined by medical personnel, their bodies were disciplined, their possibility to decide over the course of the delivery were minimal. In this context of the medicalization of childbirth, the dominant conviction was that pregnancy and childbirth should be supervised both medically and legally, while "it has become unacceptable for people to decide about these – now medical matters – themselves" (Prosen et al. 2013, 256). In the last decades this approach has been widely criticized, particularly in the aspect of control over pregnant woman's body (ibid.) and new trends, involving de-medicalization and humanization of childbirth, are now taking place in majority of maternity hospitals in Slovenia.

However, it seems that these trends are leaving behind asylum seekers and other migrant/refugee women who do not speak Slovene language and are not informed about their healthcare entitlements, which are in many cases hindered or limited. As we show in the article, these different levels of obstacles are largely a consequence of a healthcare system that is not adjusted or prepared to guarantee quality healthcare for these women. This does not mean that all migrants/refugees experience unequal medical treatment or that their childbirths are always records of discrimination and exclusion. However, the conversation with our interlocutors and previous research reveal that legally secured health rights do not guarantee full ac-

cess to those rights in medical practice, where information is lacking and sensitivity to language differences is entirely overlooked. Therefore, the healthcare system in Slovenia appears to be aimed at the Slovene population, with few exceptions. Similar are the findings from the MIPEX Country Reports: "policies are exclusively focused on standardizing diagnostic procedures and treatment methods. There is no development of treatments for health problems specific to certain migrant groups, no adaptation of standard treatments for routine health problems in order to better serve migrant communities, and no use of complementary and alternative 'non-Western' treatments for physical and mental health problems." (MIPEX 2015, 20).

Nevertheless, recent developments in this field indicate some positive trends and possible changes in the future, although the initiatives are usually short-lived and are not aimed at systemic changes in the healthcare system. Firstly, there are some project-based initiatives trying to implement interpreters/intercultural mediators in the medical settings12. Secondly, there is a growing recognition of the importance of sensitivity to language, cultural dimensions of healthcare among healthcare workers (Bombač et al 2017). As a result, different trainings in view of creating more migrant-sensitive healthcare services have been recently organized (Kocijančič Pokorn and Lipovec Čebron 2018). However, these are only first fragile steps towards a more inclusive healthcare that remain mainly exceptions in Slovene healthcare system.

References

Almeida Ligia, Jose Caldas Jose, Diogo Ayres-de-Campos, Dora Salcedo-Barrientos and Sonia Dias. 2013. „Maternal Healthcare in Migrants: A Systematic Review." *Maternal and Child Health Journal* 17(8): 1346-1354.

Amnesty International. 2016. „Female refugees face physical assault, exploitation and sexual harassment on their journey through Europe." https://www.amnesty.org/en/latest/news/2016/01/female-refugees-face-physical-assault-exploitation-and-sexual-harassment-on-their-journey-through-europe/ (Accessed 17. April 2018).

Bofulin, Martina and Romana Bešter. 2010. „Enako zdravstvo za vse?: Imigranti v slovenskem zdravstvenem sistemu." In *Državljani tretjih držav ali tretjerazredni državljani?: Integracija državljanov tretjih držav v Sloveniji*, eds. Mojca Medvešek and Romana Bešter, 270–311. Ljubljana: Inštitut za narodnostna vprašanja.

[12] For instance, in the framework of the project Together for Health (NIPH 2014) led by National Institute for Health, a pilot programme for an intercultural mediation for Albanian-speaking women was carried at the Health promotion centre in the Community health centre Celje in 2015. In the last years three intercultural mediators were made available for Arab and Farsi speaking asylum seekers in Ljubljana - mediators are collaborating in the project held by National Institute for Health and International organisation for migration.

Bombač, Lea, Uršula Lipovec Čebron, Sara Pistotnik, Andrea Turk Šverko, Andrej Trojar, Simona Repar Bornšek, Nina Sodja, Aida Hadžiahmetović, Helena Liberšar and Erika Zelko. 2017. „Zdravstvena obravnava prosilcev in prosilk za mednarodno zaščito v Sloveniji." *Družinska medicina Supplement 2017* 15(6): 28-36.

Bombač Lea, Miha Lučovnik, Tanja Premru-Sršen. 2017. „Perinatal care for refugees and asylum seekers in the South East European region." Paper presented at *World congress of perinatal medicine 2017*, Belgrade, 28 October.

Brovč, Majda, Janja Ahčin, Marinka Šlajpah and Danica Rotar Pavlič. 2009. „Ekonomski imigranti v Sloveniji in njihova stališča o boleznih – kvalitativna raziskava". *Zdravstveno varstvo* 48 (1): 26–32.

Carballo Manuel and Nerukar Aditi. 2001. „Migration, Refugees, and Health Risks." *Emergent Infectious Diseases* 7(3 Suppl): 556–560.

Castañeda, Heide. 2008. „Illegal Migration, Gender and Health Care: Perspectives from Germany and the United States." In *Gender and Illegal Migration in Global and Historical Perspective*, eds. Marlou J. Schrover, Joanne van der Leun, Leo Lucassen and Chris Quispel, 171-188. Amsterdam: IMISCOE/Amsterdam University Press.

Castañeda, Heide. 2009. „Illegality as risk factor: A survey of unauthorized migrant patients in a Berlin clinic." *Social Science & Medicine* 68: 1552–1560.

Chavez, Lilian and Cecilia Menjívar. 2010. „Children without borders: A mapping of the literature on unaccompanied migrant children to the United States." *Migraciones Internationales* 5(3): 71–111.

Dhar, Ruby. 2007. *Women and International Migration: A Cross-cultural Analysis*. Guildford: CRONEM.

Doctors of the world. 2014. „Access to Healthcare in a Europe in a Time of Crisis 2014: Focus on Women and Children." http://issuu.com/dotw/docs/mdm_2014_eu_report_access_to_care (Accessed 20. March 2018).

Eurostat. 2018. „Eurostat Statistics Explained. Asylum Statistics." https://ec.europa.eu/eurostat/statistics-explained/index.php/Asylum_statistics#undefined (Accessed 3 October 2018).

Freedman, Jane. 2016. „Sexual and gender-based violence against refugee women: a hidden aspect of the refugee crisis." *Reproductive Health Matters* 24: 18–26.

Gosenca, Karmen. 2017. „Medkulturna mediacija: priložnost za boljšo zdravstveno oskrbo : magistrsko delo." MA thesis, Filozofska Fakulteta, Univerza v Ljubljani.

Health Care and Health Insurance Act (Zakon o zdravstvenem varstvu in zdravstvenem zavarovanju -ZZVZZ-UPB3). 2006. „Zakon o zdravstvenem varstvu in zdravstvenem zavarovanju (uradno prečiščeno besedilo).” *Uradni list RS,* 72/2006. http://www.uradni-list.si/1/index?edition=200672" \l "!/Uradni-list-RS-st-72-2006-z-dne-11-7-2006 (Accessed 1. September 2018).

Heidari, Shirin and García Moreno Claudia. 2016. „Gender based violence: a barrier to sexual and Reproductive Health and Rights.” *Reproductive Health Matters* 24: 1–4.

Hupp Williamson, Sarah. 2017. „Globalization as a Racial Project: Implications for Human Trafficking. *Journal of International Women's Studies* 18(2): 74–88.

International protection law (Zakon o mednarodni zaščiti) (ZMZ-1). 2017. *Uradni list RS*, št. 16/17 – uradno prečiščeno besedilo. „Pravilnik o pravicah prosilcev za mednarodno zaščito. Uradni list RS 2017; 67/08, 40/10, 68/11.

International migration report 2017. „International migration report. Highlights.” New York: United Nations. http://www.un.org/en/development/desa/population/migration/publications/migrationreport/docs/MigrationReport2017_Highlights.pdf (Accessed 1. October 2018).

Ivnik, Tina. 2017. „Women in migration: Some notes from the west Balkan route.” *Glasnik Etnografskog Instituta SANU* 65 (3): 559-572.

Jazbinšek, Simona and Tina Palaić. 2009. „Zdravje – človekova pravica? Prosilke in prosilci za mednarodno zaščito.” *Časopis za kritiko znanosti* 37 (238): 154–162.

Jazbinšek, Simona and Uršula Lipovec Čebron. 2016. „Focus group report – Slovenia.” Unpublished report of the project Access to health care Services, Supporting Member States to respond to the health needs of asylum seekers and refugees.

Kocijančič Pokorn, Nike. 2018. „Reševanje jezikovnih zaprek v slovenskem zdravstvu: analiza stanja.” In *Večjezično zdravje: Komunikacijske strategije in večkulturni stiki s tujezičnimi bolniki v slovenskem zdravstvenem sistemu*, eds. Nike Kocijančič Pokorn and Uršula Lipovec Čebron. Ljubljana: Znanstvena založba Filozofske fakultete (in print).

Kocijančič Pokorn, Nike and Uršula Lipovec Čebron, ed. 2018. *Večjezično zdravje: Komunikacijske strategije in večkulturni stiki s tujezičnimi bolniki v slovenskem zdravstvenem sistemu*. Ljubljana: Znanstvena založba Filozofske fakultete (in print).

Kulovec, Judita. 2012. „Zdravje imigrantk v Sloveniji.' B.A. thesis. Fakulteta za družbene vede, Univerza v Ljubljani.

Lipovec Čebron, Uršula. 2010a. „Slepa pega evropskega zdravstva: Analiza nekaterih vidikov zdravja migrantov. In *Migranti v Sloveniji. Med integracijo in alienacijo, eds.* Karmen Medica, Goran Lukič, Milan Bufon, 57-81. Koper: Univerza na Primorskem, Znanstveno-raziskovalno središče.

Lipovec Čebron, Uršula. 2010b. „The Construction of a Health Uninsurant: People without Medical Citizenship as Seen by Some Slovene Health Workers." *Studia ethnologica croatica* 22(1): 187–212.

Lipovec Čebron, Uršula. 2011a. „Izbrisani prebivalci brez zdravstvenega državljanstva: medicinskoantropološka študija. PhD dis., Filozofska fakulteta, Univerza v Ljubljani.

Lipovec Čebron, Uršula. 2011b. „Reformiranje zdravstvenega sistema Slovenije: med 'lustracijskimi' in 'jugonostalgičnimi' težnjami." *Etnolog* 21: 179–201.

Lipovec Čebron, Uršula and Sara Pistotnik. 2015. „Iluzija o univerzalnem dostopu do zdravstvenega zavarovanja: Nedržavljani, prekarni, revni kot zdravstveno nezavarovani prebivalci." *Etnolog* 25: 89–111.

Lipovec Čebron, Uršula and Sara Pistotnik. 2018a. „Migrants/refugees in Slovene Healthcare - Many Open Questions and Some Possible Answers." In *Contemporary Migration Trends and Flows on the Territory of Southeast Europe*, eds. Marijeta Rajković Iveta, Petra Kelemen, Drago Župarić-Iljić. Zagreb: Filozofski fakultet u Zagrebu (in print).

Lipovec Čebron, Uršula in Sara Pistotnik. 2018b. „(Im)Mobile Populations and Health Rights: Accessing the Healthcare System in Slovenia." In *Health and Care (Im)Mobilities.* eds. Cecilia Vindriola-Padros, Ginger A. Johnson and Anne E. Pfister, 53-73. New York in Oxford: Berghahn.

Lipovec Čebron, Uršula, Marjeta Keršič Svetel, Sara Pistotnik. 2016. „Zdravstveno marginalizirane – »ranljive« skupine: Ovire v dostopu do sistema zdravstvenega varstva in v njem." In *Ocena potreb uporabnikov in izvajalcev preventivnih programov za odrasle: Ključni izsledki kvalitativnih raziskav in stališča strokovnih delovnih skupin,* ed. Jerneja Farkaš Lainščak, 14–25. Ljubljana: Nacionalni inštitut za javno zdravje.

Lipovec Čebron, Uršula, Sara Pistotnik, Simona Jazbinšek, Jerneja Farkaš Lainščak. 2017. „Evaluation of the Implementation of Intercultural Mediation in Preventive Healthcare Programs in Slovenia." *Public Health. Panorama* 2 (1): 114–119.

Merry, Lisa, Rhonda Small, Beatrice Blondel, Anita Gagnon. 2013. „International migration and caesarean birth: a systematic review and meta-analysis." *BMC Pregnancy Childbirth* 13: 27. https://bmcpregnancychildbirth.biomedcentral.com/articles/10.1186/1471-2393-13-27 (Accessed 16 October 2018).

Mikolič Južnič, Tamara. 2018. „Kdo dela z uporabniki zdravstvenega sistema, ki ne govorijo Slovensko?" In *Večjezično zdravje: Komunikacijske strategije in večkulturni stiki s tujezičnimi bolniki v slovenskem zdravstvenem sistemu*, eds. Nike Kocijančič Pokorn and Uršula Lipovec Čebron. Ljubljana: Znanstvena založba Filozofske fakultete (in print).

Ministrstvo za notranje zadeve RS. 2018. http://www.mnz.gov.si/si/mnz_za_vas/tujci_v_sloveniji/statistika/ (Accessed 12. March 2018)

Milavec Kapun, Marija, Danica Rotar-Pavlič, Uršula Lipovec Čebron, Nike Kocijančič-Pokorn, Sara Pistotnik Nataša Hirci, Ajda Jelenc, Erika Zelko. 2017. „Strategije premagovanja jezikovnih ovir med medicinskimi sestrami." In *Medicinske sestre in babice - ključne za zdravstveni sistem*, eds. Suzana Majcen Dvrošak, Tamara Štemberger Kolnik, Andreja Kvas, 564-573. Ljubljana: Zbornica zdravstvene in babiške nege Slovenije - Zveza strokovnih društev medicinskih sester, babic in zdravstvenih tehnikov Slovenije, Nacionalni center za strokovni, karierni in osebnostni razvoj medicinskih sester in babic.

MIPEX. 2015. „MIPEX—Country Report for EQUI-HEALTH." Brussels: International Organisation for Migration. http://www.mipex.eu/ (Accessed 10 January 2018).

Mixed Migration Platform. 2016. „Women and girls on the move: A gender analysis of mixed migration from the Middle East to Europe". https://reliefweb.int/sites/reliefweb.int/files/resources/20161215_MMP_Briefing%20Paper_Women%27s%20migration%20to%20the%20EU_December%202016.pdf (Accessed 12. January 2018)

NIPH. 2014. „Skupaj za zdravje." Ljubljana: National Institute of Public Health. http://www.skupajzazdravje.si/projekt (Accessed 11. October 2018).

Observatory report. 2017. „Falling through the Cracks: The Failure of Universal Healthcare Coverage in Europe." https://mdmeuroblog.files.wordpress.com/2014/01/observatory-report-2017-web-version.pdf (Accessed 1. March 2018).

Prosen, Mirko and Marina Tavčar Kranjc. 2013. „Sociological Conceptualization of the Medicalization of Pregnancy and Childbirth: The Implications in Slovenia." *Revija za sociologiju* 43(3): 251-272.

Razum, Oliver, Albrecht Jahn, Maria Blettner and Pitt Reitmaier. 1999. „Trends in maternal mortality ratio among women of German and non-German nationality in West Germany, 1980–1996." *International Journal of Epidemiology* 28(5): 919-24.

Recape, Judith, Claudia Schoenborn, Mouctar Sow, Sophie Alexander and Myriam De Spiegelaere. 2016. „Are all immigrant mothers really at risk of low birth weight and perinatal mortality? The crucial role of socio-economic

status." BMC Pregnancy Childbirth 2016: 16-75. https://bmcpregnancychildbirth.biomedcentral.com/articles/10.1186/s12884-016-0860-9. (Accessed 20 April 2018).

Rotar-Pavlič, Danica, Uršula Lipovec Čebron, Nike Kocijančič-Pokorn, Sara Pistotnik, Marija Milavec Kapun, Nataša Hirci, Ajda Jelenc, Erika Zelko. 2017. „Jezikovne ovire in kako jih presegati." *Družinska medicina, Supplement* 15(2): 12-15.

Schulpen, Tom. 1996. „Migration and child health: The Dutch experience." *European Journal of Pediatrics* 155(5): 351-356.

Scott, Penelope. 2004. „Undocumented Migrants in Germany and Britain: The Human "Rights" and "Wrongs" Regarding Access to Health Care." http://www.sociology.org/ejs-archives/2004/tier2/scott.html (Accessed 2. May 2018).

Stewart, Donna, Anita Gagnon, Jean-Francosi Saucier, Olive Wahoush and Geoffrey Dougherty. 2008. „Postpartum depression symptoms in newcomers. " *Canadian Journal of Psychiatry* 53: 121–124.

Van der Zee, Renate. 2016. „Life as a female refugee: 'You don't know who to trust'." http://www.aljazeera.com/indepth/features/2016/02/life-female-refugee-don-trust-160210092005932.html. (Accessed 16. April 2018).

Wilson, Anne. 2011. „Trafficking risks for refugees." http://digitalcommons.unl.edu/cgi/viewcontent.cgi?article=1003&context=humtraffconf3 (Accessed 8. April 2018).

Wittkowski, Anja, Sonia Patel, John Fox. 2017. „The Experience of Postnatal Depression in Immigrant Mothers Living in Western Countries: A Meta-Synthesis." *Clinical Psychology and Psychotherapy* 24(2): 411-427.

Wolff, Hans, Manuella Epiney, Ana P Lourenco, Michael C Costanza, Jacqueline Delieutraz-Marchand, Nicole Andreoli, Jean-Bernard Dubuisson, Jean-Michel Gaspoz and Irion Olivier. 2007. „Undocumented migrants lack access to pregnancy care and prevention. " *BMC Public Health* 8: 93 https://bmcpublichealth.biomedcentral.com/articles/10.1186/1471-2458-8-93 (Accessed 20 April 2018).

Примљено / Received: 11. 04. 2018.
Прихваћено / Accepted: 30. 10. 2018.