

**Perceived Accessibility and Fitting of Maternity
Care and Maternal Health Promotion Activities
Among Refugee Women from Arabic Origins
In the Netherlands**

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“Perceived Accessibility and Fitting of the Maternity Care and the Maternal Health Promotion Activities among the Refugee Women from Arabic Origins in the Netherlands”

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

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Declaration:

Where other peoples’ work has been used (either from a printed source, internet or any other source), this has been carefully acknowledged and referenced in accordance with departmental requirements. The thesis “Perceived Accessibility and Fitting of the Maternity Care and the Maternal Health Promotion Activities among the Refugee Women from Arabic Origins in the Netherlands” is my own work.

Signature:



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List of Abbreviations and Dutch Words

AZC: Asylum Seekers Centre (Asielzoekerscentrum)

Buurtteam: Neighborhood team of social workers affiliated with the municipalities

CBS: the Dutch Central Bureau of Statistics

Centrum voor Jeugd en Gezin: Centre for Youth and Family

COA: Central organization of Asylum seekers (Centraal Orgaan opvang Asielzoekers)

Eigen Bijdrage: personal basic contribution in the health costs.

EU: the European Union

HCP: Health Care Provider

Huisarts: Dutch general practitioners practice (Family Doctors)

IND: The Dutch Immigration and Naturalisation Service

IOM: International Organisation of Migration

JGZ: Jeugdgezondheidszorg: The public health service for children aged 0-4 years old

Kinderbijslag: Child benefits

KIT: The Royal Tropical Institute (Koninklijk Instituut voor de Tropen)

Kraamzorg: home care for mother and baby in the first eight days after delivery.

Kraamverzorgster: Maternity assistant providing natal and postnatal home care services

SAMM: Severe Acute Maternal Morbidity

Syriërs Gezond: a Facebook page explaining the Dutch health care system in Arabic (an initiative of GGD Regio Utrecht and Pharos)

UNHCR: United Nations High Commissioner for Refugees

Verloskundige: Midwife

VluchtelingenWerk: Dutch Council for Refugees

Abstract

Background and problem statement

Arab refugee women fled their countries due to war and violence and came to the Netherlands seeking a new life. They had to go through the hardships of the journey, plus the routine procedures to get a legal status. Accessibility of these women to the Dutch maternity care services is affected by their perceptions and experiences of a system, which is different from the services in their home countries.

Study aim

This study aimed to explore the perceived accessibility and fitting of maternity care services among refugee women from Arabic origins, who have interacted with maternity care services within one year before the study, and are legally settled in the Netherlands. By analysing the women's experiences, the study intends to discuss differences, strengths, and drawbacks, and aims to provide recommendations to service providers and policy makers who deal with the services.

Methodology

In this exploratory qualitative research, we have interviewed refugee women, their partners, and key informant service providers.

We have also conducted a literature review to see which information already existed.

The Levesque Framework of Health Care Accessibility (1) was adopted for the analysis of the results.

Results and conclusions

Respondents had mostly good experiences reaching and accessing the maternity care. All women appraised the availability, accessibility and appropriateness of the services.

However, the language barrier appears to be the main obstacle that the Arab pregnant refugee women had to face. In addition, the research also found insufficient information provision about the services and health issues, cultural differences, and inadequate health seeking behaviour.

In order to prevent problems and to improve the services, we have identified several priorities for action as recommendations.

Key words

Refugees - Pregnancy - Maternal health - Accessibility – Arab

Word count: 13051

Introduction

Historically, the Netherlands have always been an attractive country for migration and nowadays it is facing a remarkable wave of refugees and other migrants coming from areas where human and socio-economic conditions are very critical.

During my attendance of the Master of International Health here in the Netherlands, I grew an interest in the health issues related especially to migrants and refugees. Moreover, I felt the responsibility to reach out to people who had been forcefully displaced, particularly those coming from an Arabic background. This latter reason because of the communicative advantage of knowing their mother tongue.

After reading several reports and papers on the issues of refugees in the Netherlands, I found topics related to reproductive health most appealing to me because of different traditions, norms and cultural aspects that reflect on several ethical dilemmas and need proper and complex consideration.

I decided to focus on a specific issue, which is pregnancy. Pregnancy is a personal and emotional situation that involves the whole family, and every culture has developed its own customs and traditions. In addition to this, healthcare and maternity care services are different from country to another.

In this work, I propose to take into consideration all the cultural, social and clinical aspects related to pregnancy, contextualizing them within the framework of the Dutch health care system. In fact, the Dutch maternity care services represent a unique case very different even from other Western countries. Independent midwives are present and available outside of the hospitals, and are part of the formal health care system. Statistics report more than one third of the deliveries done at home, assisted by these midwives.

Most refugees, especially those from Arab countries, who form a majority of the recent influx of refugees in the Netherlands, are absolutely not used to this kind of health care system, and may feel overwhelmed, particularly if they have just arrived and are still trying to integrate in the Dutch society.

This study aims to explore the perceptions and the experiences of Arab-speaking refugee women with reference to the maternity care services in the Netherlands, in order to analyse the accessibility and appropriateness of these services to this group.

The results registered will be shared with all the organizations involved, to contribute to develop further the services and their achievements in the future.

Finally, it will be possible to apply the results regarding the needs and the expectations of the refugees to other countries' health systems, where refugees from Arab origin are present.

1. Background

1.1 The Refugees' Problem

The world and Europe are witnessing unprecedented displacement rates since the World War II (2). By the end of 2016, 65.6 million people had been displaced from their own homes to escape war zones, danger, persecution and violence (3). According to the “Refugee Convention”, signed in 1951, and the consequent protocols and treaties, these people have the right to be protected (2).

1.2 Refugees in the Netherlands

The Netherlands is one of the most attractive host countries. According to the UNHCR (United Nations High Commissioner for Refugees), the Netherlands had received 101,744 refugees by the end of 2016 (3). Refugees from Arab origins form a big part of the recent refugees' influx in the Netherlands: in fact, on 31,642 total asylum applications in the Netherlands in 2016, 14,044 (44%) asylum seekers were from Syria, Morocco, Algeria and Iraq alone, that means almost half of the requests (4).

After the war in Syria in 2011, the Netherlands, along with many other countries, has witnessed an increased flow of Syrian refugees who are currently the biggest group in the Netherlands (5).

Between the beginning of 2014 and September 2016, around 41,000 Syrians had a legal residency status in the Netherlands. Most of them live in or around Amsterdam, Rotterdam, and Utrecht (5). By law, these refugees are obliged to take an integration exam and pass a certain level of language proficiency (6). To pay for the necessary lessons, they get a loan that they do not have to pay back if they succeed. In addition, they are expected to learn about Dutch culture and Dutch systems, including the health system (6).

1.3 Refugee Women in the Netherlands

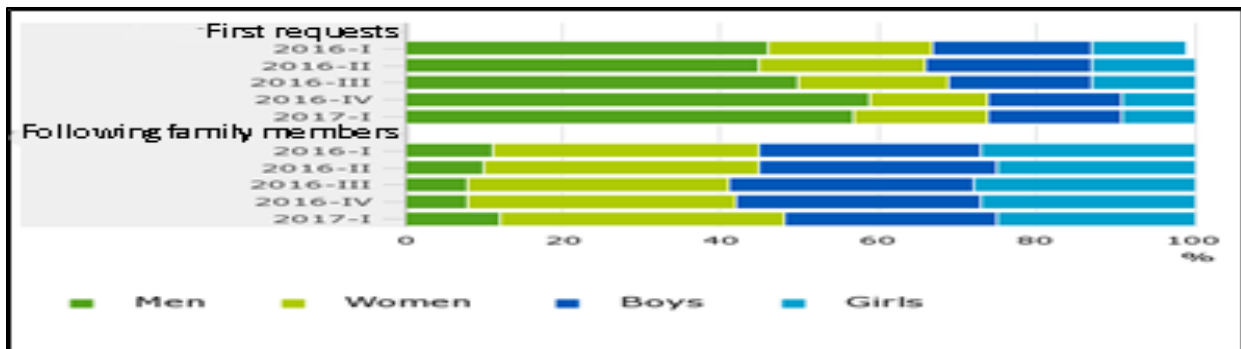


Figure 1 - Demographic composition of “First time asylum seekers” and “Following family members”. Source: IND, CBS 2017 (4).

According to the latest UNHCR reports on refugees' demographics, men compose the majority of the first arrivals (4). Women and children arrive in a second wave, usually under the modality of family reunion requests (4), as Figure 1 shows. In 2011, 30% of those who reached the Netherlands were women (7).

1.4 Maternity care in Arab Countries of Origin

Maternity care services are not regulated in the majority of the Arab countries where the refugees come from. There, people pay for the private sector, which is dominating the service provision because of the poor quality offered by the public, free, system (8). Figure 2 shows the percentage of antenatal care provided by the private sector in both Egypt and Jordan (8). For instance, in Syria in 2005, the private sector provided 80% of the antenatal care. (9)

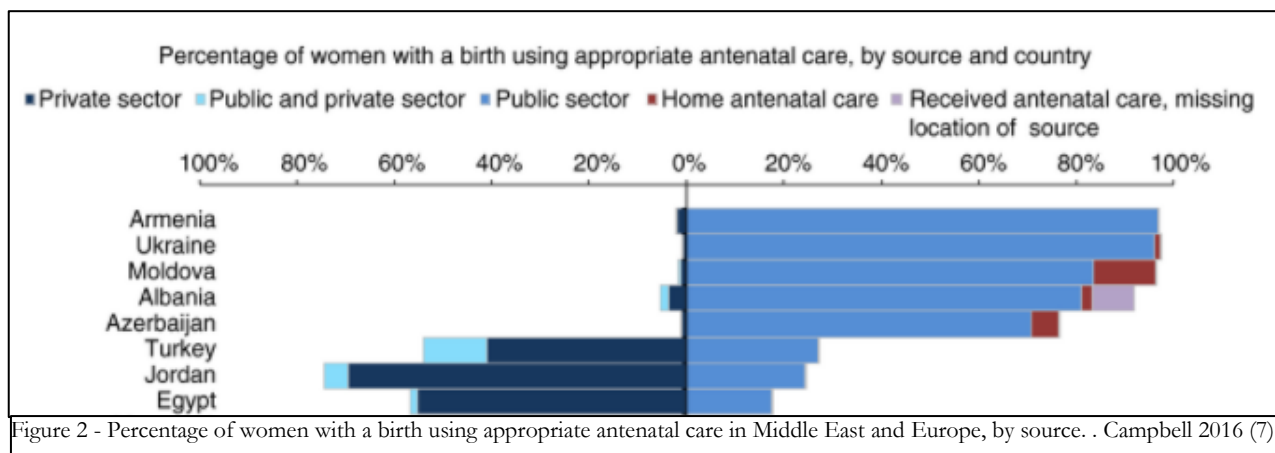


Figure 2 - Percentage of women with a birth using appropriate antenatal care in Middle East and Europe, by source. . Campbell 2016 (7)

Unsupervised private sector resulted in many facilities practices that do not fit with evidence-based protocols and some practices identified were even harmful (10).

A survey in 2006 showed that 75.3% of Syrian women who had given birth 2 years before the study, had received antenatal care from trained doctors, while only 8% got it by midwives (9).

In a study performed in 2005 (11), Syrian women also showed an apparent preference to give birth at hospital (65.8%). The same study showed that 85% of those women preferred to be seen by a female obstetrician too (11).

However, all of this information about Syria refers to the situation before 2011, and because of the civil war and the collapse, there are no current studies available about the present conditions. We can only expect them to have worsened a lot.

1.5 Maternity Care in the Netherlands

The Dutch maternal care services are different from most other countries, because they are mainly run by independent midwives (12). In case of low risk pregnancy, women are expected to be seen only

by first line (primary care) midwives and family doctors (for non-pregnancy related complaints). Secondary and tertiary care are involved only in case of complications (13). As long as the women stay in the normal pathway of the service, the insurance covers all the costs (13). The normal pathway includes monthly visits, a check every two weeks in the last phase of the pregnancy, and then every week (13).

Furthermore, there are no family planning clinics; in fact, family doctors prescribe contraceptives which are sold in pharmacies or provided in hospitals (14).

Such a unique system may be challenging for refugee women, whose first introduction to the foreign Dutch healthcare system is often the maternity care services.

The Netherlands has been a pioneer in integrating migrants in health policies. A special board for medical care of migrants was established in 1975 and the free translation service started in 1983 (15). However, in 2011, the government subsidized the translation services and it became a responsibility of individuals to learn the language. Health care providers and hospitals can still use the service on their own expenses but try to limit its use to reduce the costs (15).

2. Problem Statement

Because of war and violence, asylum seekers flee their own countries of origins and face the hardships of the journey (2). Refugee women, especially single mothers, face another challenge to adapt and interact with a foreign community (14). Often, during the long journey or in their countries of origin, these women may have been subjected to different forms of ethnic and religious persecution, violence, mutilation, slavery and deprivation (16). In their new countries, they face many challenges including the language barriers and lack of information about the national health systems (17,18). They have to deal with different legal, geographic, administrative, socio-cultural, and economic barriers (18), and gender issues (14). In fact, the process of legal settlement in the Netherlands is highly regulated and usually consists of several legal and logistic challenges and may cause emotional distress(14).

With reference to the health services, refugee women constitute a special group. If compared to the native populations in the developed countries, they show different health problems and conditions, including malnutrition, anaemia, infectious diseases, high parity, untreated complication of previous conditions, physical and emotional consequences of sexual violence, unintended pregnancies, induced abortions, and female circumcision (16), as well as malaria, HIV and sexually transmitted diseases (17). Moreover, a study in 2011 has shown that asylum seeking women in the Netherlands have four times more risk of Severe Acute Maternal Morbidity (SAMM), compared to native Dutch citizens (19). Other studies have also confirmed a higher risk of psychosis (20), and severe vitamin D deficiencies among immigrant pregnant women, even of the second generation (21,22).

Refugees have a higher birth rate compared to native residents of host countries. For example, in 2000 the COA (Centraal Orgaan opvang Asielzoekers) reported that in an AZC (Dutch refugee centre - Asielzoekerscentrum) the refugee women had a birth rate of 2.86% (14) compared to 1.72% in the general population (5).

Overall, these needs and background may affect the effectiveness and appropriateness of maternal services, as well as the services' accessibility and their utilization, and finally even their health outcomes (16).

2.1 Justification and Study Questions

The Dutch health care system and maternity care services are different from what refugee women from Arab countries are used to. Additionally, the large numbers of refugees imposes several challenges for the Dutch maternity care system and midwives who have to adapt and deal with the different health problems, cultures, and expectations, which lead to the need for more resources, training, information, and capacity building (14). Understanding the perceptions of refugee women about the services can help policy makers and service providers to offer better services, adapting them to the needs of refugee women.

When compared to the other major groups of immigration from Europe, Sub-Saharan Africa, Surinam and Indonesia, the Arab refugee women are unique in many aspects, such as background, culture and norms. Unfortunately, we could not identify any available literature in English regarding to the recent situation, demographics, specific health problems and perceptions of refugee women from Arab countries of origin in the Netherlands.

For this reason, the study intended to answer the following questions:

- a. What perceptions and experiences do pregnant refugee women from Arabic origins have in relation to maternity care services in the Netherlands?
- b. How do pregnant refugee women of Arabic origin experience the interaction with maternity care systems and its providers?
- c. What do refugee women know about pregnancy care? How do they receive such information and what additional knowledge would they would to receive?
- d. How to improve the accessibility of maternity care services and maternal health promotion for refugee women?

3. Objectives

This study aimed to explore the perceived accessibility and appropriateness of maternity care services among refugee women from Arabic origins, who have interacted with maternity care services within one year before the study, and are legally settled in the Netherlands. By analyzing their experiences, it intends also to discuss differences, strengths, drawbacks and to provide recommendations to the service providers and the policy makers who usually deal with the services.

Specific objectives

- a. Explore the perceptions and experiences of pregnant and recently pregnant refugee women of Arabic origin legally settled in the Netherlands regarding access to maternity care services in the Dutch healthcare system.
- b. Explore the available knowledge and sources of information on the maternity care services
- c. Propose suggestions to health providers aiming to improve access and appropriateness of maternity for pregnant women of Arabic origin legally settled in the Netherlands.

4. Methodology

4.1 Study Design

We adopted an exploratory qualitative study design and narrative analysis (23). We conducted also a literature review to examine the current situation of services. On Pubmed, we performed several searches, using different combinations of the keywords: Refugees, Migrants, Maternal Health, Dutch, Netherlands, Arab, Interventions, and Accessibility.

4.2 Theory and Framework

The study tried to answer the research questions about accessibility, defining the access as (fit) between need and supply (24). We adopted the Levesque’s framework of access (1); see Figure 3. It is a patient centred approach to describe access to health services as a process of six steps (the light blue arrow in the middle): health needs, perception of these needs, seeking health, reaching healthcare, service utilization, and health consequences. Accessibility to the process depends on five dimensions of health services’ characteristics (the top row) and their reflection into five personal abilities (the bottom row). They define the individual’s ability to interact with a service, as following (1):

Approachability: is the health services discoverability. It relates to factors like information, outreach activities and transparency. The **ability** of the people is **to perceive** the necessity of seeking health services and is mainly depending on individuals’ health literacy.

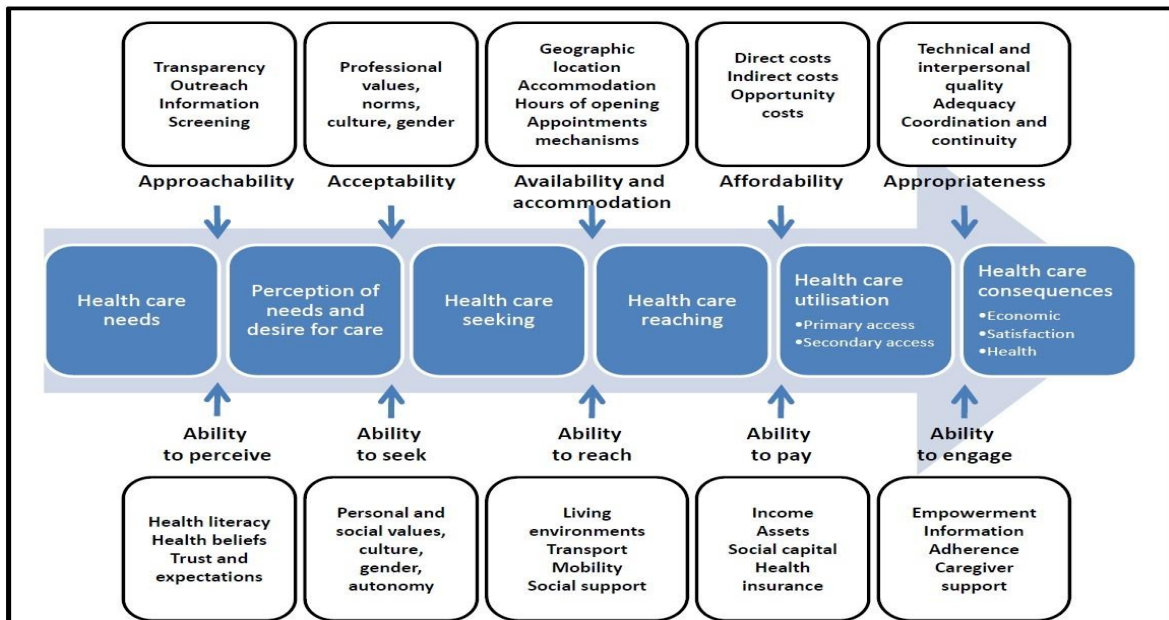


Figure 3 - Levesque’s proposed conceptual framework of access to health care. (1)

Acceptability: is the adaptability of the services to an individual's culture and social determinants ensuring appropriate and equitable service provision. It mirrors in the personal **ability to seek** health services, such as autonomy and knowledge about health care.

Availability: is the physical and timely reachability of the services and service providers, as well as the capacity to provide the services. The **ability to reach** healthcare is related to the individual's ability to move and mobilize.

Affordability: refers to the direct and indirect costs of getting the services including the payment methods and resources. The **ability to pay** is the personal capacity to cover the service costs without burden.

Appropriateness: is the fitting of the service with the patient needs. It covers adequacy, quality and effectiveness of the services. The **ability to engage**, instead, is about the personal communication and the individual ability to participate and share in informed decision-making.

4.3 Target Group

The target group of this study consisted of pregnant and recently pregnant refugee women from Arabic origins, older than 18 years, who have used maternity care services in the period between May 2016 and May 2017. We also involved partners of non-participating women from the same target group and key informants who had contacts with the target group within the last year, including community workers, gynaecologists, and doctors from the Jeugdgezondheidszorg (the public health service that accompanies the children after birth).

4.4 Sampling and Recruitment

The selection process aimed to select a wide diversity of level of education, mastery of the Dutch language, age, family, size, and location of residence in the Netherlands.

We applied four ways in order to reach the target group: firstly, through hanging posters (Annex 3) in Arabic and Dutch in the VluchtelingenWerk (Dutch Council for Refugees) offices in five cities, in market places and in the big mosque in Utrecht (Ulu Camii Moskee). Secondly, the study author and his supervisor identified some prospect respondents among formal and informal networks and social gathering places, such as mosques, markets, and cultural centres. Thirdly, we used extensively social media by posting on refugees', Arabs' and new comers' groups on Facebook. Finally, the respondents themselves referred their friends or colleagues (snowballing).

Recruitment continued until the achievement of saturation of data. The last two interviews (number eight and nine) actually did not add any new information. Consequently, the study team and the supervisor agreed that there was no need to find additional respondents.

4.5 Procedures

We conducted the semi-structured interviews based on the framework with the women and their husbands in Arabic through one male and one female native Arabic speaking researchers (see the interview guide in Annex 2). Only the interviews with the key informants were conducted by the male researcher alone (see also Annex 2 for the interview guide).

We expected that the women might feel more comfortable talking to a female researcher and therefore we offered them that option. Seven of female respondents actually choose that option. All respondents signed a consent form before the interview (see Annex 4).

With permission of the interviewees, the researchers recorded the interviews, and then transcribed them. Interviews conducted in Arabic were translated into English while being transcribed. Then, an independent volunteer native Arab medical student double-checked all the translations and transcriptions. We ensured anonymity by removing any personal identifiers of the interviewee.

4.6 Analysis

The data analysis has been completed using a thematic coding based on Levesque's conceptual model. We coded the data into 13 themes: accessibility into 10 areas, 5 dimensions and their 5 corresponding abilities. Then, we added an eleventh theme for other emerging relevant data, and two other themes about sources of information and possible suggestions for changes. Those topics crossing over were included under two or more themes.

The study author completed the coding process, then a fellow researcher double-checked three interviews and the thesis supervisor revised them. Reviews were generally consistent with the original coding.

4.7 Quality Assurance

To ensure better exploration of the topic, we aimed at a maximum diversity of respondents during the recruitment and the selection, along with the triangulation of the data. Moreover, the data collection continued until we did not receive any new data to ensure reaching data saturation.

We adopted a number of specific measures, such as providing a female interviewer, and using the native language of the respondents in addition to the regular measures such as piloting the study tools, regular updates with the supervisor, recording the interviews, and double revision of the transcripts and coding to make sure that the study procedures were going according to the study protocol and respecting the research ethics recommendations.

4.8 Ethical Clearance

The KIT Research Ethics Committee approved the research proposal on 16th of May 2017 (Annex 1).

5. Results

In total, we conducted 14 interviews (Tables 1 and 2).

Respondent Code	Pregnant (R), or New mother (NM)	Age	Origin	Dutch and English levels: Advanced (A), Intermediate (I), Beginner (B), Non (N)	Level of education	Location	Deliveries in the Netherlands / Number of kids
Z35	NM	35	Syria	(N) Dutch, (N) English	Primary school	Zeewolde (refugee camp)	1/3
A28	NM	28	Syria	(N) Dutch, (B) English	High school	Amsterdam	1/2
B30	NM	30	Syria	(I) Dutch, (I) English	University	Bunnik/ Utrecht	1/1
M28	P	28	Syria	(B) Dutch, (I) English	University	Maartensdijk	0/0
R23	P*	23	Syria	(I) Dutch, (I) English	High school	Roosendaal	1/2
A29	P	29	Syria	(B) Dutch, (I) English	University	Alphen n/d Rijn	1/1
U33	NM	33	Syria	(A) Dutch, (I) English	University	Utrecht	1/2
U23	P	23	Palestine	(B) English, (N) Dutch	Primary school	Utrecht (refugee camp)	0/2
G21	NM	21	Yemen	(N) Dutch, (I) English	Primary school	Groningen (phone)	2/2
U27	NM	27	Syria	(B) Dutch, (I) English	University	Utrecht (Phone)	2/2

Table 1: List of interviews with respondents

Respondent Code	Function	Location
VU	Volunteer at the refugees camp	Refugees camp, Utrecht
GA	Gynaecologist,	Rijnstate hospital, Arnhem
GE	Gynaecologist	Ziekenhuis Gelderse Vallei, Ede
DU	Doctor at JGZ	CJG Geuzenveste, Utrecht

Table 2: List of interviews with key informants

5.1 Approachability and the Ability to Perceive

5.1.1 Available Information about Maternal Care Services

Different types of information about maternal care services are available, but they are mostly in Dutch, which poses difficulties for respondents who do not yet know the language. This affects their ability to perceive health issues and know about the services.

Knowledge and entry points to the pregnancy services differed primarily among those who live in a refugee camp and those who have already moved to their permanent homes. Some women still waiting at the refugee camps reported that the camp's family doctor had referred them to the nearest midwife. Women living in municipalities said that they had to go to the family physician who gave them the information about nearby midwives or referred them to a specialist when needed.

The services available are different from region to region; our respondents were comparing themselves with their colleagues who live somewhere else. For example, one respondent explained the differences in support provided by the municipalities. Another respondent reported that all the refugees in Utrecht deliver at the hospital, even without a medical reason.

Three respondents complained about the few echo visits.

“There was no echo or anything, just questions and listening to the heart beats with the instrument. In my opinion such examination isn't enough and not accurate,” complained B30.

Only one respondent said that she had searched online and had found out that the “rays” were not good for the baby; therefore, she was happy about the limited number of echo examinations.

The women only seek information or ask whenever they perceived that something was wrong. Four women mentioned that they did not need information because they felt that everything was fine.

However, all the respondents mentioned that they lacked information about many aspects of the services in Arabic and English. It had been hard for six women to reach the services because of a lack of explanation and the need for guidance:

“Here they need explanation; it isn't too easy to reach. They need guidance all the time,” said U33 about Syrian women.

Several issues were not clear, or our respondents needed more information about them, such as the insurance system and its coverage. A recently delivered woman said that she did not have any idea about the insurance coverage; her friend had told her that the insurance covered everything, but she did not get any explanation from midwives or doctors. Another woman reported that she knew just one month before the delivery that she would have to pay in case of choosing to deliver at the hospital.

Another respondent said that she got her information about insurance from her husband, and she did not know exactly how much they had paid nor any details about the insurance coverage.

“The insurance in Holland is complicated and hard to understand,” concluded R23.

“But in general, I guess the insurance system isn’t clear for many of them,” reported VU about the refugee women.

DU also highlighted that refugee women from Arab origins usually have unanswered questions. She told us about a seven-month pregnant woman who did not know where she would give birth or what would happen after she gave birth. Another respondent said that he and his wife did not know where to go to get information about contraceptives. In addition, there were misunderstandings about the service providers and services themselves.

“Some people they don’t understand how the services in Holland are organized because it is very different from their own country. For example, the fact that I’m not a paediatrician but I am a doctor. How is that possible?” said DU.

Other informants also confirmed the lack of information, especially in the Arabic language. Sometimes even English materials were not easy to reach or women had to go through Dutch websites to reach them.

“We felt there is a big gap between what we would like to inform... like we do with Dutch patients and refugee patients,” mentioned GA.

Although, a JGZ-doctor highlighted that many refugee women cannot read. All our respondents could read at least Arabic.

Furthermore, we heard about other areas that the respondents identified as having gaps of information: the availability of the translation service, prescription of vitamins, and care for the new born, common illnesses of young children, municipal support for new families.

5.1.2 Sources of Information

Midwives, doctors and maternity assistants provided our respondents with oral information such as what to do, resting, physical activity, diet, vitamins, and contraceptives.

Moving between services or from one place to another was easy because of the stored patient information on computers.

All respondents had different information booklets in Dutch, which most of them could not read. One respondent was helped by her aunt to read it. There were some Arabic materials. Few respondents mentioned that the website of the booklet has information in Arabic. Respondents reported also discussing with the midwives. Moreover, other respondents used to search online for their questions.

They said that they reached Arabic information through Facebook groups, forums and the website of Syriers Gezond (an initiative to explain the Dutch health care system in Arabic). However, there are no posters or awareness materials in the camps about pregnancy or maternal health. A pregnant woman, who was not proficient in Dutch yet, told us that her midwife had invited her to attend meetings for expectant mothers, but they were held in Dutch.

“They gave me a booklet, I was supposed to read about pregnancy and what should I do [...] I didn’t read it,” said A28 about the Dutch booklet she received.

It is evident that the current written information in Dutch does not meet the needs of Arabic speaking women. In contrast, pregnant women depend on their previous experience or information, which they get from their family, friends, neighbours and social groups, including social media groups. However, such uncontrolled sources of information may cause confusion.

Finally, respondent A29 said that her Turkish neighbour, who had delivered at home before, had confirmed to her that it was the better and more comfortable way.

5.1.3 Experiences, Reputation and Expectations

Generally, respondents had appreciated the services and regarded them as excellent.

“Thanks God, the medical system is very good, I find everything is perfect,” said G21.

Nevertheless, the lack of information and dependence on information from friends or neighbours resulted in false reputation and negative impressions.

“Here, they started telling me that I had just arrived and maybe where I had been living before they cared more for you, while here no [...] what happened was completely the contrary,” said U27 regarding what she heard from her neighbours in Utrecht about the service providers.

However, when asked if she had had any fear before going to the service.

“No, it is known here that they care medically and they care for the human beings. They are patient and give you by default,” said U23.

5.1.4 Health Literacy and Habits

In their countries of origin, respondents used to go directly to the specialist, to do several echo examinations, to hospital deliveries, and to different standards for prescribing medication, antibiotics and supplements. The respondents perceived themselves as different from Dutch women.

“I see that the body [...] of Dutch women is different from ours, they are used to their strong bodies, so that they don’t give any vitamins, except vitamin D and C,” said B30 about the service providers.

The same respondent said, when her gynaecologist about the possible complications of her upcoming caesarean section informed her:

“I was stressed and I got worried; I started crying in front of the physician. She made me very afraid of the caesarean section,” said B30.

She had had a caesarean before in Syria, and the doctors there had told her that it was an easy operation and would require much time.

Arab refugee women also sometimes have different concepts about indications for health procedures.

“I wanted to deliver caesarean because of the pain,” said M28.

Key informant GA shared her experience with refugee Arab women saying that they usually do not have a healthy diet nor know their medical history or the procedures they had been subjected to. That made it more difficult to assess the risk for interventions.

“Their health questions are because they don’t really know what is normal [...] in general; I think not many refugees know what they can come for,” said GA.

5.2 Acceptability and the Ability to Seek

5.2.1 Perceptions about the Services

Despite the misunderstandings mentioned in point 5.1.1, respondents regarded the services as very good and appraised them.

“It was very good, more than you expect,” said U27.

Most of them stated that they did not face any unfavourable situation. According to some respondents, the services were even better than the ones in their countries. Respondent M28 mentioned, in particular, how the health care providers care for the mother and that the husband is allowed to attend the delivery with his wife.

*“Very nice, they always asked about me first [...] they cared for me even more than for the baby,”
Said M28.*

Most of the respondents reported waiting times were generally good and acceptable. Respondent R23 told us that he found the visits are numerous while the intervals were short. He even felt that sometimes there was no need.

5.2.2 Perceptions about the Service Providers

Healthcare staff were treating the respondents very well. Nine of the ten respondents preferred females to men service providers. Female staff usually provide the service. Male involvement was minimal and none of the respondents mentioned being embarrassed or uncomfortable. Respondents reported filling a form and choosing if they prefer a male or female doctor. One respondent had a male specialist for delivery, she told us:

“I told them that I preferred to stay only with females, but they said that it was better... the specialist [...] I felt shy for a while, and then felt comfortable as my husband was with me,” said B30.

Another respondent said she had told the hospital staff that she did not have a problem to be examined by a male doctor. She did not want them to suffer searching for a female doctor just for her.

A male respondent said:

“For me, there is no problem, for her, she is shy and prefers a midwife to a male doctor. [...] women feel more at ease to women, and we were comfortable,” said R23.

The sex of the translator also played a role.

“If there is a translator on the phone, who may be a male, women don’t want to talk to a male on phone about their menstruation, so that is kind of hard,” said GA.

Dealing with midwives was new for many respondents. One respondent said she did not trust the midwives and wanted to see a doctor. Another respondent said she lost trust in her midwife after she told her several expected dates for the delivery. Although she did not have a medical necessity, she was upset not to be able to go to a doctor.

On the other hand, many respondents were content with their midwives. One respondent affirmed:

“Doctor and midwife are the same things [...]. At the beginning, you may trust a doctor as having the experience. A midwife isn’t the same thing. However, in the end, I didn’t feel that,” said M28.

Regarding treatment by the health providers, one respondent said:

“They don’t have such firmness, like no is no, or yes is yes. They always discuss with you and explain the reasons and in the end, you are convinced,” said B30.

A HCP mentioned the importance of building trust with refugees saying:

“I have noticed that building a relation of trust is difficult and it helps when I tell them that I’m not someone from the COA. That I am a doctor and everything they tell me is safe, and I won’t tell anyone else,” said DU.

Negative experiences with service providers were individual and cannot be generalised. One respondent with a three months old baby, was sad about her experience with the camp doctor

“We wanted to form a family. We went to the doctor, and I told her that I couldn’t get pregnant. She didn’t help me,” said M28.

However, she returned another time when there was another doctor who finally helped her and provided her with the information and pieces of advice she needed.

5.2.3 Delivery Site

Although it is accepted to deliver at home in the Netherlands. All of the respondents preferred to deliver at a hospital rather than at home.

Only respondent A29respondentdelivered at home. She was happy about it. However, when asked about the location and costs of the delivery at hospital, she claimed eventually that if the hospital would have been close by and the delivery there would have been free, she would probably have preferred to deliver at the hospital. Another respondent mentioned that she knew that there is no complication nor danger for delivery at home, but she was still willing to pay to deliver at the hospital.

“Here it is very normal to have delivery at home [...] I didn’t like; we are used to go to the hospital,” said M28.

5.2.4 Cultural Differences

All women said that they felt that their culture and traditions were respected and they were happy about it.

“I went to the operation room with my full cloth and headscarf. There was no male doctor except the anaesthesiologist,” mentioned Z35.

Difference in the patient-doctor relationship between the Netherlands and Syria were reported. Respondents were most of the times waiting for information for questions they did not ask.

“Here they depend on what you like and want them to offer [...] in our Arabic society, we are used to the fact that the physician guides us. The patient doesn’t know what is better to do,” said B30.

“When I delivered, I felt there is much stuff they were supposed to tell me, but they considered it normal,” said M28.

Although, when she asked questions, they answered her and gave her all time needed. They told her also to look up the information online or they would send her the answers by email.

“I think with the midwives they don’t ask everything, because they feel they are supposed to be told,” said GA about Arab refugee women.

“Arab speaking women they don’t call us when they have a question [...] maybe it is modesty, but they don’t come out of their selves. May if there is really really acute problem,” said DU.

“I felt that she didn’t receive or understand that this is a shared decision making,” said GE.

5.2.5 Health Seeking Behaviour

All respondents could identify the standard pathway of pregnancy services and reach them. Most of them did the pregnancy test themselves and then went to the family doctor or midwife. Some of them did the visit on their own, while others went with their husbands.

The respondents understood the need to monitor the pregnancy and they were keen on even more examinations. No one reported missing monitoring visits. After delivery too, a HCP confirmed that attitude, and said:

“They are very accurate and they don’t miss appointments most of the times,” said DU.

They were careful to buy vitamins and supplements and do any optional examination or test if they could afford it. However, sometimes they reached the service later than Dutch women do, as a HCP told us explaining:

“When they are in the centre the doctor will refer them, but when they are on their own already, they don’t know how to access antenatal care,” said GA.

Moreover, most of the respondents mentioned that they were aware that they could ask when they had a problem. Furthermore, they searched online, repeated the visit or tried to reach another health care provider when they felt they did not get what they needed.

“Syrians are an active community; they ask and find their way,” said U33.

During her pregnancy, another woman used to call doctors back in Syria. She took iron supplements from a prescription of a friend of hers who had been pregnant before. A volunteer at the camp mentioned:

“When I ask ah why you don’t go to the doctor, many times they will just say we know this recipe of food it will make us better,” said VU.

5.3 Availability and the Ability to Reach

5.3.1 Location

Midwives and family doctors are usually in the same neighbourhood as the respondents. They were between five and fifteen minutes biking, or less than thirty minutes walking. In some places, the midwives were at the hospital. When located in the same town, hospitals ranged from five to thirty minutes by tram or bus.

Some women reported that they had done the echo at the same midwife centre. However, others said that the echo was not in the same centre. They had to move from one location to another, sometimes in the nearest city, on the same day, and more than one woman claimed that it has been tiring.

Some towns have a hospital, but there they do not have an obstetrics and gynaecology department, so that the more specialised procedures, like the test for Down syndrome and the delivery, were only available in other cities. The ambulance does not come for the normal pregnancy.

“They called the ambulance and the ambulance said that they wouldn’t come. I felt embarrassed and asked them to call a taxi for me,” said R23, about his neighbours help during his wife’s previous delivery.

Our key informant in Arnhem also described this situation.

“The hospital in Zevenaar is closed since a couple of years, so people who are from there, who need to be referred, they have to come here,” said GA.

5.3.2 Availability of Staff

Waiting times were appropriate. They go on their appointment, and they wait a maximum of five to ten minutes.

One respondent was not pleased with her discharge from hospital within three hours after her delivery. They had told her it was crowded.

Additionally, two woman perceived the service pathway as preventing them from reaching the specialist services they expected and were used to get in Syria.

A youth doctor said that they arranged more time for the appointments with refugees families. She said:

“Because I have noticed when I see them more often, they are willing to tell me what they want to ask,” said DU.

5.3.3 Mobility and Transportation

In general, it was easy for most women to reach the services. The family doctor or the doctor at the camp referred them and gave them the directions to the nearest midwives.

Respondents reported walking up to thirty minutes to the midwifery centres. A woman said that at the beginning, she was afraid to bike, then she starting biking, but during the last months, she felt that biking was tiring, and so she used to walk. Others used to take the bus or tram to the midwife and hospital. One respondent said she used her smartphone to reach the address.

However, for some people taking transportation was hard.

“We were new. I didn’t know the language. I didn’t know how to take transportation. It was difficult for me even taking the bus,” said R23.

That was regarding his wife first pregnancy. Things seemed to be better during the second pregnancy. He referred:

“Tomorrow she has a visit, and she will go on her own as I started working. We have a car, we don’t need the transportation, and my wife can take the bus on her own without me,” said R23.

One respondent pointed out that when she had to go to do the echo in a centre in the city centre, public transportation dropped her far off the point. It was sometimes tiring for her to walk that distance. Moreover, it was too expensive to take a taxi.

Most respondents did not have a car. More than one respondent reported having an obstacle to go to the hospital for the delivery.

“We don’t have a car. It would be difficult to move,” said A29.

It was difficult when the insurance did not cover transportation to the hospital. They had to arrange it on their own expense (which is also the case for Dutch people). Two respondents reported depending on neighbours who had a car to transport them.

“We didn’t have a car, and the hospital was far. Deliveries usually happen at night, how you can go there?” wondered U33.

Others got a ride from their neighbours, midwife or their language coach.

The volunteer at the camp confirmed the difficulties with transportation describing how it was difficult for a woman she knew to take a taxi to the hospital, because she could not speak English.

“If someone’s water is broke, taxi won’t take them all the time [...] some taxis won’t take babies without seat for security reasons and that is kind of hard,” said GA.

5.4 Affordability and the Ability to Pay

5.4.1 Insurance

Most respondents were still depending on the government unemployment benefits. They all had basic insurance coverage (which is obligatory in the Netherlands). The basic package covers midwife visits, 3-4 echo examinations, the delivery, and the *kraamzorg* (home care for mother and baby in the first eight days after delivery).

Insurance does not cover transportation, vitamins, medication and extra tests even when recommended by the midwife. Moreover, when the pregnancy is normal women and HCPs reported that the delivery at the hospital is not covered by insurance.

Insurance plans differed in their coverage of elective procedures, such as the test for Down syndrome and male circumcision.

*“The Down syndrome test [...] our insurance covered it, but some other insurance plans don’t,”
said the husband of A29.*

Only one respondent said she had to pay for the Kraamverzorgster service per hour, which was not a lot, as she described. This must have been her eigen bijdrage (personal contribution).

Some other services such as the Centrum voor Jeugd en Gezin (Centre for Youth and Family) are free. The municipality (local government) covers it.

5.4.2 Financial Aid

There were differences between the supports respondents received depending on their municipality. One said she did not get any support for the bed and baby cart while her colleagues did. She had a previous child and they expected her to have his stuff. However, he was born in Syria, and they did not have any of his stuff here.

*“It differs according to your municipality. In ours, we don’t get any help, neither loan nor grant,”
said B30.*

However, a youth doctor said about the services in the Centre for Youth and Family:

“For children everything is free, but if some people don’t have money to buy stuff [...] we bring them in contact with the Buurtteam (Neighbourhood) [...] sometimes, we bring them in touch with volunteer organisations,” said DU.

Furthermore, there is no support or special arrangements for transportation.

5.4.3 The Ability to Pay

None of the respondents had a paid job. They depended on their husbands providing. However, most of the times, they could pay for extra expenses not covered by the insurance like transportation, medication and blood tests. Some respondents said that such expenditures were hard to cover before their husbands got a job and they had to make debts.

“Of course not able to, as we are refugees, it was a significant sum, we hoped the insurance cover them, or they are less than that,” said M28 about delivery at the hospital, which wasn’t indicated by the midwife.

Financial abilities affected some respondents’ decisions. One woman said that the price of delivery at the hospital contributed to her decision to deliver at home.

“I went to test, I didn’t buy the test as we were in the camp and they didn’t give us more money, just they offered us food,” said A29.

“I have a young brother in Syria who has Down syndrome [...] they said we should do an echo that the insurance doesn’t cover [...] I couldn’t afford that,” said R23.

Sometimes to reach the echo centre or the hospital they had to take a taxi, which was usually expensive for them.

5.4.4 The Burden of Starting a New Family

All respondents reported receiving a *kinderbijslag* (child benefits – every three months for all children aged 0 to 18) after delivery, which they said covered most of the expenses of napkins, clothes and medication. Many women stated that it was beneficial for them.

More than one respondent mentioned that it was expensive for them to prepare for the baby. One respondent said they got help from individuals that covered almost half of the needs. Another stated that they took a loan from the city hall. It did not cover everything and they had to use their savings.

*“Here there are the grants they give after delivery, *kinderbijslag*, so the things stay balanced. But there is the issue of baby stuff [...] they were a burden. We even had to be in debt,” said the husband of A29.*

5.5 Appropriateness and the Ability to Engage

5.5.1 Quality of Services

All respondents reported that most of the times the service and the treatment have been outstanding.

“Their treatment and their care were excellent. They didn’t keep anything from us,” said Z35

More than one respondent stated that they felt at ease and comfortable, as if to be among their own family. Many respondents stated that they did not feel any difference between them and Dutch citizens.

“She was always delighted and happy with the way they treated her at the hospital. She said they were very good, and she had a very good midwife,” confirmed VU, regarding an Iraqi woman she knew.

Certainly, services are different from their own country. Here, they always monitor and care about the details, as one respondent said. Women were also in general happy with the post-natal home service.

More than one respondent mentioned the difference between services at the camp and outside. They agreed that it is better outside than in the camp. Even though while at the camp the translator service is provided by the COA, while outside they have to arrange on their own.

Other respondents perceived that the echo visits were too few. Another respondent considered that the core examination by midwives was not accurate and it should have been under control of the doctor, as well as the fact of the doctors not prescribing her any vitamins or medication.

“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 U33.

5.5.2 Continuity of the Services

Two respondent mentioned the fact that changing midwives every visit was not comfortable for them. However, the rest of respondents did not feel it as a problem, because all staff were excellent and helpful. One respondent said there was a small team, so sometimes she could see the same midwife again. Moreover, all midwives had all information stored on the computer system so they did not need to ask everything from the beginning.

From her experience, a youth doctor mentioned how they try to apply the continuity of the service in the Centre for Youth and Family. She said:

“We try to plan it that way, to be the same person. We work together [...] every other time, they see me or the nurse,” said DU.

5.5.3 Negative Experiences

All respondents, except one, said that they did not have any unfavourable situation.

“When I had the symptoms of delivery, I used to go for two weeks every four days to the midwife [...] I discovered that the water was gone one week before, I went to her, and she was saying normal,” said B30 about her bad experience.

She wanted to have a normal delivery in a bathtub. However, when the delivery happened, it was an emergency. They injected in her back without asking her and used the Vacuum to bring the baby out.

Furthermore, the same woman mentioned her pregnancy was misdiagnosed and it was discovered by chance while going to perform a curettage operation.

Other negative impressions about the service are mentioned in their respective sections of the findings and included: not receiving the information they needed, not reaching specialists, not getting medications, being discharged early after delivery and uncooperative camp doctor.

5.5.4 Communication and Decision-making

Only one respondent stated that she could communicate well in Dutch and could go to the midwife alone. Her English was good too.

“90% if not more, don’t have good understanding of English,” said VU.

Most of the women we interviewed were not yet good or confident with their Dutch and just few could speak English. They usually depended on their husbands who knew either Dutch or English. When the husband could not go with them, they had to take someone else, such as a friend or family member.

“I could communicate a little in Dutch, the questions were usually easy, and I used to prepare what I wanted to ask before going,” said B30.

“I speak English [...] for what I did not understand, they were ready to draw it for me on paper or bring me a book that was on that thing...” said U27.

“Sometimes, for example, when I couldn’t take my friend who translates for me, and my husband couldn’t come either, I found some difficulties,” said A28.

She also noted that sometimes she felt that her friend was keeping something from her. Another one pointed out that when she had problems with the *kraamverzorgster*, she had to wait for three days until her husband contacted the company.

Another respondent who took her aunt to help her to translate said that her aunt decided for her not to have a caesarean although she wanted to.

“They listened to my aunt and did what she told them. So, I think if I delivered caesarean it wouldn’t be good,” said M28.

Key informants have also reported the difficulties of communication they faced and the importance of communicating in a familiar language. They mentioned that communication in a different language takes more time and effort.

“Then it is really difficult to communicate directly to the woman, to ask her how she is doing and if she understands me. Because I talk directly to the man [...] we try to activate them to learn Dutch, but also to bring someone who can translate for them. The disadvantage of that is that they won’t tell me something intimate or something personal,” said DU.

“You see on their face how happy they are to hear some familiar words. I think this is a sign of how awful it must be, to go to a doctor and have check-ups for your baby and don’t really understand what is happening,” said GA.

The use of phone translation service was reported sometimes to be difficult because of the time it requires and the discomfort of talking to a male translator. Additionally, explaining a medical situation to non-medical personnel on the phone maybe laborious.

“I usually work at the delivery department I don’t use the talk to phone [...] during delivery, the one isn’t in the room. It is on the phone, so he can’t really see what is happening, and then it is a little bit more difficult to explain. It cause maybe problems or delay,” said GE.

A HCP also mentioned the efforts to improve that situation, by explaining her involvement in a regional work party aiming to adapt the services for refugee women and one of their priority aspects was communication materials in their own language. Some hospitals still offer the service of phone translation even after the funding was cut.

“For example communication with Arabic, because it is improved now, documenting stuff. One or 2 years ago there was nothing. Now there is more and they are working on it,” said VU about the efforts done by the refugee’s camp and the municipality.

5.5.5 The Language Barrier

Although language is an aspect of the communication, the language barrier affected the accessibility to health services in multiple levels.

In cases when both wife and husband were still beginners in Dutch, they said that was hard to translate, especially the medical terms. Some of them had been looking up translations online. When asked if she requested a translator, one respondent said that it was challenging to explain her suffering of female inflammations. At the end, her aunt who lives in the Netherlands helped and could translate.

The inability to speak and understand the Dutch language (or how to read at all) was an obstacle to understand letters. For example, a youth doctor said about Arab families’ attendance to the appointments:

“I think also a lot of times because they can’t read, so if they get the invitation but they can’t read it, that is a problem,” said DU.

Being weak in Dutch also prevented one of the respondents from joining the preparatory meetings for pregnant women.

“We understood 50% of the talk and the rest I didn’t understand,” said R23.

He also talked about their inability to call the hospital or call a taxi. They had to depend on their neighbours to do that.

“If I need something, sometimes the midwife won’t precisely understand what you need, or you didn’t get the full explanation,” said U33.

5.5.6 Cultural Barriers

Several respondents also identified the differences in the culture and doctor patient relationship. One told us about the type of questions asked by the family doctors:

“Now I know how their doctors talk with their patients, and that the way of interaction between doctor and patient isn’t as in our country”.

Another respondent said that she could not deal with the *kraamverzorgster*, as they both did not understand each other, due to language and culture matters. Such cultural differences can also affect the way they communicate and present their illness.

“Usually the complaints may be presented a little bit differently [...] so it takes me more time to discover why people are coming,” said GE.

When asked about the culture and traditions of Arab women, she also mentioned:

“I think there is a difference between having a delivery in Syria and what women are used to in the Netherlands, the way they endure pain and the way they handle pain,” said GE.

Arab women are also different from one country to another. One HCP mentioned the fact that Syrians are, in her opinion, more open than Moroccans are.

Getting used to the new system, culture and environment is one of the main issues facing Arab refugee women. One respondent, who is also a volunteer at an NGO where she answers health questions of Arabic speakers, stated:

“Most of the complaints are about not habituation or not receiving the same thing they were receiving in Syria,” said U33.

However, health staff also needs to get used to the intercultural differences, as a HCP said.

“Health care workers may not be used to work with refugee women; there are a lot of things they don’t really know. For example, intercultural communication is something that you really have to learn. And it isn’t something that we are trained in,” said DU.

5.5.7 Integration and Social Networks

Three respondent has explained how the second pregnancy was different from the first, because they became better with the language, and they had a deeper understanding of the system and a larger social network.

Six respondents reported not having anyone to help, neither family nor friends. One respondent said that she had to work at home alone and cook. She could not go out much or engage with other people as the midwife had advised her. She said that the presence of her aunt made her feel comfortable. Key informants also recognised such needs.

“What is normal in Arab culture is, usually, people get a lot of support from the family. Now, they came here and their extended family isn’t around, so people are feeling lonely especially for the pregnant woman,” said GA.

Another HCP confirmed this, mentioning that Arab women face social deprivation. Those women do not have friends and other contacts yet and when they do not have their families around, they usually feel alone.

Neighbours, especially Turks and Moroccans, were there to help and supported a number of respondents. In addition, contact persons and language coaches also used to help. The camp volunteer explained also, how the language affected women’s integration by limiting them to the camp and not going out, neither getting them involved with the government procedures nor the available community activities.

5.6 Suggestions by the Respondents and Key Informants

As mentioned before, the majority of the respondents were pleased with the maternal care services.

“There is nothing better than this,” said U27.

The importance of the availability of translation services was brought up on several occasions. Translators should be professional figures with a health background, along with strong linguistic and cultural knowledge.

Women were looking for more information and guidance. Key informants also highlighted the importance of providing access to an efficient and trusted source of information. One HCP suggested having a flexible time schedule.

All respondents suggested having more support or coverage over the basic insurance for refugees. A refugee woman proposed also to have a place where they can leave the kids while going to the visits, whereas another respondent suggested that in general Arab women have the need to change and adapt to the new system by themselves.

Respondents from villages or small towns, where there is no delivery department at the hospital nearby, suggested creating a new one, and making it free.

Other suggestions include:

- Seeing the same service providers every visit
- Getting more explanation and Arabic awareness materials
- Health staff to give information and to be trained on cultural intercommunication
- Getting more Vitamin D and iron supplements
- Midwives to visit the refugee camps and have information meetings with the women there
- More echo visits and to do the echo at the midwifery centre
- Having female medical doctors monitoring the pregnancy instead of midwives.

6. Discussion

Through an exploratory qualitative research conducted among refugee women from Arabic origin about the perceived accessibility and appropriateness of maternal care, we discussed the differences, strengths, drawbacks, and recommendations to service providers and policy makers dealing with these services. We will present the six steps of the process of access to health care, expressed by Levesque's framework (health care need, perception of needs and desire for care, health care seeking, health care reaching, health care utilisation and health care consequences), comparing them with the results from our research.

Maternal health services in the Netherlands are available and accessible, information is obtainable and easy to reach. However, often the refugees do not know either the Dutch or the English language and this complicates reaching the information. The availability is also affected by the refugees' attitude to not actively ask questions or seek help when needed.

The interviews have shown that the respondents have a basic knowledge about the general outline of the maternal care services and the 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 previous experiences and shared information from their friends, colleagues, and social media, using them as a reliable source; although, sometimes these media may give untrue images, wrong rumours or irrelevant information. In addition to this, the respondents presented different views and concepts about diseases, illnesses and their body, such as the need for vitamins, warming the baby, caesarean section and common illnesses supposed to be well known by all citizens in the Netherlands. All these aspects 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 recognise their condition, go to the service needed accordingly, although gynaecologists mentioned that Arab refugees 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 new for some respondents: some of them had concerns dealing with them, and preferred medical doctors, because of the information and experiences they had. Anyway, after dealing with midwives most of them regarded the service as excellent without having any problem.

The majority of the respondents preferred to be examined by female staff, and appreciated having female midwives. They also tended to deliver at the hospital than at home, although knowing that was safe and costed less. These results are in line with a survey conducted in Syria before the war (11).

Furthermore, respondents' culture and traditions were respected by HCPs. 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 advises. Conversely, the style of the mutual relationship with the Dutch health service providers left them waiting for answers at questions that they did not ask. Moreover, the respondents have mentioned in several contexts the differences (sometimes from inaccurate perception) between them, the Dutch women and society and this may also have contributed to the gap in service accessibility, expectations and perceived quality.

Then, the fourth step is reaching the health care service. Generally, the first line of the services were close to the places of residence. The refugee women had problems reaching the hospital, which sometimes was in another city, as well as moving between the midwife and the echo centres, mainly because they did not have a car. As they are neither familiar with the transportation system nor the Dutch or English languages, they had to depend on their colleagues or neighbours. However, they reported that the staff were available, easy to reach and the appointments' system was working properly.

Moreover, health care utilization depends on affordability and the ability of individuals to pay. In general, the services are free for the basic insurance scheme that all refugees had to have by law: this plan does not cover extra tests, dietary supplements, vitamins and the delivery at the hospital when not indicated. There are also several channels of financial aids by the government and through individuals to support families in need to prepare for a new baby. However, it still represents a burden especially for families who do not have a job yet and are living just on the government allowance.

Finally, the last step of the process is reaching health care consequences, which depends on the services' appropriateness and the individuals' ability to engage. As mentioned before, the refugees have generally appreciated the services for quality and excellence; only a few respondents had negative experiences, but comparing them to the ones of other respondents and key informants, we can consider them as solitary sporadic incidences, not a systemic phenomenon or integrated practice.

A small number of respondents (two) raised the continuity of the service as a problem, while others did not mind. However, key informants and background literature review also confirmed the importance of continuity of the service to build trust.

After all, 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 about how to proceed. Consequently, women who could not speak Dutch properly had a compromised accessibility, limited engagement and restricted ability to share in decision-making, and especially, in the first place, reaching information. Therefore, we can consider the language barrier as the main issue impeding Arab pregnant refugee women from accessing the 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.

However, 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 neighbours to help. Certainly, this social support was most prominent in the respondents at their second pregnancy in the Netherlands.

If compared to each other and to the inputs we got from key informant service providers, the perceptions of the refugee women and their inputs were consistent. However, these experiences are not usually objective: an example is the case of Syria, where pregnant women usually referred to the private sector health services, as a respondent said. In fact, as long as they paid it, they could 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 are not surely met, and lead the Syrian women seek alternative ways around the system, consult colleagues or take prescribed medication from friends.

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 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.

The suggestions proposed by the women to improve the services depended also on their habits and health literacy, for instance replacing midwives with female medical doctors or adding more echoes, which are respectively unrealistic and proved inefficient (12,25,26) and probably harmful (27). Proposals such as restoring the coverage for the translation service and providing more information in Arabic were also mentioned by the key informants and efficiently proved in different studies (14–16,25,28).

As mentioned by the key informants, there are several efforts on the ground to improve the services, including the communication materials and the “Migrants and Refugees Health Regional Work Party” in one region. Their recommendations are to large extent in line with the study findings and we strongly advice to share such experiences, extending them to other regions too.

As mentioned before, we adopted the Levesque's framework of service fitting, which allowed us to develop some comments about its structure and analysis. We conducted interviews in line with its model, except for the question about suggestions for improvements; we also inserted the question

about knowledge of information's services and sources within the approachability and ability to perceive dimension of the analytic framework.

Accessibility is not a simple equation, because dimensions and aspects are interconnected, and several issues actually appear to cross over, such as the economic indigence, that may affect the ability to pay for some services, the ability to reach transportation, as well as the ability to engage.

In spite of other abilities that reflect well the dimensions of accessibility, the abilities to seek and engage appear more interconnected and may replace each other in reflecting respectively acceptability and appropriateness. Therefore, engagement with services depends on the cultural and social factors described under acceptability. Furthermore, the ability to seek depends on the personal autonomy, knowledge about the services and their equitability that fits also with the appropriateness.

Strengths and Limitations

The study is exploratory and has a qualitative nature. To maximise representativeness, we strived for a wide variety of respondents and triangulation of the data by interviewing key informants from different services. Nevertheless, the results cannot be generalised.

The research concerns the subjective perspective and perceptions of refugee women about maternal services. Because of the huge amount of information and language barriers, they talked mainly about their personal understanding of the situation, by processing information according to their previous experiences, expectations, and health literacy. For example, the respondents mixed doctors, midwives and nurses, considered ultrasound as x-rays and viewed not getting antibiotics prescriptions as an inappropriate service.

We did not reach the original provisional target group of 15 interviews, because the recruitment and data collection's processes took longer than planned. It proved difficult to reach women settled outside the camps. No official way of contacting them was successful, e.g. through the organisation of midwives of the refugees council, nor was the incentive of a free photo session for the family. In the end, only social media and snowballing proved successful approaches to reach our target group.

Most recruited respondents were Syrian women, and this may represent a limitation of the study, although we also reached one Palestinian and one Yemeni woman. However, the majority of Syrians can be justified because of the current wave of Syrian refugees and the fast legal procedures for settlement.

Unfortunately, we could not conduct any interview with a midwife, although we contacted several professional and personal practises in four cities. Certainly, this may represent another limitation of the study, because of the decisive and crucial role of midwives in the Dutch system, being the first to deal with pregnant women.

The study took into consideration the possible sensitivity of some women to talk to a male interviewer, planning, consequently, to have a female interviewer available; hence, we prevented discomfort and along with interviewing the respondents in their native language, we facilitated gaining their confidence, trust and openness.

We conducted all the interviews with the women in Arabic and then we translated them into English, adopting a literal translation approach, in order to keep the authenticity and the meaning of the original emotional style of the women's words.

Only two respondents, who were particularly happy and pleased about everything, did not have any comments or suggestions; however, if compared to others' perceptions and to the inputs of service providers, their opinions may be influenced by the halo effect of a pleasant experience or their perception of a connection between the study team, the municipality and the government. During the interviews, we always tried to probe further and highlight the study independence.

Only one woman requested the presence of her husband during the interview, who shared his input on some questions, but tried to make sure that she answered freely. In another case, we prevented a double interview by interviewing the husband first and the woman later. These mixed contributions were interesting because it allowed us to notice the different perspectives in describing the service accessibility between women and men. While women usually talked about quality and appropriateness, men instead focused more on reaching the services and their affordability.

7. Conclusions

7.1 Perceptions and Experiences of Pregnant Refugee Women from Arabic Origins in Relation to Access and Interaction with the Maternity Care Services in the Netherlands

Respondents had mostly good experiences reaching and accessing maternity care, appraising the availability, accessibility and appropriateness of the services and reporting only few problems concerning insufficient information about services and health issues, cultural differences, health seeking behavior, and the language barrier.

Overall, according to the Levesque's framework, we can summarize the respondents' accessibility and interaction with the maternity care services as following:

- **Approachability:**

Despite of the information gap, services generally facilitated women referral and accessibility, as most of the women followed the pathways of the service by depending mainly on their colleagues, family and their own previous experience.

- **Ability to perceive:**

Refugee women from Arab origins came to the Netherlands with their own health understanding, habits and expectations. That affected their health literacy. The Dutch maternity services appear very different from the ones in their countries, as regards to the care of midwives during the pregnancy, which was new for many women and considered as a primitive way. Moreover, the refugee women showed particular beliefs about pregnancy and needed care, which sometimes are unrealistic and not scientifically proved, and may affect their interaction and perception of the services.

- **Acceptability:**

Respondents were pleased with the services as they felt respected and appreciated the examination conducted, usually, by only women. In some cases, we noticed a problem of loss of trust with the midwives, due to misunderstanding or previous wrong diagnosis' experiences. Most of the respondents did not agree to give birth at home, even when they had to pay for delivering at hospital.

- **Ability to Seek:**

The refugee women interviewed showed autonomy and ability to reach out for the services without control of the partner, knowing about the normal pathway and the first line services. In general, they appeared keen on pregnancy monitoring and attending the visits, although sometimes arriving late as

mentioned by a key informant, showing interest in advices and acquiring information about pregnancy and care for the newborn.

- **Availability:**

The midwives centers and the family doctors, who are front line services for maternity care, are always close to the residence places of all women, usually in the same neighborhood, with a maximum of 15 minutes biking. Secondary and tertiary maternity care are in some locations not available in the same village or town. Nevertheless, all appointments appeared well organized, assuring minimal waiting times.

- **Ability to Reach:**

Transportation system is problematic for new comers, because they do not own a car, and preferred walking or biking to the not so far midwives centers. When they had to go to the hospital, they took a taxi, which is expensive and difficult to call because of the language barrier. However, the respondents who have been in the Netherlands longer, with a stronger social network, showed better understanding of transportation and ability to reach the services.

- **Affordability:**

The Dutch regulation requires for everyone to have the basic package of insurance, which covers all maternity services, the midwives and delivery; the women had to pay separately for extra services such as supplements, tests and delivery at the hospital, if not indicated by midwives. Other systems for financial aids by the government, city halls, NGOs and individuals are also available.

- **Ability to Pay:**

Generally, pregnant refugee women from Arabic origins do not have a job during the first 2-3 years of their settlement in the Netherlands, and they depend economically and financially on the husbands or on the government allowance. While some families could afford to upgrade their insurance plan, pay for extra medication and the expensive delivery at hospital, others instead had difficulties in paying for transportation and tests and preparing for the delivery and having a new family member was a burden for them.

- **Appropriateness:**

Our target group perceived the Dutch maternity care services as high quality services, appreciating the system and the service providers. No one felt discrimination in being not Dutch. The only problem reported concerns the continuity of the services, because some women felt uncomfortable with changing the midwife or doctor every visit.

▪ Ability to Engage:

The language barrier is the biggest challenge that the pregnant refugees face in the Netherlands. The cultural differences and their lack of Dutch and English mastery limited their communication with the service providers, and they had to depend on their husbands, family or friends. Even in presence of a translator, both women and doctors felt a deficiency of communication that did not make the women engaged in making well-informed decisions regarding their cases. However, integrated respondents resident in the Netherlands since longer period and maybe at the second pregnancy, showed better engagement and familiarity with the services.

7.2 Knowledge about Pregnancy Care: Sources of Information and Knowledge Needs

Pregnant refugee women from Arab countries were familiar with the normal pathway of maternity services, knowing how to reach the midwives, different care and support services.

We recognized misconceptions among the respondents regarding services and care, such as the notions that the care itself was not enough, or that they were mistreated. There were some cases of misunderstanding of services or mixing between the jobs titles of service providers. Moreover, many women showed unrealistic expectations, like the need for more echo or prescribed medication.

Sources of Information:

- Healthcare staff: the camp doctor, the family doctor (general practitioner), midwives and *kraamverzorgster* (post-natal assistant)
- Medical friends or doctor in Syria
- Arabic and Turkish friends, colleagues, neighbours and acquaintances
- Dutch colleagues, contact person and language coach
- Awareness booklets mostly in Dutch
- Email from the service providers, such as the midwife and the youth doctor
- Internet and Arabic websites
- Social media and Facebook groups (Syriars Gezond, أخوات في هولندا and other expats groups)
- Group meetings with other pregnant women held in Dutch

We spotted a need for credible sources of information in a familiar language, as the majority of the newly arrived women did not have a mastery of Dutch nor in English.

Gaps of Knowledge:

- The Dutch healthcare system and functions of each service
- Information about insurance system; its plans and different coverage

- Family planning and different contraceptive options
- How to care for the newborn and how to deal with common illnesses
- Health education about vitamins, supplements and Antibiotics
- Available financial aids for families

7.3 Recommendations

After studying the literature regarding the Dutch health services at the time of the 2001 immigration wave (14,25), the IOM recent report on health integration policy in the Netherlands (15) and the studies from the EU (28) and Australia (16), we could have a wider perspective of the evidence-based available intervention policies and practises to improve health services for refugees.

Therefore, based on the inputs we received from our respondents and key informants, we defined some areas of action oriented to policy makers, services providers and further research development, to ameliorate accessibility of refugee women to maternity care services and maternal health promotion, and ensure a better effectiveness.

7.3.1 Recommendations Oriented to Policy Makers:

a) Maternal Health Promotional Activities

Health literacy and knowledge about health services is one of the biggest problems of Arab pregnant refugee women in the Netherlands, and it should be part of the integration efforts for newcomers. There is a considerable need for credible official sources of information to certify adequate knowledge about services and maternal health in general, and coincidentally to prevent the spread of rumours or bad reputation. Urgent topics to focus on are:

- Insurance system
- Maternity care pathway and its evidence based approach
- Maternal health
- Midwives training and skills
- Health attitudes and differences between the Dutch system and their home countries

These topics can be delivered through different interactive activities that ensure women's engagement, such as:

- Maternal health sessions for pregnant Arab refugees in the asylum seekers centres and other social gatherings, ensuring the engagement of a competent women's group who can be trained as peer educators in order to reach their fellows

- Production of promotional materials, booklets and posters in Arabic
- Provision of online platform with information and ability to answer questions
- Group meetings for pregnant and recently pregnant Arab women (especially newcomers) to share experiences

b) Restore the Fund and Improve the Translation Services

Translation services are essential. Both respondents and key informants appraised the service of translation by phone and suggested that the insurance or government should cover it for hospitals and midwives.

The translator is expected to be more than just a person with bilingual competences, but as a mediator who is neutral, familiar with the culture and not affecting the women's engagement and decision-making. Moreover, to make sure that the translation service is effective and appropriate to our target group, it should be less time consuming, preferably done by a female translator with a medical background, supported also by peer educators from the suggested outreach program, which may also accompany the women who are alone.

7.3.2 Recommendations Oriented to Service Providers:

a) Cultural training for Health Care Providers

Cultural communication is a skill that all healthcare staff need to learn, because despite of being tolerant and accepting the women, healthcare providers may face difficulties in communication due to cultural differences, attitudes and diverse backgrounds. Similar trainings are beneficial to improve the way they articulate with their patients, take history, answer questions and give information.

b) Continuity of the Service

Continuity of the service can provide a chance to build trust and enhance the engagement of refugee women. Midwifery centres can easily arrange appointments, ensuring that one or two midwives are responsible for the case along the whole period of pregnancy.

c) Availability of the Services

Having the ultra sound examination in the same midwifery centre would save a lot of effort and time. Also if possible to reduce the need to travel to another city to reach the hospital. While adding specialised medical centres in small villages is inefficient, providing a proper and cheap means of transportation can help reduce the suffering and increase accessibility of refugee Arab women.

d) Individualised Services

People are different, especially regarding their social and cultural circumstances, so it is important, for each case, to foster a trained team of social workers, who can identify problems and help the refugee

women, which can collaborate with the health staff, providing to the pregnant woman a complete treatment and support.

Moreover, we should introduce flexibility of the time schedule, by empowering service providers to control their schedule and to allocate more time or even more appointments when needed. Such flexibility can facilitate refugee women's openness and better communication, as shown by the experience of the youth doctor from the Centre for Youth and Family that can represent a model to adopt in other centres too.

e) Cooperation between Services and Regions

There are several initiatives happening in parallel channels not yet converging in different regions that recognised the specific needs of pregnant refugee women. Cooperation and communication between such initiatives would foster the ability of the system to adapt more efficiently and help each partner to benefit from the already available expertise and experience in the field, in forms of experience sharing meetings, seminars and joint task forces.

7.3.3 Further Research Development

Further research, especially in English, is required regarding the demographics and social determinants of Arab refugee women and the extent of their health problems. Certainly, it would be more effective to adopt as study tools the native languages of target groups and the collaboration of the organisations who work with the refugees in integrating and facilitating the research.

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Annexes

Annex 1 – Ethical Approval



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Our reference KIT Health Amsterdam, 16 May 2017

Subject Decision Research Ethics Committee on Proposal SB2

Dear Mahdi,

The Research Ethics Committee of the Royal Tropical Institute (REC) has reviewed the proposal entitled "Perceived accessibility and appropriateness of the maternity care and the maternal health promotion activities among the refugee women from Arabic origins"

The decision of the Committee is as follows:
the REC has seen the additions, and approves the proposal.
However, the REC also would like to suggest that the icebreaker would be removed, or replaced by a question like; like the ideal family size (number of children) of the participants. The current questions are not really ice-breakers and may potentially be too leading and as such influence the FGD responses.

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

Kind regards,

P. Baatsen,
Chair Research Ethics Committee, KIT

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Annex 2 - Study Guides

Semi-structured interview with the target group and the partners topics and probes:

Adopted from the DfiD manual of qualitative research methodologies (29). All questions were translated in easy language Arabic.

كم عمرك؟

ما هي أعمار أطفالك؟

ما هو رأيك في الخدمات الطبية بشكل عام في هولندا؟

في رأيك ما هي احتياجاتك الأساسية من خدمات الحمل والولادة؟

هل عانيت أي مشاكل أو مضاعفات أثناء الحمل؟ يرجى ذكر امثلة

ما هي معلوماتك عن خدمات الحمل والولادة في هولندا؟

ماذا تعرفين عن خدمات الحمل والولادة في هولندا؟ كيف وصلتك هذه المعلومات؟ ما مدى سهولة الوصول لتلك المعلومات؟ ماذا تقترحين بخصوص تحسين ذلك؟

ما هي خبراتك مع الخدمات ومقدميها؟

ماهي الخدمات التي احتجتها والتي حصلت عليها؟ ما هي خبراتك في التعامل معها؟ ماذا كانت توقعاتك للخدمات؟ وهل لاققت توقعاتك؟ ما هو رأيك فيها؟ ماذا أعجبك؟ ماذا لم يعجبك؟

ما رأيك في ملائمة الخدمات لحقك في الحصول عليه وسهولة الحصول عليها؟

كيف تصلين الى هذه الخدمات؟ وما هو رأيك في مناسبتها لك وجودتها؟ ما رأيك في توفرها ومكانها؟ كيف تشعرين بترحاب واستقبال مقدمين الخدمة والمكان لك لأسرتك؟ ما هي المصروفات المطلوبة لتلقي الخدمات؟ وما رأيك في ملائمته لحاجتك وثقافتك ومعتقداتك؟ ماذا يجعل هذه الخدمات أصعب أو أسهل في الوصول؟

ما رأيك في قدرتك الشخصية على الحصول على الخدمات؟

متى تعرفين أنك بحاجة للوصول لخدمات الحمل والولادة؟ ماذا تفعلين حينها؟ هل تجددين صعوبات لأسباب شخصية في الوصول للخدمات، يرجى ذكر الاسباب ان وجدت؟ في رأيك ماذا يسهل لك الوصول للخدمات؟ في رأيك ما هي العوامل المادية التي تؤثر على الحصول على الخدمات؟ ماذا جعل تعاملك مع الخدمات ومقدميها أسهل أو أصعب؟

في رأيك ما هو أكبر عائق أو مشكلة لك للحصول على الخدمات التي تحتاجينها اثنا الحمل؟ ماذا تقترحين لضمان توفير خدمات أفضل في المستقبل؟

1) General information: a conversational opening of the interview

Probes: How old are you? How many kids? Was it your first experience with pregnancy? What do you think about the healthcare system in Netherlands in general?

2) Health care needs around pregnancy, delivery and post-delivery

Probes: What were your needs during pregnancy, delivery and post-delivery? Describe if you had any specific health problem during pregnancy? What type of care did you need? What were your expectations of the service?

3) Available information about the service and their sources

Probes: What do you know about services of pregnancy care in Netherlands? How did you know that? How easy to find this information? What would you like to change regarding that?

4) Perceptions and experiences of the service

Probes: What were your experiences with pregnancy services? What do you think about the services provided to you or your partner? Did it meet your expectations? What did you like most? What didn't you like?

5) Perceived easiness to access the pregnancy care regarding:

Probes: How do you reach them? How do you receive them? What do you think about their availability? How welcoming are they? What are the payments needed? What do you think about their adaptation to your culture and needs? What are the good and bad aspects of it?

6) Perceived personal ability to access the services

Probes: When do you recognise that you need to go to the service? What do you do then? Are you able to reach them? What makes it easy or hard for you personally to reach the services? What financial burden it may put on you? What made your interaction and dealing with the service easier or harder?

7) Possible solutions proposed by the target group

Probes: In your opinion, what is the most important barrier to you to receive the service? What would you suggest to provide you better service in the future?

Sometimes, questions were asked in the third person when needed.

Semi-structured interview with Key informants guide:

Adopted from the DfiD manual of qualitative research methodologies (29).

1) General information; a conversational opening of the interview

Probes: What is your position? How do you interact with pregnant refugee women? What do you think about them?

2) Available information about the need and available services

Probes: What are the health care needs of pregnant refugees? From your experience, what are the pregnancy problems facing refugee Arab women? What do you know about services of pregnancy care in Netherlands? How does this information reach the refugees? What may affect that?

3) Perceptions and experiences of the service

Probes: What do you think about the services provided to pregnant refugee women? What were your experiences with them? What do you think about the quality of these services?

4) Perceived easiness to access the pregnancy care regarding:

Probes: How do refugees reach the services? How do they receive them? What do you think about availability of the services? How welcoming are they? What are they payments needed? What do you think about their adaptation to Arab refugees' culture and needs?

5) Perceived personal ability to access the services

Probes: what do Arab refugees personally think about the services? Do you think they accept it? What do you think about their health seeking behaviour? Are they able to reach them? What makes it easy or hard for them personally to reach the services? What financial burden it may add on them? What do you think makes Arab refugee interaction and dealing with the service easier or harder?

6) Possible solutions proposed

Probes: In your opinion, what is the most important barrier for Arab refugee women to receive the service? What would you suggest to provide them better service in the future?

Annex 3 - Invitation Poster



Beste (bijna) moeders,
Wilt u ons helpen met ons onderzoek? We horen graag uw ervaringen met zorg rond zwangerschap en geboorte in Nederland.
We zoeken vluchtelingen van Arabische afkomst die zwanger zijn of bevallen zijn in het afgelopen jaar.
We willen u graag spreken (face-to-face of via skype) maar u kunt ook onze online vragenlijst invullen (<http://bit.ly/maternitystudy>).
Voor contact en vragen:
Mohamad Abdelwahab, m.elmahdi@pharos.nl,
0616215209
Dank u,
Mohamad Abdelwahab
Master student (Koninklijk Instituut voor de Tropen, Amsterdam)

أعزائي الأمهات وأمهات المستقبل،
تقوم بعمل دراسة عن خدمات الحمل والولادة المقدمة للاجئات العرب في هولندا. يمكنك مساعدتنا اذا كنت حامل حاليا أو قد وضعتي مولودك خلال السنة الماضية عن طريق الإجابة على بعض الأسئلة في مقابلة شخصية أو اتصال أو عن طريق ملء استمارة الدراسة <http://bit.ly/maternitystudy>
الأسئلة عن رايك وخبرتك في التعامل مع هذه الخدمات. الدراسة باللغة العربية وتقوم زميلة بجراء المقابلات الشخصية والمشاركة أو الاستفسار برجاء التوصل على:
m.elmahdi@pharos.nl
0616215209
شكرا،
محمد عبد الوهاب
طالب ماجستير الصحة الدولية (المعهد الاستوائي الملكي-أمستردام)

Photo@Abdelwahab M. 

Annex 4 – Consent Forms – Arabic and English

إقرار المشاركة في المقابلة الشخصية

اسم الدراسة:

خدمات رعاية الأمومة وأنشطة تعزيز صحة الأم في هولندا من وجهة نظر اللجان الحوامل من أصول عربية.

طالب ماجستير صحة دولية في المعهد الملكي للأمراض الاستوائية في أمستردام وتحت إشراف د [...]]

هدف الدراسة:

تهدف الدراسة أود معرفة رأيك في خدمات الحمل المتاحة للجان العرب الحوامل المقيمين في هولندا. ودراسة إذا كانت مناسبة لاحتياجاتهم، وهل توجد عوائق يوجهونها، والاقتراحات لتطوير الخدمة في المستقبل.

نتائج هذه الدراسة سيتم مشاركتها مع منظمة القابلات –الدايات- والمنظمات الأخرى المعنية بهذه الخدمات. لإتاحة المعلومات التي قد تساعد في تحسين الخدمات المقدمة لك وللجان العرب.

هذه الدراسة جزء من مشروع تخرج محمد المهدي، طالب ماجستير الصحة الدولية بالمعهد الملكي الاستوائي في أمستردام KIT. بالتعاون مع منظمة فاروس PHAROS بأوترخت. وتحت إشراف الدكتورة [...]]

عدم الراحة والمخاطر والفوائد:

ستتاح النتائج لمنظمة قابلات الولادة (الدايات) ومنظمات الرعاية الأخرى في هولندا.

- أنت لست مجبرا أو ملزما بالمشاركة ضد إرادتك. إذا كنت ترغب في المشاركة، مدة المقابلة من 30 الى 60 دقيقة.
- أنت حر في رفض الرد على أي سؤال. لديك الحق في وقف الإجراء في أي وقت. في أي لحظة، يمكنك طرح الأسئلة أو إبداء الرأي
- يمكنك رفض إجراء المقابلة مع باحث ذكر وطلب باحثة. ينطبق فقط على المشاركات من الإناث.
- إذا شعرت بالضغوط النفسي أو الخطر، يمكننا إحالتك إلى أقرب طبيب عام أو وفقا للتأمين الخاص بك حيث يمكنك العثور على المساعدة المطلوبة.
- إذا وافقت على المشاركة في هذه المقابلة، فسيتم سؤالك عن تفاعل النساء اللجان الحوامل مع الحمل وبعد الخدمات الصحية المقدمة أثناء وبعد الحمل.
- لا يترتب على المشاركة أي عائد مادي مباشر

السرية وعدم الكشف عن الهوية:

عندما توافق على المشاركة، سيتم إضافة ما تقوله على البيانات من المقابلات الأخرى بدون ذكر الاسم. ولن يتم الإفصاح عن ما قلته خلال المقابلة لأي شخص. ولن يتمكن أحد من تحديد ما ناقشناه بالضبط.

للتأكد من دقة المعلومات التي تم جمعها واستخدامها لاحقاً، نرجو أن توافق على التسجيل الصوتي للمحادثة. تأكد من السرية الكاملة لكل التسجيلات والملحوظات المكتوبة. فقط الباحثين سوف يمكنهم الوصول إلى التسجيلات، والتي سيتم الاحتفاظ بها في خزانة مغلقة. وسيتم تدمير/ حذف هذه السجلات بعد أن يتم ترجمتها وكتابتها.

سيتم الاحتفاظ باسمك فقط على هذه الموافقة، وليس في تسجيل المقابلة ولن تكون قابلة للتتبع.

يمكنك طلب إيقاف التسجيل في أي وقت إذا لزم الأمر. يمكنك أيضاً رفض وجود رجل أثناء المقابلة.

إن أرائكم وتجاربكم قيمة من أجل استكشاف الخدمات المتاحة ويمكن أن تساعد في تطوير هذه الخدمات في المستقبل.

الإجراءات:

ستجرى المقابلة من قبل باحث/باحثة في مكان خاص حيث لا أحد يستطيع أن يسمع ما يقال. ومن المتوقع أن تستمر المقابلة لمدة تقل عن ساعة واحدة، وقد يعود الباحث لتوضيح بعض القضايا.

الإقرار:

لديك الحق في طرح أي أسئلة تريد. وطلب شرح أكثر عند الحاجة. إذا كنت لا ترغب في المشاركة في هذه المقابلة يمكنك رفض القيام بذلك، ويمكنك أيضاً التوقف في أي وقت ورفض الإجابة على أي سؤال. لن يتم معاقبتك بأي شكل من الأشكال إذا رفضت المشاركة.

يتم توقيعه من قبل المشارك/ المشاركة في المقابلة والذي يعطي هذا الإقرار

اسم المشارك:

تم شرح الغرض من المقابلة لي وأنا أوافق على المشاركة في هذه المقابلة بعد أن أعطيت موافقتي.

أفضل اجراء المقابلة مع باحث / باحثة

طلب

خاص:

التاريخ

التوقيع

توقيع الشاهد

<p>سكرتير لجنة أخلاقيات البحث العلمي KIT، المعهد الاستوائي الملكي</p> <p>Linnaeusstraat 35F [1093 EE]</p> <p>أمستردام، هولندا</p> <p>بريد اليكتروني: s.huider@kit.nl</p> <p>ت: +31 20 568 8237</p>	<p>إذا كان لديك أي أسئلة أو تريد تقديم شكوى حول البحث يمكنك الاتصال:</p> <p>المشرف على الرسالة</p> <p>[...], دكتوراه، طبيب عام</p>
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Consent for interviews

Aim and questions asked

This study is to explore what Refugee women from Arab countries think about pregnancy services in the Netherlands, how suitable are these services, what are the obstacles they face, and what are their suggestions to improve them.

Results will be made available to the organization of midwives and other relevant care organizations in order to help in improving the service for you and other women.

This study is done by an International Health masters student in KIT “The Royal Tropical Institute” in Amsterdam, in cooperation with PHAROS, and under supervision of Dr [...]

Discomfort, risks and benefits

Results will be made available to the organisation of midwives and other care organisations.

- You are not forced or obliged to participate against your will. If you would like to participate, you will be required to attend a half to one-hour interview.
- You are free to refuse to respond to any question. You have the right to stop the procedure at any time. At any point, you can ask questions or give feedback.
- You have the option to choose between male or female interviewer (applicable only to female respondents)
- If you feel stressed or in danger, I can refer you to the nearest General practitioner or according to your insurance where you can find the needed help.
- If you agree to participate in this interview, you will be asked about the interaction of pregnant refugee women with pregnancy and after pregnancy health services.
- There is no direct financial benefit expected from this interview

Anonymity and confidentiality

When you agree to participate, the data you provide will be added with the other interviews. What you say during the interview will not be told to anyone. No one will be able to identify what we exactly discussed.

To make sure that the information is correctly collected and later used, we would like to ask your permission to tape record the conversation. Everything that will be said, written down and taped will

be kept totally confidential. Only researchers will have access to the recordings, which will be kept in a locked cabinet. These records will be destroyed/deleted after being transcribed and translated.

Your name will be kept only on this consent, not in the interview; also, quotes will not be traceable.

Please note you can request to stop the recording at any point if necessary. You can also refuse the presence of a male interviewer.

Your views, opinions and experiences are valuable in order to give us insights of the services and may help future developments.

Procedures

The interview will be conducted by a researcher in a private place where nobody can hear what is said. The interview is expected to last approximately for less than one hour and the researcher may come back to clarify some issues.

Consent

You have the right to ask any questions that you would like and request anything you would like to be explained further. If you do not want to take part in this interview, you can refuse to do so and you can stop at any time and refuse to answer any question. You will not be penalised in any way if you refuse to participate.

DECLARATION: TO BE SIGNED BY THE RESPONDENT GIVING THE ASSENT

Agreement respondent:

The purpose of the interview was explained to me and I agree to participate in this interview after I have given my consent.

Preferred interviewer: _____

Special request: _____

Signed Date

WITNESS SIGNATURE

Signed Date

If you have any questions or want to file a complaint about the research, you may contact:

Thesis supervisor	Ethics Committee
[...] PhD, General Practitioner Senior researcher and adviser at Pharos	Secretary, KIT Ethics Committee, Royal Tropical Institute Linnaeusstraat 35F [1093 EE] Amsterdam, The Netherlands Email: s.huider@kit.nl Ph: 0031 20 568 8237