

Barriers to health care access among undocumented migrant women in Norway

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Abstract

The aim of this study was to explore undocumented migrant women's subjective experiences of their health conditions and access to health care. The study is based on eight qualitative interviews with undocumented migrant women and eight qualitative interviews with health personnel at a health center for undocumented migrants in Oslo. The women were recruited by self-selection from patients at the health center. Both the women and the health professionals related the women's health problems to their living conditions. Even though all of the women had extremely difficult living situations, their living conditions varied. Some lived in an apartment with a partner. Some had to move among the homes of various friends and had to be out all day while those friends were at work. The women with paid work had more structured daily lives than the others, with living situations that gave them some opportunities for rest and privacy. Domestic work in the black market for labor was associated with health problems due to the heavy and repetitive tasks performed while cleaning private homes. Limited rights to health care, fear of being reported, financial difficulties and poor language skills were mentioned as barriers to health care. These barriers lead to delay in seeking medical care and use of alternative health-seeking strategies. Factors that indirectly affected the health of the women included a lack of knowledge of both their rights and the available services in Norway. The pregnant women were unaware of their right to receive prenatal care.

Keywords: *Undocumented migrant women; access to health care; living conditions*

The number of undocumented migrants in Europe is increasing. In Norway, the number is estimated to be approximately 18,000 (Zhang, 2008). Due to the lack of available data, this estimate has limitations.

Undocumented migrants can be defined as "third-country nationals without

a valid residence permit or visa allowing them to reside in the country of destination and who, if detected, may be liable to deportation" (Biswas, Kristiansen, Krasnik, & Norredam, 2011). Undocumented migrants are not a homogeneous group with respect to their status as migrants; instead, they can be divided into different

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categories. One category is failed asylum seekers who go underground to avoid deportation after having been refused asylum. A second category is migrants who enter the country illegally and never register with the authorities. A third category is “overstayers,” which describes migrants who remain after their visas expire.

European countries provide various levels of access to health care to undocumented migrants (Biswas et al., 2011; Biswas, Toebes, Hjern, Ascher, & Nørredam, 2012; Björngren-Cuadra & Cattacin, 2010; Chauvin, Simonnot, & Vanbiervliet, 2013; Ottesen, 2008; Priebe et al., 2011). A comparative study among European Union (EU) member states found that in 12 member states undocumented migrants can only access emergency care. In 10 member states, not even emergency care can be accessed. Only five member states give undocumented migrants the right to access care that is more extensive than emergency care (Cuadra, 2012).

Due to barriers to accessing health care, many undocumented migrants ignore minor ailments, which can lead to serious problems. The costs of care, the lack of awareness about entitlement to health care, the fear of being reported to the police, poor language skills, and a lack of knowledge about the local health care system are some of the main barriers to accessing health care for undocumented migrants (Baghir-Zada, 2010; Chauvin, Simonnot, et al., 2013; Myhrvold, 2010; PICUM, 2007; Priebe et al., 2011).

The fact that undocumented migrants have limited access to health care raises concerns. Compared to the general population, undocumented migrants must be considered a vulnerable group because of their lack of legal residence status, poor

living conditions, and social vulnerability, which can be defined as “an exclusionary process induced by the legal situation and living conditions which undocumented migrants in many cases face” (Wyssmüller & Efonyi-Mäder, 2011).

Women often migrate during their childbearing years, and they are frequently exposed to biological and psychosocial risks that tend to increase their social vulnerability (Almeida et al., 2013). A study from the Netherlands (Schoevers, Van den Muijsenbergh, & Lagro-Janssen, 2009) found that undocumented women—particularly those in the subgroup of rejected asylum seekers—rate their health as very poor.

The findings of a recent literature review (Munro, Jarvis, Munoz, D’Souza, & Graves, 2013) indicate that pregnant undocumented migrants constitute a particularly vulnerable subgroup of migrants due to their reported social precariousness and their underutilization of health services. Furthermore, the study shows that this group of undocumented migrants is largely understudied (Munro et al., 2013).

Research carried out in seven EU countries in 2012 found that pregnant undocumented immigrants have only limited access to prenatal care (Chauvin, Parizot, & Simonnot, 2013). Compared to women with legal residence, undocumented women have more unintended pregnancies and delayed prenatal care, use fewer preventive measures, and are more likely to be exposed to violence during pregnancy (Wolff et al., 2008). Undocumented women are at greater risk of experiencing adverse perinatal outcomes and receiving inadequate care than documented ethnic minority women (de Jonge et al., 2011).

Research on undocumented migrants in Norway is scarce. Undocumented migrants have different reasons for both coming to Norway and not wanting to return to their home countries. Recent research demonstrates that despite group members' common status as undocumented migrants, there are large variations in living conditions within the group. Some have incomes and live in apartments, whereas others live on the streets (Øien & Sønsterudbråten, 2011). What they have in common is that because of their migrant status, they are excluded from the regular labor market and have limited access to health care (Hjelde, 2009; Øien & Sønsterudbråten, 2011). The links between group members' undocumented status and their health problems are complex and multi-dimensional. Inadequate nutrition and the experience of living with fear and insecurity can create and exacerbate health problems (Hjelde, 2009; Øien & Sønsterudbråten, 2011).

Previous studies have observed poor health among undocumented migrants in Norway (Hjelde, 2009, 2010; Øien & Sønsterudbråten, 2011). Stress-related illnesses and mental health problems have been emphasized as issues. Undocumented migrants need health services but tend either to remain untreated or to delay seeking help (Hjelde, 2009, 2010). They face exclusionary practices when they attempt to access the Norwegian health care system and the labor and housing markets (Gasana, 2012). They feel that their access and rights to health care services are unclear (Hjelde, 2009, 2010). The concept of structural vulnerability is used to explain and understand the undocumented migrants' experiences by examining the factors and structures

underpinning their difficulties accessing basic needs, including health care, employment, and housing (Gasana, 2012).

ACCESS TO HEALTH CARE IN NORWAY

Undocumented migrants are entitled to emergency health care from specialized and municipal health care services. However, the definition of *emergency health care* is very strict (Aschehoug, 2010). Undocumented migrants are also entitled to *necessary* health care from municipal health care services. A new paragraph that was added 2 years ago changed the wording from entitlement to *necessary* health care to health care that is *absolutely necessary*. The criteria are now very similar to those for *emergency help*. Researchers have noted that these restrictions might violate the human rights core obligation to "essential primary care" (Sinding & Kjellevoid, 2012).

Some groups of undocumented migrants have expanded rights to health care. During pregnancy, undocumented women have the right to prenatal care, care during labor and birth, and postnatal care. They have also the right to induced abortions. Children under the age of 18 have the same rights as those with legal residence. Furthermore, undocumented migrants have the right to health care for infectious diseases, and mentally unstable persons have the right to psychiatric care (Sinding & Kjellevoid, 2012; Søvig, 2011).

Because undocumented migrants are not members of the Norwegian National Insurance Scheme, they have no right to an assigned general practitioner. They are obliged to pay the full cost for treatments, even those associated with childbirth.

Exceptions are made for prenatal care, forced admission for psychiatric treatment, treatments for contagious diseases, and vaccinations, all of which are free of charge (Aschehoug, 2010; Søvig, 2011).

In some countries, health professionals can face criminal charges for treating undocumented migrants and are obligated to report them to the authorities (Castañeda, 2009). This is not the case in Norway. In Norway, health professionals have a duty to maintain the confidentiality of all patient information, and it is illegal to share patient information.

The aim and focus of this study is to explore undocumented migrant women's perceptions of their health status and their access to health care.

METHODS

Conversational interviews were conducted with undocumented migrants and health personnel. The interviews were conducted by the first author, using a flexible, open approach.

Recruitment procedure and participants

One challenge in performing research on undocumented migrants is recruitment and the identification of social arenas or entry points where participants can be found (Brunovskis & Bjerkan, 2008; Øien & Sønsterudbråten, 2011). The informants in this study were recruited from the Health Center for Undocumented Immigrants in Oslo.

The undocumented migrants were recruited by self-selection. To recruit informants, a poster was made in five different languages that presented the project and researcher. It included both

a picture and contact information. The posters were displayed in the waiting room and consultation rooms on the 8 days the researcher was present at the facility. Six of the interviews were conducted on the same day. One woman chose to come back another day to be interviewed and one woman chose to be interviewed elsewhere. Data were collected between February and June 2012.

The sample

This study is based on 16 qualitative interviews. Eight interviews were conducted with undocumented migrant women and eight with health personnel. The migrant informants were from Africa (4), Asia (3), and Europe (1). Three of the women had never been in contact or registered with Norwegian authorities. One had not left the country after her visa expired and was in the overstayers category. The rest were rejected asylum seekers. Four of the women were aged between 20 and 29 years, three were between 30 and 40 years, and one was between 50 and 60 years.

The health personnel were recruited by email. The manager of the health center sent an email to the volunteer doctors and nurses with information about the project. The inclusion criteria were that the volunteers had worked at the health center for at least 1 year. Those who were interested were encouraged to contact the researcher by sending an email confirming that they wanted to participate. Four doctors, two midwives, and two nurses responded. Except for one doctor, all of the volunteer health workers were female. All of them had worked at the health center for approximately 2 years.

The interviews

Qualitative interviews were conducted using an interview guide. The health personnel and one of the undocumented migrants were interviewed in Norwegian. Two of the migrants were interviewed in English and five were interviewed using interpreters (one of those interviews was face to face and the other four were by telephone). All of the interpreters were female. Seven of the interviews with health personnel were conducted at their workplaces; one took place at the health center. The interviews with the undocumented migrant women lasted approximately 45 minutes, and the interviews with the health care workers lasted 60 minutes.

Assumptions made in the initial interviews about living situation, perceived health problems, barriers to seeking health care, and strategies for solving health problems were elaborated on in the following interviews to ensure that the issues were relevant and important to the informants and to reveal nuances and context.

Field notes regarding the informants' nonverbal expressions and other immediate reflections were made just after the interviews were completed. All of the interviews with the health personnel were both audio recorded and transcribed.

Ethical considerations

The project was approved by the Norwegian Social Science Data Services (NSD), on September 8, 2011 (project number 27663). Research on undocumented migrants is particularly sensitive (Brunovskis & Bjerkan, 2008). Due to the security risks for the informants (i.e. because they were undocumented

migrants), the interviews were not audio recorded. This arrangement was in accordance with advice given by the NSD. Instead, notes were taken during the interviews. To protect anonymity, the respondents gave their informed consent orally instead of in writing. This article omits information that could compromise the migrants' anonymity, such as the names of their original countries.

Participants were informed that non-participation would not have any negative consequences on their treatment at the health center. This information was included both on the posters and at the beginning of the interviews. It was also important to inform the participants that the researcher conducting the interviews could not influence or be of any help in the respondents' cases. However, by participating, the researcher would gain knowledge that could contribute to a better understanding of the living conditions of undocumented migrants among politicians and authorities.

Only female interpreters were used. When using interpreters, potential threats to validity can arise. The fact that the same themes emerged in several of the interviews—and that several of the results have been highlighted in other studies—supports the results reported here. However, it is reasonable to expect that some nuances and understandings of context will be lost when using interpreters.

Data analysis

The analysis was carried out in three phases inspired by the constant comparative method (Corbin & Strauss, 2008). The three phases are the initial, axial, and selective coding phases. In the first phase, initial coding, the themes of daily life,

employment, health, reproductive health, and access to health care were recognized. In the next phase, axial coding, the analysis provided a closer and more detailed description of the women's daily lives, living conditions, and health situations. Comparisons among the interviews provided a richer picture and deeper understanding of the women's daily lives and their health situations. In the final phase, not only the importance of the women's living conditions and health but also their barriers to seeking health care were identified and described. The same approach was used to analyze the interviews with health personnel. A thorough review and comparison of the interviews, field notes, analysis, and presentation of the results were conducted to ensure that the interpretation was in line with what was communicated in the interviews.

The results of the data analysis suggest that power is a key factor in undocumented migrant women's access to health care. Different dimensions of power related to barriers in access to health care were identified in accordance with Lukes' three-dimensional view of power: power as decision-making, as agenda setting, and as preference shaping (Lukes, 2005).

RESULTS

Both the women and the health professionals related the women's health problems to their living conditions. The health personnel perceived the connection between undocumented status and health problems as multifaceted. In terms of the women's health situations, they meant that their status as undocumented created and was clearly contributing to health problems. Being unable to obtain

housing and having a stressful daily life would cause health problems.

The main problem is not their health problems. When they have no place to go to, their days become chaotic. I wish I could do more than just prescribe medication.
(Female doctor)

There were significant differences in the housing situations among the women. Some lived in an apartment with a partner, whereas others stated that they lived in very difficult and unstable situations. Four of the women had lived with friends temporarily and had moved between various friends' homes, living "one day here and one day there." Some had to be out all day while the family members with whom they lived were at work. They felt like they were a burden and dependent on others. They found it especially humiliating to be constantly moving and dependent on the goodwill of others. Even meals were associated with stress. One of the women said that it did not feel good to eat "other people's food."

All of the women in this study had worked in their home countries, and one had legally worked in Norway before her work permit was withdrawn. When the interviews took place, only three of the women were working. They were employed in domestic work in the black market for labor. Their health problems were related to heavy and repetitive tasks performed while cleaning private homes. They were extremely underpaid, earning approximately 60 Norwegian kroner per hour. One of the women said that she did not eat much because she had to pay for public transit and telephone cards. However, despite the hard work and long hours, work was a source of income that made it possible for the undocumented

migrants to rent an apartment and have a life that was not very different from the lives of people with legal status. The women with paid work had steady routines in their everyday lives, with work during the day, contact with friends, leisure activities, and living situations that gave them opportunities for rest and privacy.

In this study, the women who did not work had very different daily lives. They were completely dependent on others. Long days with no activity were a source of mental stress. When they were asked to describe their activities on an average day, they all said, "I do nothing!" One described an ordinary day as "too long and too much. I'm not working."

Health situation

There were variations in how the informants described their health. Four of the women described their health as "poor." One said that she used to have good health but had developed a chronic illness that caused serious health problems. The interviews showed the challenge in making a clear distinction between physical and mental health problems. Several of the women reported experiencing various types of pain, such as headaches, musculoskeletal pain, abdominal pain, and sleep disorders.

The health personnel highlighted the women's living conditions as causes of both their physical and psychosocial health problems. By this, the personnel mean that the health problems often manifested with symptoms such as headaches, musculoskeletal pain, abdominal pain and skin problems. Some of the health personnel pointed out that many of the undocumented migrant women

from Asia worked as housecleaners, so their work involved heavy and repetitive tasks. This type of work can cause musculoskeletal pain. They were also concerned about the women's nutrition, their low levels of vitamin D, and anemia. These issues can all cause fatigue and musculoskeletal pain, and they were considered common health problems among the women who came to the health center.

Some of the women described experiencing stress. One woman related it directly to her status as an undocumented migrant. Due to a change in the agreement between Norway and her country of origin, she felt that she was in great danger of being deported. She said that she was very afraid and that sometimes she just wanted to die. Some of the informants said that they often felt sad. The woman who lived on the streets said that she often felt sad and cried a lot because she missed her children in her country of origin. Only one of the women reported that she was in good physical and mental health. She came to the health center to accompany a friend and to seek help with contraception.

Half of the women were pregnant at the time of their interviews. None of the women had used contraception. Despite their precarious situations, with the exception of one woman, they seemed to be happy about their pregnancies. One of the women said that the pregnancy gave her hope for the future. She said that she wanted to be pregnant and was happy about it. She had a partner and an apartment to live in. Another one of the women was also optimistic about the future of her coming child. The child's father had legal residence in Norway and she assumed that he would be able to take

care of the child regardless of what might happen to her.

The interviews with the health professionals confirmed that it was common for the undocumented migrant women to not use contraception and to have unplanned pregnancies. The abortion rate among the women was high, especially among the women from Asia. However, the health professionals also had the impression that several of the women were happy about being pregnant despite the fact that it was unplanned and despite their precarious living conditions. Their interpretation was that the women had reached a point in their lives where it was natural to establish a family and that it was important to them to have children.

The women were not aware of their rights to prenatal care. The health professionals in this study gave examples of pregnant women being refused prenatal care by receptionists at public health clinics based on their residency status. This also indicates a lack of information among health professionals regarding undocumented migrant women's right to prenatal health care. Another example was an undocumented migrant woman who was required to pay in advance for an induced abortion.

The health center gave the pregnant women information about their right to prenatal care, made a referral to a local health center for prenatal care, and made a hospital reservation for the birth. The interviews with the health professionals confirmed that many of the pregnant women were not aware of their right to prenatal care, and many came to the health center as late as the 32nd week of their pregnancies.

Barriers to seeking health care

Fear of being reported to the police was the informants' main reason for not seeking health care. "Had I been legal here, I could have gone to see the doctor," said one of the women, who reported that she was "tired inside and out" but did not go to the doctor because she was afraid. One of the women said that she thought she was seriously ill and was very scared, saying, "I thought I was going to die!" The woman learned about the health center through an acquaintance. She went there even though she was afraid that it might be a trap. It turned out that she was pregnant. It was her first pregnancy, and she did not know anything about pregnancy symptoms. When the interview took place, she had just learned that she could trust that the health center would not report her to the police.

Finances were another barrier to seeking health care. Poor language skills were also mentioned as a reason for not seeking health care. Other barriers included the women not knowing about the health care system and their right to health care in Norway. The pregnant women were not aware of their right to receive prenatal care.

The health personnel named many barriers encountered by the undocumented migrant women in accessing health care. Those barriers included a fear of being reported to the police, a lack of financial resources, and poor language skills, in addition to their lack of knowledge about their rights. The health personnel also gave examples of women being required to pay before abortions and giving birth, when hospitals would normally send a bill afterwards.

Alternative strategies for solving health problems

When the respondents were asked what they did the last time they had a health problem, most of them answered “Nothing!” One said that she just cried. However, we also found that when health problems arose, the respondents used different strategies to address them.

Some of the woman had self-medicated based on advice and support from their networks in their home countries. They said they contacted family to seek advice and to have medicine sent to them. One of the women said that she solved her health problems by getting medicine from friends or having it sent from home. She explained, “I explained that I was in pain, kidney pain. The pain was in my belly. I got tablets from my home country and chose the treatment myself.” Another said she could not go to the doctor because she was afraid and instead treated herself by “drinking some medicine.” Sometimes she received medicine from her parents in her country of origin.

DISCUSSION

This study examines how undocumented migrant women described their health problems, access to health care, and daily lives and, furthermore, how health personnel at a health center described and understood the women’s situations.

Several of the participants in this study were pregnant at the time of the interviews. Previous studies have indicated that undocumented migrants have a higher rate of unplanned pregnancies than women with legal residence and that a lack of access to contraception is the

main reason for this discrepancy (Goth, Netskar, & Misvær, 2012).

The health situations among the women varied. Both the women and the health personnel related the women’s health problems to their living conditions. Research on undocumented migrant women’s health problems indicates that failed asylum seekers rate their health as very poor (Schoevers et al., 2009). Undocumented migrants find it especially humiliating to be constantly moving and dependent on the goodwill of others (Hjelde, 2010). Waiting and not knowing what will happen to them makes the waiting open-ended and contributes to feelings of randomness and being lost in time (Brekke, 2004).

The interviews showed that there were large variations in the women’s life situations. Some described a nearly “normal” daily life, with housing, paid employment, and positive feelings about the future. Others lived under extreme conditions, with some living on the streets. However, even though they had nearly “normal” daily lives and relatively positive feelings about the future, the women lived parallel lives apart from the rest of society and lacked formal rights. Moreover, some of the women who described themselves as having a near-normal daily life had uncertain housing and employment in the black market for labor. It is possible for undocumented migrants to stay in Norway for a long time without being detected by the police, as long as they avoid criminal activity and pay for their tickets when using public transit (Friberg, 2004).

All of the women in this study had worked in their home countries, and one had worked legally in Norway before her

work permit was withdrawn. We observed that work was important to the women. For some, social networks were their gateways to housing and employment. Work is a source of income that can make it possible for undocumented migrants to rent apartments and have lives similar to those of people with legal status (Gasana, 2012; Rutledal, 2012; Øien & Sønsterudbråten, 2011). Work can also serve as a meaningful use of time and a recognition of who the undocumented migrants are (Gasana, 2012). For the undocumented migrants, work can mean more than just making money to survive (Kjærre, 2011). Despite difficult work and long hours, working helped to reduce problems associated with lacking personal dignity and direction; it was a way to “remain sane.” This was also the case for the women in this study. Being deprived of the right to work meant long days with no activities, which was described as a heavy burden. Losing the ability to work could dramatically change the women’s situations. Findings in the relevant literature state that undocumented migrants without income or an occupation that can engage them and give meaning to their lives are more vulnerable to problems with their health and general well-being compared to people who have the opportunity to work (Wyssmüller & Efonyi-Mäder, 2011).

Both the women and the health personnel described a lack of access to necessary health care from the Norwegian health care services. According to Watters (2011), it is important in research on migrants to integrate entitlement, access, and appropriateness and to focus on the relationship among these factors. Despite strict national legislation regarding rights to health care, undocumented migrants

can access services that they are not formally entitled to. Although Norway only offers undocumented migrants minimum rights to health care, NGOs can provide access to health services in the absence of entitlement (Watters, 2011). The Health Center for Undocumented Migrants offers a range of services that allow undocumented migrants to consult doctors, nurses, psychologists, physiotherapists, and other specialists for free. Furthermore, through an agreement with a hospital, the health center can refer undocumented migrants to that hospital to receive necessary health care services that they are not formally entitled to. At the time of the interview, all of the women had received necessary health care at the health center. Studies also show that health professionals may treat undocumented migrants even though they have no or limited entitlement to access health care services (Dauvrin et al., 2012)

As described in other studies (Gasana, 2012; Hjelde, 2009, 2010; Øien & Sønsterudbråten, 2011) the women in this study faced several barriers to accessing Norwegian health care services. According to Watters (2011), barriers to accessing health care can be viewed as either “active” or “passive.” With reference to Lukes (2005), these barriers can relate to various dimensions of power (Watters, 2011).

The first dimension of power is exercised in an open and visible manner with a focus on decision-making (Lukes, 2005). Denying undocumented migrants access to health care appears as an active barrier related to the first dimension of power (Watters, 2011). For the undocumented migrant women in this study, the main active barrier was restrictions in formal rights to health care. The most important

barrier to health care for undocumented migrants in European countries is restrictive national laws (Chauvin, Simmonot, Vanbiervliet, Vicart, & Vuillermoz, 2015).

Active barriers also appear when undocumented migrants are denied access to health care despite having formal rights (Watters, 2011). For example, in our study we observed that pregnant women were refused prenatal care by receptionists or required to pay in advance for an induced abortion.

Another active barrier to health care mentioned by the women was health care costs. In Norway undocumented migrants are obliged to pay the full costs for treatment, while in Sweden they are allowed to access state-subsidized health care with the same type of coverage as asylum seekers (Socialdepartementet, 2015).

According to Lukes (2005), power can also be exercised through non-issues and non-decision-making. This represents the second dimension of power, which involves control of the agenda and is related to passive barriers (Watters, 2011). Here power is exercised in an indirect and hidden manner “simply by taking a matter off the agenda.” Passive barriers appear when health authorities fail to give migrants relevant information about their rights (Watters, 2011, p. 151). In accordance with other studies (Dauvrin et al., 2012; Dorn et al., 2011; Hjelde, 2010), our study shows that a lack of information about health care rights among both health care users and providers can be an important barrier to migrants receiving health care. For example, the pregnant women in this study did not know about the requirement that Norwegian health professionals maintain their patients’ confidentiality. Fear of

being reported to the police was the main reason for not seeking health services. Pregnancy is a particularly precarious time for undocumented women because they become more visible due to their need to interact with the health care system. These women were afraid to seek health care and did not know what to do before they learned about the health center through their personal network. At the time of the interview, the women had received information from the health center about their rights to prenatal care and had been referred to a public health center for prenatal checkups. The health center had also made hospital reservations for the births. These factors could help make the women feel safe and may partly explain why most of the women stated that they were happy about being pregnant, despite their precarious status as undocumented migrants.

The third dimension of power is preference shaping. According to Lukes (2005, p. 28), power can be exercised by “shaping their perception, cognition and preferences in such a way that that they accept their role in the existing order of things.” Lukes (2005) mentions control of information—through mass media and through the prose of socialization—as a form of “thought control” (p. 27).

One of the women in our study stated that if she had been “legal,” she could have gone to see a doctor. Using the term *illegal* instead of *undocumented* or *irregular* can cause undocumented migrants to be perceived as “undeserving” (Willen, 2011, 2012; Willen, Mulligan, & Castañeda, 2011). Access to health care for undocumented migrants can be regarded, even by health care workers, as a privilege instead of a right, a privilege that only “deserving” taxpayers are entitled to

access (Vanthuyne, Meloni, Ruiz-Casares, Rousseau, & Ricard-Guay, 2013). According to Jørgensen (2012, p. 59), using the term *illegal* can cause migrants to be placed outside the law and outside the norms of “how people should be treated,” causing them to be treated as non-citizens stripped of rights they should have been entitled to.

Khosravi (2010, p. 111) points out that undocumented migrants play a part in society through political and juridical processes, media coverage, academic research, and the labor market, but they are still partially kept out of society. “. . . They are not *excluded* but are *excepted*, they have not been thrown out, but neither are they considered participants. They are included in society without being recognized as members” (Khosravi, 2010).

Implications for health care policy and practice

According to Lukes (Hayward & Lukes, 2008, p. 7) power lies in non-decision-making, when groups or organizations have power “to act or not to act.” By acting or acting otherwise, they could have made a difference (Hayward & Lukes, 2008). According to the report Migration and Health (Helsedirektoratet, 2008) created by the Norwegian Directorate of Health, undocumented migrants should be given explicit rights to preventive and curative health care services in primary care. The report also concluded that information systems should be established to help ensure that “illegal” migrants are educated about their rights to health care and that it is important to inform them about Norwegian health care workers’ confidentiality oath.

However, the national strategy on migrant health for 2013–2017, “Equal Health and Care Services—Good Health for All” (Helse og Omsorgsdepartementet, 2013) states that the main focus of the strategy is the group of migrants coming from countries outside the EU and European Economic Area with permanent residence in Norway. Undocumented migrants are not mentioned at all. When action is stalled by not having a strategy for providing health care to undocumented migrants and by failing to educate undocumented women about their health care rights, the health problems and the barriers to health care access that these individuals face are made invisible to policy makers and the Norwegian public.

Informing pregnant, undocumented migrant women of their rights could make a difference. A lack of pre- and postnatal care can lead to severe consequences for both mother and child. The exclusion of HIV-positive pregnant women from the health care system in particular raises great concern (Ascher, Björkman, Kjellström, & Lindberg, 2008). This exclusion can increase the risk of a child being infected after birth by almost 15 times (Ascher et al., 2008).

Studies on maternal health care for migrants have demonstrated that culturally sensitive strategies are necessary to increase awareness of relevant health care and social support services in women’s communities (Dias, Gama, & Rocha, 2010; Merry, Gagnon, Kalim, & Bouris, 2011). Public health education policies must target both undocumented women and the community in general to increase health literacy and the likelihood of migrants seeking maternal care (Almeida, Caldas, Ayres-de-Campos, Salcedo-Barrientos, &

Dias, 2013). European research on best practices in health care for migrants concludes that an important component of best practices is practitioner training and provision of information to both health care professionals and migrants (Priebe et al., 2011).

Educational training programs, informational materials for migrants, and clear guidelines on the care that different groups of migrants are entitled to can contribute to increased cultural awareness among health care professionals (Priebe et al., 2011). It is essential to increase knowledge among health care providers regarding the complex life situations faced by undocumented migrants and by undocumented women in particular. Good living conditions and social and economic resources are crucial to the ability to take care of one's own health (Kickbusch, 2001).

The primary responsibility for information lies with the Norwegian health authorities. Experiences from other countries show that training and information campaigns among health care and social service providers have helped increase knowledge among professionals regarding the rights of undocumented migrants. The campaigns have also increased knowledge among undocumented migrants themselves. In these campaigns, federal and local authorities have played an important role in providing information and facilitating access to health care (Wyssmüller & Efonayi-Mäder, 2011).

The impact of active and passive barriers to accessing health care can lead to the use of alternative methods to solve health problems. Fear of being reported to the police can result in alternative health-seeking strategies. As seen in other studies (Biswas et al., 2011; Castañeda,

2009; Hjelde, 2009; Wyssmüller & Efonayi-Mäder, 2011), some of the women in this study used medications in an unregulated manner, which can have harmful consequences.

Barriers to accessing health care—such as inability to pay, administrative problems, lack of knowledge or understanding of the health care system and one's rights, and language barriers—can result in delayed care. In a recent report on undocumented migrants' access to health care, one patient in five had given up trying to access care or treatment in the last 12 months due to these barriers (Chauvin et al., 2015).

According to Jørgensen (2012) a dominating tendency in Scandinavian countries is to present irregularity as an individual choice. Migrants are seen as responsible for their own fate, which legitimizes restrictive policies and actions, leading to migrant disempowerment (Jørgensen, 2012). For example, a restrictive asylum policy aims to reduce the number of asylum seekers by making Norway a less attractive choice. Rights to health care services can be pull factors and can attract fortune hunters and "health tourists." Nevertheless, a report from Doctors of the World debunks the myth that migrants come to Europe for medical reasons, showing that only 3% had migrated for health reasons (Chauvin et al., 2015). Moreover, there is no evidence that the limited access to social and health care services has led to an increased number of repatriated asylum seekers in Norway (Brekke, 2008).

STUDY LIMITATIONS AND STRENGTHS

This is a qualitative study. The aim was to reveal insights into the situations

encountered by undocumented migrant women. The strength of this study is that it obtained information about undocumented female migrants' own feelings about and judgments of their health and living situations. This was supplemented by information from health professionals who worked with them.

A small group of undocumented migrant women participated in this study. All were recruited at a health center for undocumented migrants. The groups that might be at the greatest disadvantage, who do not have contact with this type of health center, were not represented in this study. Five of the interviews were conducted using an interpreter. When using an interpreter, the researcher may not know if the interpreter summarized or modified responses. Therefore, quotations should be used with care. Two interviews were conducted in English and one was conducted in Norwegian. Misunderstandings might have occurred due to cultural differences and the informants' abilities to communicate in Norwegian and English.

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