

Maternal Health Care Challenges Confronting Arab Muslim Refugee Women in Triad North Carolina

Shahla Y. Namak, Julianne K. Kirk

Arab Muslim refugee women represent a new underserved population in North Carolina with many health needs and challenges. Barriers in language, economic and social status, culture, and health all play a role in this population's successful assimilation. Without support, fear and isolation may impede them from becoming active in society. Moreover, the impact on overall wellness of families may be at stake. Highlighting these issues can bring awareness to the needs.

Arab Muslim refugee women (AMRW) face many maternal health care challenges and cultural vulnerabilities. According to the Refugee Processing Center, from 2013 to the end of 2018 a total of 433 Iraqi families and 1,057 total individuals from Iraq resided in North Carolina [1]. There are also 904 total Syrian refugees from 229 families living in the state [1]. Among the AMRW residing in the Triad, there is a large cohort cared for by providers in a Federally Qualified Health Center (FQHC) in Winston-Salem, North Carolina, called United Health Centers [2]. The FQHC is a primary care site that offers obstetrics, general gynecology, pediatrics, and preventive health care. We will discuss the challenges confronting AMRW along with their views on receiving culturally sensitive reproductive health.

Barriers to Care

AMRW primarily rely on their husbands for transportation. A small minority of AMRW hold a driver license but this is uncommon as most never get the opportunity to train and take the necessary testing, which can make transportation to health care appointments difficult. Muslim families usually only have a single car. Stakeholders in the community (Mosques, religious organizations, etc.) often donate a used vehicle. Traditionally, the father is the sole provider and the vehicle driver until adult children learn to drive and help out with transportation. While not routine, transportation by bus is also an option for some AMRW, though public transportation may be confusing and uncomfortable for those who do not understand the language or fear discrimination based on their race or manner of dress [3].

Family income for Arab Muslim families is often dictated by the jobs that are available to men and their sons, many of

which offer salaries below the poverty level. The majority of AMRW in the Triad community do not have skills that could bring a sustainable income. Very few AMRW are able to start a small family business. Poverty often impedes the ability to seek higher education or skills to improve standard of living. For those with skills, finding employment can be difficult because documents from the home country are often lost, as many refugees have left quickly and under duress.

AMRW's health insurance status varies as well. World Relief Triad is an organization that offers a wide array of services and help for new refugee arrivals, including help applying for health coverage [4]. For refugee women and their families, Refugee Medical Assistance is available for eight months to a year, and some families are also eligible for Medicaid or the Children's Health Insurance Program (CHIP). Many health care providers will not accept uninsured refugees as patients [5]. Within the community, there are some local options including non-governmental services such as Health Care Access for Forsyth County, which connects eligible uninsured individuals with the medical community by coordinating care with physicians, clinics, and hospitals and providing access to low-cost copays for primary and specialty care [6]. Charitable clinics including the North Carolina Association of Free and Charitable Clinics also provide opportunities for AMRW and their families to access health care through organizations such as the Community Care Center of Forsyth County [7] and a student-run, physician-staffed free clinic called Delivering Equal Access to Care (DEAC) [8]. AMRW can also apply for financial assistance for charity care through local hospitals and/or Crisis Control Ministry, Inc. [9-11]. In addition, many FQHCs offer a per-visit payment plan that includes the cost of lab work.

Electronically published March 11, 2019.

Address correspondence to Shahla Y. Namak, MD, Department of Family and Community Medicine, Medical Center Boulevard, Wake Forest School of Medicine, Winston-Salem, NC 27157 (snamak@wakehealth.edu).

N C Med J. 2019;80(2):116-119. ©2019 by the North Carolina Institute of Medicine and The Duke Endowment. All rights reserved. 0029-2559/2019/80213

Patient-Provider Interaction

Allowing time to listen to an AMRW's journey, their stories, and their challenges before they fled from their homeland can have a meaningful impact on a trusting patient-provider relationship. An FQHC in Winston-Salem serves over 30 Arab Muslim families for primary health care needs. The families are Arabic speaking and span one to three generations. The family size ranges from three to eight and the ages are generally birth to 70 years. The FQHC also provides maternal child health care from family physicians, and about half of those who seek care at the clinic are women. AMRW prefer a female physician, particularly during pregnancy. Counseling about the need for health care and medical visits is essential as most will defer seeing a provider unless it is urgent. Language is an important factor and an Arabic-speaking provider is ideal, as trust is necessary for ease of communication. AMRW are not required to bring a translator and providers accepting federal payment are required to provide language translation services [12].

For AMRW, especially young girls and those who are unmarried, body exposure is conservative. Body exposure is kept to a minimum and respect is essential. The provider should announce themselves before entering the exam room to ensure the AMRW is ready, as some may need to adjust their hijab. Exams done by a physician are usually limited and a pelvic exam is reserved until after marriage unless it is deemed medically necessary. AMRW are expected to be virgins at their first marriage, and many believe that a gynecological exam will interfere with this. In general, AMRW do not believe they need gynecological health screenings, so they prefer not to have one unless they are having symptoms or are pregnant. If a male physician is performing any exam, the patient's husband will most likely be present, and a female chaperone is always suggested. Discussion of sexually transmitted diseases, a best practice recommendation, may imply to the woman or her husband that she has been unfaithful and deviated away from monogamy, so framing the discussion carefully will be imperative to make the patient feel comfortable.

Domestic violence statistics in the Arab Muslim community are not well studied since women feel hesitant to discuss or report events due to shame and the potential consequences of divorce, abandonment, and living in isolation. Women's concerns for their future and the potential impact on their families are also barriers to reporting family violence. For some women there is a lack of knowledge that domestic violence is a reportable problem [13].

The matter of menstruation and what to expect is not a subject that families, especially women and mothers, particularly feel comfortable discussing. AMRW usually have not received any guidance about menstruation or sex education. Patients typically have many questions about menstruation as they do not understand the norm. These topics are gradu-

ally becoming part of school curriculum in many Muslim women's homelands. Typically, young girls are shy to talk about their body changes with their mothers and end up discussing the matters with sisters and cousins or best friends.

Though it is not common among AMRW, it is important for health care providers working with this population to understand that they may encounter genital mutilation, and that this practice is considered to be due to culture and not to religious practice. About half of cases of genital mutilation occur in Egypt, Ethiopia, Sudan, and pockets of the Middle East [14]. If found, providers should discuss the potential for future psychological impact on the patient and refer to a gynecologist for evaluation and management.

Contraception

Reversible contraception is accepted as a means of birth control for AMRW. In some families, the husband is the authority that decides how many children his wife will have and when she will become pregnant. Preference of contraception relies on the patient's husband's acceptance of a certain method [13]. Some choose condoms and/or natural methods like coitus interruptus and/or calendar counting of safe days for intercourse. Because of the need to be "purified" in order to pray, AMRW who have a normal period or irregular vaginal bleeding will be excused from prayers because of impurity [15]. For this reason, it is important to AMRW that a contraception method does not cause spotting or other symptoms that may require them to forego prayers. Many choose a non-hormonal intrauterine device or hormonal options such as combined birth control pills. A contraception method is chosen through each woman's own experience or influence of family or friends.

The belief of AMRW is that if a pregnancy occurs, it is a gift from God and abortion is not an option in most circumstances. Even when the socioeconomic status is strained, an unplanned pregnancy is welcomed. Younger women tend to consider contraception more acceptable compared to older women. Education may play a role in this pattern. Islam encourages spacing of about 30 months between pregnancies for the mother to recover [16]. Many AMRW believe in breastfeeding for one to two years and that it prevents pregnancy. If conception occurs during breastfeeding, there is a concern that this will affect the fetus's nutrition and breastfeeding will cease.

Prenatal and Postpartum Care

The majority of AMRW wait to inform family of pregnancy until late in the first trimester. Culturally, some are concerned for a false pregnancy or miscarriage and worry that a bad outcome will occur from the pregnancy if they announce it too soon. It is important to provide education about sexual intercourse during pregnancy as many will think it will harm the fetus. Nutrition, general health, and emotions of the AMRW are prioritized. Healthy nutrition,

according to AMRW culture, means avoiding excessive weight gain and maintaining a diet of milk, eggs, vegetables, fruits, and meat or fish. Islam excuses pregnant women from fasting. Some AMRW continue to fast unless it causes tiredness and dehydration, especially during the summer. If the AMRW previously smoked (some report occasional use of hookah) they will discontinue. Women do not typically drink alcohol or eat pork whether or not they are pregnant as it is prohibited by religious and cultural rules.

Pregnant AMRW will not rush to the doctor unless there is something urgent. Women will turn for advice during pregnancy to their sisters or family members who have had a prior experience with pregnancy. It is not unusual for older generations (current grandmothers) to have never seen a provider during multiple pregnancies. It is important for providers to advise AMRW and their families that prenatal care requires regular visits. Marriage is welcomed between cousins in the Muslim culture and providers will need to potentially perform genetic testing when needed [17]. One difficult subject is when there is a miscarriage or parents are told that the fetus is abnormal. Elective medical abortions may be carried out before 120 days into an AMRW's pregnancy, which is the point that Islam and other religions designate as ensoulment, or the moment that a human fetus gains a soul. But if the diagnosis is later (ie, more than 120 days) many women will carry the child until delivery [18]. Other permissible reasons for elective abortion include rape, proven severe congenital abnormalities, and if there is any risk to the mother or the fetus because of health, family, or social constraints [13]. AMRW will take prescription medicines including prenatal vitamins but they use simple herbs in treating nausea and vomiting such as fresh mint tea or rose water in warm water.

AMRW prefer vaginal delivery without anesthesia as they believe the forceful recurrent labor pain is what helps delivery along. There are concerns about regional anesthesia causing a slowing of contractions and failure of childbirth. There is the belief among AMRW that a Caesarean section may delay recovery and affect future fertility and child birth. Usually, men do not attend deliveries, but this is changing with acculturation. Prayer is a significant part of a daily ritual that is done five times per day, including during child birth, which features constant supplications.

When a baby is born the father will read the call to prayer and recite the words of Allah in the baby's ear so it will be the first thing they hear coming to this life. In general, the birth of a male child is met with more welcome by parents, who take pride in the longevity of the family name and often believe the birth of a boy is a symbol of strength. Male circumcision is preferred to occur in the first week after birth or within the first 40 days of life. The mother is fed well after her delivery to help her regain the blood loss in labor with meals that contain cooked organs like liver and spleen. She is given sweets made with fenugreek seeds (helba) added

to a recipe of sweet bread or as a drink, which is believed to help promote milk production for breastfeeding. The baby will be given small amounts of sugar water until the mother's milk comes in. The mother and baby stay home for 40 days to lessen the risk of exposure to illnesses and to rest unless there is a need for a doctor visit.

Views from Arab Muslim Women

A survey of AMRW patients of the Winston-Salem FQHC was conducted to assess their understanding of uterine bleeding, human papillomavirus (HPV), contraception, pregnancy preparation, and gynecological screening. Nineteen women participated with an average age of 36; 14 lived in the United States for less than four years; nine had less than a high school education (Namak SY, Kirk JK, unpublished data, 2018).

For menstruation, women commented with the following: *"I can't function as any other day," "it delays fasting and prayers," and "pain during period prevents prayers."*

When asked about HPV their understanding was mixed, with the following comments:

"because we are Muslim we don't need vaccine," "people are scared from the treatment," and "it protects people."

Comments about providers and health care included concerns about gender and the following:

"I prefer a female doctor," "I do not think a male doctor will think about the women's health," "there is a need for an interpreter at visit," "doctors need to be really excellent at care," they expect "doctor to do a yearly checkup," and "I advise doctor[s] to [use a translator] to explain [treatments to patients]."

Health Policy Action

Initiatives to evaluate AMRW health literacy, especially when discussing illness or trauma, are paramount. Informed consent during procedures is a concept that will take time to communicate effectively. Consent for the AMRW would likely need to include the involvement of her husband or the elder in the family, depending on the subject. Providers need to expand their medical visit to include the components of social determinants of health and, if possible, a social worker to assist with potential resources such as food pantries, transportation, medication assistance, and help paying rent and other bills.

Health policy action for Arab Muslim refugees in the region should include more formalized partnering with World Relief Triad to assist families from the moment they land in the community and for years to come. One successful collaborative in the Triad involves Good Neighbor Teams established by Interfaith Winston-Salem and a coalition of local faith organizations to help welcome immigrants and refugees to the area [19]. Many AMRW will need assistance

applying for citizenship and English lessons. Formal assistance with refugee children's application to school or technical training within a short time from arrival is needed, and more accessible pre-K classes may also benefit the children of AMRW, though many prefer their young children to stay at home. Learning the English language is a priority that warrants health policy action to assure appropriate inclusion of AMRW so they are not left behind, especially if they have child care obligations and no transportation. **NCMJ**

Shahla Y. Namak, MD associate professor and director of global health, Department of Family and Community Medicine, Wake Forest School of Medicine, Wake Forest University, Winston-Salem, North Carolina.

Julienne K. Kirk, PharmD professor, Family Medicine and Women in Medicine and Science, Wake Forest School of Medicine, Wake Forest University, Winston-Salem, North Carolina.

Acknowledgments

Potential conflicts of interest. The authors have no relevant conflicts of interest.

References

1. Refugee Processing Center. Admissions & Arrivals. Refugee Processing Center website. <http://www.wrapsnet.org/admissions-and-arrivals/>. Accessed on January 9, 2019.
2. United Health Centers website. <http://www.uhcenters.org>. Accessed January 9, 2019.
3. Nguyen K, Vaughn J, Hinson J, Rounds K. Refugees and Maternal and Child Health. The University of North Carolina at Chapel Hill Leadership in Public Health Social Work Education website. <http://lphswe.unc.edu/refugees-and-maternal-and-child-health>. Accessed January 9, 2019.
4. World Relief Triad. Refugee Resettlement: Resettlement is the open arms and guiding hand of our community. World Relief Triad website. <https://worldrelieftriad.org/refugee-resettlement>. Accessed January 9, 2019.
5. Islam N, Patel S, Brooks-Griffin Q, et al. Understanding barriers and facilitators to breast and cervical cancer screening among Muslim women in New York City: perspectives from key informants. *SM J Community Med*. 2017;3(1):1022-1036.
6. HealthCare Access website. <http://www.hcaccess.org>. Accessed January 9, 2019.
7. North Carolina Association of Free and Charitable Clinics. Community Care Center of Forsyth County Inc. North Carolina Association of Free & Charitable Clinics website. <http://ncafcc.org/clinic/community-care-center-of-forsyth-county-inc>. Accessed January 9, 2019.
8. Wake Forest School of Medicine. Delivering Equal Access to Care DEAC Clinic. Wake Forest School of Medicine website. <https://school.wakehealth.edu/About-the-School/Facilities-and-Environment/Learning-Environment/DEAC-Clinic>. Accessed January 9, 2019.
9. Wake Forest Baptist Health. Financial Assistance. Wake Forest Baptist Health website. <https://www.wakehealth.edu/Patient-and-Family-Resources/Billing-and-Insurance/Financial-Assistance>. Accessed January 3, 2019.
10. Novant Health. financial assistance for the uninsured. Novant Health website. <https://www.novanthealth.org/home/patients--visitors/your-healthcare-costs/financial-assistance-for-the-uninsured.aspx>. Accessed January 3, 2019.
11. Crisis Control Ministry. Services. Crisis Control Ministry website. <https://crisiscontrol.org/services/>. Accessed January 3, 2019.
12. Eckstein B. Primary care for refugees. *Am Fam Physician*. 2011;83(4):429-436.
13. Shahawy S, Deshpande NA, Nour NM. Cross-cultural obstetric and gynecologic care of Muslim patients. *Obstet Gynecol*. 2015;126(5):969-973.
14. Von der Osten-Sacken T, Uwer T. Is female genital mutilation an Islamic problem? *Middle East Quarterly*. Winter 2007;14(1)29-36.
15. Dhimi S, Sheikh A. The Muslim family: predicament and promise. *West J Med*. 2000;173(5):352-356.
16. Inhorn MC, Serour GI. Islam, medicine, and Arab-Muslim refugee health in America after 9/11. *Lancet*. 2011;378(9794):935-943.
17. Akrami SM, Osati Z. Is consanguineous marriage religiously encouraged? Islamic and Iranian considerations. *J Biosoc Sci*. 2007;39(2):313-316.
18. Albar MA. Induced abortion from an Islamic perspective: is it criminal or just elective? *J Family Community Med*. 2001;8(3):25-35.
19. Clifford D. Welcoming our new neighbors. *JournalNow.com*. https://www.journalnow.com/opinion/columnists/dean-clifford-welcoming-our-new-neighbors/article_0179d4a9-0749-5541-aac1-0be7c81f8908.html. Published October 13, 2017. Accessed January 14, 2019.