

Are Dutch maternity care services primitive?

A qualitative research investigating perceptions about the health maternity care services of some Syrian refugee women living in the Netherlands'

My name is Mohamed (Mahdi) Abdelwahab, a healthcare management specialist from Egypt.

During my attendance of the Master of International Health in the Royal Tropical Institute (KIT) in Amsterdam, I grew interest in the health issues related especially to migrants and refugees. Moreover, I felt a responsibility to reach out the people who have been forcefully displaced, particularly those coming from an Arabic background, because of the communicative advantage of knowing their mother tongue. Refugees from Arab origins form a big part of the recent refugees' influx in the Netherlands: in fact, of 31,642 total asylum applications presented in the Netherlands in 2016, 14,044 (44%) asylum seekers were from Syria, Morocco, Algeria and Iraq alone [1].

Pregnancy is a personal and emotional condition that involves the whole family, and surely, every culture has developed a set of concepts and traditions about it. These differences affect service provision: the Dutch maternal care services, for example, are different from most of the other countries, as they are mainly run by independent midwives [2]. However, in 2006, 75.3% of Syrian women who had given birth two years prior to the study, had received antenatal care from trained doctors, while only 8% from midwives [3]. Such differences are challenging for Arab refugee women, whose first introduction to the foreign Dutch healthcare system is often represented by the maternity care services.

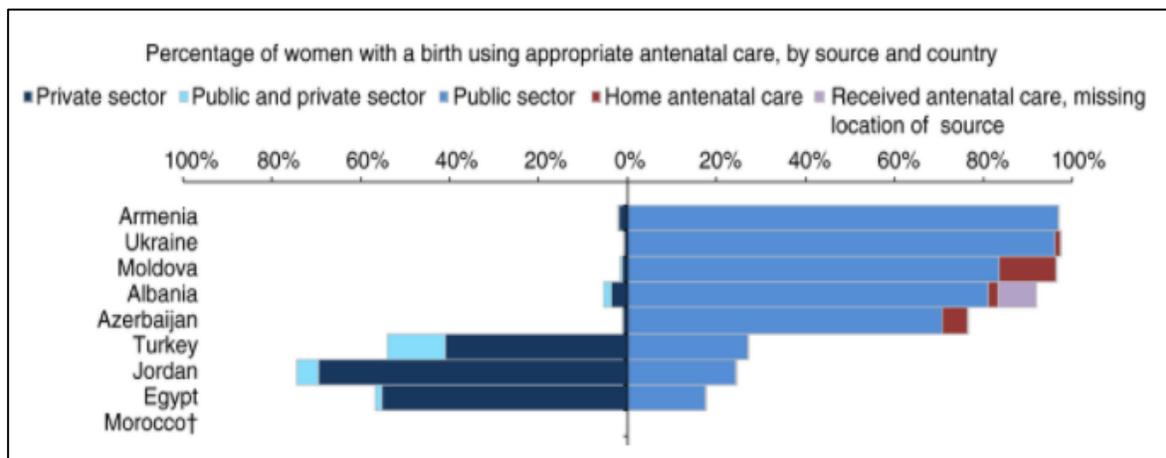


Figure 1 Percentage of women with a birth using appropriate antenatal care in Middle East and Europe, by source. . Campbell 2016 [6]

After my working experience within the field of Sexual and Reproductive Health in the Middle East and reading several reports and papers on the issues of refugees in the Netherlands, I noticed that the topic is hardly researched, and usually investigated with caution and tremendous sensitivity. This may be due to the different traditions, norms and cultural aspects that reflect on several ethical dilemmas and need for sure a proper and complex consideration. All these reasons led me to decide to work on a qualitative research about these issues, taking into consideration and highlighting such differences.

Therefore, in May 2017, I started my research internship at PHAROS. Under the supervision of professor Maria van den Muisenbergh, Dr Gudule (PHAROS), and Fernando Maldonado (The Royal Tropical Institute - KIT), I received the final approval from the Research Ethics Committee on my research proposal entitled: "Perceived accessibility and fitting of the maternity care and the maternal health promotion activities among the refugee women from Arabic origins in the Netherlands".

Firstly, it was a big challenge reaching participants for the study. We targeted pregnant or recently delivered (within one year prior to the study) Arab refugee women. In order to be able to contact them, we used different channels, such as the social media groups of newcomers and Arab communities in the Netherlands, where we shared invitation posters; snowballing through connections and social networks



Figure 2: Poster in Dutch and Arabic used in centers, mosque, and social media. Photo and design: M. Abdelwahab

proved effective in reaching our target group too.

With the help of my friend and class mate, Anouar Trabelsi, I completed the data collection by the end of June 2017. During those two months, we had the opportunity to discover the Netherlands through fourteen interviews, which occurred all around the Netherlands: Almere (AZC Zeewolde), Alphen aan den Rijn, Amsterdam, Arnhem, Groningen, Roosendal, and Utrecht. All interviews were recorded in Arabic, then transcribed and translated, and finally analyzed.

Key findings:

The interviews show that the respondents have a basic knowledge about the general outline of the maternal care services and ways to reach them. Nevertheless, because of the language barrier and communication issues, they often need more explanation and guidance regarding insurance, family planning, contraceptives, caring for a new-born, and common illnesses. Moreover, they depend on their



Figure 3: On our way to AZC Zeewolde, we walked for 30 minutes from the nearest bus stop. And on our way back... we had to hitchhike!

previous experiences and shared information from their friends, colleagues, and social media, using them as a reliable source; however, sometimes these media may provide untrue scenarios, false rumors or irrelevant information.

The respondents presented different views and ideas about diseases, illnesses and the relation with their body, such as the need for vitamins, warming the baby, caesarean section and common illnesses, which are all well-known aspects by the citizens in the Netherlands. All these issues interfere with the perception of needs and desires for care, and have a strong impact on the process of health care access.

To continue, the second link in the process is health care seeking. According to the respondents, they could recognize their condition and go to the required service accordingly, although gynecologists mentioned that Arab refugees would usually come to the service later, and ask fewer questions than Dutch people do. Overall, the services were good and provided proper treatments, and the women did not face any embarrassment with service providers.

The midwives' role and examination is totally new for some respondents: some of them had concerns in dealing with them, and preferred specialized medical doctors, because of the information and experience

they had. However, after dealing with midwives most of them regarded the service as excellent without having any problems.

These experiences are not usually objective: an example is the case of Syria, where pregnant women habitually refer to health services provided by the private sector, as one respondent said. In fact, as long as they have paid for it, they were able to do whatever they wanted: go to a specialist, get any medication or do more echoes. Therefore, this creates unrealistic expectations from the health system of a developed country like the Netherlands, which surely are not met, and lead the Syrian women to seek alternative ways around the system, consulting colleagues or taking prescribed medication from friends.

Some suggestions proposed by the women to improve the services were clear reflections of their habits and their health literacy, as replacing midwives with female medical doctors or adding more Ultra Sound examinations, which are respectively unrealistic and proved inefficient [2] and probably harmful [4].

“Here they depend on the primitive way [...] in Syria, the pregnant woman goes to a specialist doctor [...] to go only to midwife here was a new experience and somehow not admired idea,” said a 33 years old participant who had delivered few months before the interview.

Respondents’ culture and traditions were respected by the healthcare providers. The majority of the respondents preferred to be examined by female staff, and appreciated having female midwives. They also tended to deliver more at the hospital than at home, knowing that it would be safe and would cost less. These results are in line with a survey conducted in Syria before the war, where most of the respondents preferred to be delivered by specialized doctors in hospitals [5].

One of the most prominent cultural differences noticed was the Arab women’s perception and dealing with health services staff. They are used to a paternalistic style in patient-doctor relationship, and expected to receive direct information and advice. Conversely, the style of the mutual relationship with the Dutch health service providers left them waiting for answers to questions that they did not ask. Moreover, the respondents have mentioned in several contexts the differences between them, the Dutch women and society and this may also have contributed to the gap in service accessibility, expectations and perceived quality.

Overall, communication was hindered largely by the language and cultural barriers, causing misunderstandings and leaving both the women and health care providers confused and not sure how to proceed. Consequently, women who could not speak Dutch properly had compromised accessibility, limited engagement and restricted ability to share in decision-making, and especially reaching information in the first place. Therefore, we can consider the language barrier as the main issue impeding Arab pregnant refugee women from accessing services.

Moreover, some key informants highlighted this issue, reporting about the inability to interact directly with the woman, if she does not speak Dutch or English, and the need to communicate through the

husband or a friend. Sometimes, they felt that they could not reach the woman herself or that her companions were making the decisions for her, confirming an experience referred by a respondent, whose aunt decided for her not to have a Caesarean section, or the limited knowledge of women regarding insurance, transportation, expenses, which are usually issues kept in their husbands' domain.

Surely, the integration of refugees in Dutch society plays a relevant role too, according to the duration of stay, level of education and mastery of the English and Dutch languages. We recognize an evident relationship between these factors and the women's knowledge, experiences and interactions with the services, as well as the social networks formed and the availability of family, friends or neighbors to help. Certainly, this social support was most prominent in respondents at their second pregnancy in the Netherlands.

In conclusion, gender roles may also play a considerable role in the service accessibility, although none of the women complained about their husband's decisions nor mentioned being forced or prevented from reaching the services when needed, but referring to the support and care received. However, the majority of them are not yet fully integrated: they spend most of the time at home, especially when they are pregnant or have children. Consequently, this condition reduces their opportunities to develop social networks, and slows down their ability to improve their Dutch language. Overall, each of these aspects in turn reflects on the ability to engage and discuss with the service providers.

Recommendations:

One of suggestions stressed on by both sides of participants and key informants is restoring the coverage for the translation service and providing more information in Arabic, which proved to be very efficient in previous studies.

Another recommendation was to unite efforts and programs implemented in different cities or regions. To follow on that, I am glad to be sharing in the preparation of the Share-Net thematic meeting devoted to the Maternal Health of Refugees, which will take place at the end of this year.

Moreover, I am currently with a colleague to develop a proposal to raise awareness of Arab refugees and immigrants, who share the same language and cultural problems, and ensure their accessibility to trusted sources of information.

Conclusion:

Arab refugee women recognise the quality of the services and do not have major problem in physically reaching them. However, the lack of information, plus the language and cultural barriers hinder the full accessibility and that would need to be addressed to make sure they get the equitable service that they deserve.

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