Recognizing the Unique Health Care Needs of Pregnant Afghan Refugees

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CULTURALLY INFORMED CARE FOR PREGNANT AFGHAN REFUGEES

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CULTURALLY INFORMED CARE FOR PREGNANT AFGHAN REFUGEES

Abstract

Healthcare providers in the US, specifically in areas of high refugee resettlement, have recently been overwhelmed by the recent influx of Afghanistan refugees. This increased demand has exposed the lack of culturally competent care that healthcare workers are able to provide, leading to the question: How can healthcare providers in the United States (US) recognize the unique health care needs of pregnant Afghan refugees? This research paper addresses the question through the collection of previous research surrounding medical care for pregnant Afghan refugees already in databases. First, background information was obtained about the situation from which pregnant Afghan women are escaping, including how the Taliban has influenced women's health and how the Islamic religion views care of pregnant women. Next, an extensive literature review was performed to raise awareness about the prenatal period, childbirth, the postnatal period, and women's health literacy in Afghanistan. This information was organized and presented to educate US healthcare workers. Next, the information was applied through analyzing the beliefs, customs, and practices of Afghan women and relating them to the context of the United States healthcare system. Results of the research showed that culture heavily impacts health care for pregnant Afghan women refugees and can negatively impact care if not understood by providers. Education of healthcare providers is essential to provide culturally competent care to pregnant Afghan women refugees and will prepare healthcare workers as more Muslim refugees continue to arrive in the US.

Keywords: Afghan women, pregnancy, refugee, culture, maternity care, prenatal care, childbirth, postpartum care, education, Taliban rule, health-seeking behavior

Recognizing the Unique Health Care Needs of Pregnant Afghan Refugees

More than 74,000 Afghanistan refugees have entered the US since August of 2021 (International Rescue Committee, 2022). Due to the recent influx of Afghanistan refugees into the US, there has been an increased demand on healthcare workers, leaving places of high refugee resettlement overwhelmed and struggling to provide culturally competent care in hospitals (Butler & Sheriff, 2022). Many of the refugees have pressing medical issues, either acute or chronic, that are exacerbated by recent trauma. While most Afghan refugees entering the country have undergone basic screening, some physical and mental conditions go undetected without further examination (Butler & Sheriff, 2022). There are several barriers to providing care, including language, foreign customs, and diseases not commonly occurring in the US. One of the most unique challenges to overcoming cultural barriers is the issue of Afghan women's health, particularly pertaining to pregnancy and childbirth (Butler & Sheriff, 2022). For healthcare providers to give culturally competent care to pregnant Afghan refugees, they must have an awareness of Afghan culture and traditions that impact women's health. Additionally, to better care for their patients, they must understand the history of women's health literacy and education in Afghanistan.

Background on Afghan Influence Regarding Maternal Care

While refugees coming from Afghanistan are being inundated with American culture, they should be cared for by providers with a basic understanding of the Muslim culture to be given the best health care possible. Care becomes more complex when the patient is pregnant. To accomplish this goal of identifying how to provide the best culturally competent care to Afghan pregnant women, an extensive review of the literature was performed, and information was collected about Afghan maternal care. For healthcare workers to provide culturally competent

care to pregnant Afghan refugees coming into the US, they must understand the difficult circumstances these women are coming from and the key elements of the Muslim culture and Islamic religion that impact their care. Because women are coming from a society heavily influenced and controlled by the Taliban, the history of the Taliban should be understood by providers. In addition, certain aspects of the Muslim culture, such as women's role in Afghanistan, help healthcare workers to address pregnant Afghan refugees through their cultural lens to a greater degree. Finally, components of the Islamic religion, such as food restrictions, fasting practices, and the strict dress code significantly impact the care provided to Afghan women and should be acknowledged and understood by healthcare providers. According to the Pew Research Center, the number of Muslims in the US has slowly increased from 2.35 million in 2007 to 3.45 million in 2017 (Mohamed, 2020). With the recent influx of Afghanistan refugees into the US, the number of Muslim patients in America will continue to increase, leading to an amplified need for healthcare providers to provide culturally competent care to pregnant Afghan refugees through gaining an understanding of the current Afghan medical practice, the Islamic religion, and the Muslim culture.

Historical Review of Taliban Rule

The Taliban has played a significant role in shaping the culture and political climate in Afghanistan. Therefore, understanding basic history of the Taliban will provide healthcare workers with some information about the context these women have lived in. The sudden entry of refugees into the US from Afghanistan was due to the rapid takeover of the country by the Taliban, a radical militant Islamic group (Cambridge University Press, 2021). Between 1996-2001 the Taliban took control of Afghanistan, overthrowing Soviet occupation. During Taliban rule, women and girls were barred from schools and many jobs, in addition to other oppressive

regulations (Cambridge University Press, 2021). These restrictions were enforced under strict Shariah law, the set of regulations derived from the Quran, the Islamic holy book, as well as from the Sunnah and Hadith, the sayings and deeds of Muhammed (Cambridge University Press, 2021). After the September 11, 2001 attacks, the US Congress passed an Authorization for Use of Military Force and 20 years of U.S. military operations in Afghanistan began (Cambridge University Press, 2021). Two trillion dollars, 6,461 U.S. soldier deaths, 66,000 Afghan soldier deaths, and 46,300 Afghan civilian deaths later, the costly fight against terrorism ended in tragedy (Cambridge University Press, 2021). Under the Trump administration, the US made a deal with the Taliban to begin a 14-month withdrawal of U.S. forces from Afghanistan in exchange for the Taliban promising to prevent terrorist attacks on the US and their allies (Cambridge University Press, 2021).

In May of 2021, under the Biden administration, the US began its final withdrawal out of Afghanistan (Cambridge University Press, 2021). Following the mid-April US announcement of this withdrawal, Afghan President Ghani stated, “Afghanistan’s proud security and defense forces are fully capable of defending its people and country, which they have been doing all along” (Cambridge University Press, 2021, p. 748). However, the Taliban began capturing and controlling Afghan territories with unexpected speed, leading to the eventual capture of Kabul, the capital city, on August 15th, 2021 (Cambridge University Press, 2021). Because of reports of executions of Afghan soldiers, who attempted to surrender prior to the capture of Kabul, as well as concerns about the Taliban targeting people who had worked with the Afghan government, the US began airlifting Afghans at risk in late July. President Biden deployed 6,000 troops in August to secure the Kabul airport and facilitate the transportation of 123,000 people between August 14-30 (Cambridge University Press, 2021). Unfortunately, the US failed to evacuate

many Afghans who had previously aided the US, leaving tensions high and the country in shambles (Cambridge University Press, 2021). The Taliban has created a culture of fear and taken away opportunities for women to receive any type of health education, which is why their history, and the effects of their rule are vital for healthcare providers to understand.

Women's Health Literacy and Education in Afghanistan

Due to the restrictions of the Taliban, education for women has been limited. Although progress was made between the first Taliban takeover in 1996 and the second Taliban takeover in 2021, there is currently little education for women in Afghanistan (Cambridge University Press, 2021). Because of a lack of education, health literacy is low, particularly in more rural areas of the country. Another reason for low health literacy is the patriarchal society, where male dominance is normal and expected. One ethnographic study of fourteen Afghan women, who were all interviewed one-on-one, found that the patriarchal society negatively affected women's access to education (Amiri et al., 2019). The women noted that dependence on men heavily prevented women from seeking health literacy and health care (Amiri et al., 2019). One woman interviewed stated, "I had a great opportunity to go to university, but my parents would not let me. While my brother did not want to continue with education, my parents forced him to go to university" (Amiri et al., 2019, p. 9). For women, seeking independence is discouraged by Afghan culture, making them dependent on their husbands for health care and education.

Another reason for low health literacy among Afghan women is lack of trust in the expert opinions of healthcare professionals (Amiri et al., 2019). The same study of fourteen Afghan women found that many women seek advice from friends and neighbors over healthcare professionals due to their perceptions or previous negative experiences with healthcare providers. Since health literacy and education are limited due to the Taliban, the patriarchal society, and

lack of trust, health-seeking behavior is lacking among pregnant women and maternal care is limited for women in need (Amiri et al., 2019). This is one of the reasons Afghanistan has one of the highest maternal mortality ratios in the world, with one study finding that 400 out of 100,000 live births ended in the death of the mother (Najafizada et al., 2017). This is a shocking ratio, especially in comparison to the regional ratio of 320 and the global ratio of 280 deaths per 100,000 live births.

Islamic Food Regulations

Not only does health literacy and education affect maternal care, but diet also plays a prominent role in a woman's care. It is vital for healthcare workers to understand Islamic food requirements so that they can provide appropriate care to the woman incorporating traditions of her culture and the beliefs of her religion (Al-Teinaz et al., 2020). Halal, meaning lawful or permissible in Arabic, is the word that encompasses everything that is permissible in a Muslim's life. Halal is a principle applied to every area of Islamic life (Al-Teinaz et al., 2020). Muslims believe that all things are halal unless Allah has forbidden them, in which case they become haram, meaning prohibited and unlawful in Arabic. "Say: tell me what Allah has sent down for you of sustenance, then you make (a part) of it unlawful and (a part) lawful. Say: has Allah commanded you, or do you forge a lie against Allah?" (Quran 10:59). The Quran teaches that there is a day of judgement, known only by Allah, where everyone will be judged according to their deeds (Al-Teinaz et al., 2020). A Muslim's strict adherence to the halal lifestyle, including food regulations, is a significant part of determining whether they will be punished in hell or rewarded in heaven in the afterlife (Al-Teinaz et al., 2020).

There are two suras, or chapters, of the Quran that focus on food, the Al-Ma'ida and the Al-Baqara (Al-Teinaz et al., 2020). First, Islamic food is required to be halal. Second, it is

required to be tayyab, which means fit for human consumption. Finally, food must not come in contact with any food that is haram. Haram foods include pork and its by-product, animals that have been improperly killed, and dead animals or animals that have been slaughtered after death. In addition, blood, animals killed in the name of anyone other than Allah, and animals that have toxins or poisons are forbidden to be consumed. Wine and all intoxicants are forbidden and almost all reptiles and insects are also haram. Fish is the only meat that is exempt from the slaughtering rules. Some of the slaughtering rules include that animals must be well fed and looked after before slaughter, the animal must not see any blood, and no stunning is allowed before slaughter. Food processing is also regulated and any foods that have been processed with equipment not cleansed according to Islamic Shariah law is forbidden. In addition, any haram food that encounters halal food contaminates that food. This rule is particularly problematic when halal and haram foods are being produced or stored in the same location.

According to the Quran, there are forbidden foods during pregnancy, which must never be consumed (Merits et al., 2018). These regulations must be strictly observed throughout the pregnancy in order that the unborn child will not even desire certain foods in the future. There are two groups of food in the Muslim tradition: hot foods and cold foods (Merits et al., 2018). Certain conditions are considered hot, and others are considered cold. Pregnancy is a hot condition, which requires cold food to be consumed. Examples of cold foods to consume are vegetables, fish, dairy products, and fruit, while examples of hot foods to avoid include cinnamon, ginger, and cereal products (Merits et al., 2018).

Halal Medication Requirements

According to Islamic tradition, medications also need to be halal (Khan & Shaharuddin, 2015). While many pharmaceutical companies have “halal certification guidelines,” there is very

little content instructing pharmacists on what qualifies as halal and how the medications should be processed. Because pharmacists do not typically possess the basic knowledge to provide their Muslim patients with halal medications, there is a deficit in patient care (Khan & Shaharuddin, 2015). In Islam, there are two main pillars that clarify rules regarding issues of halal: hadith, the words of Muhammad, the prophet of Allah and sunnah, the acts performed by Muhammad. One hadith, narrated by the wife of Muhammad, Umm Salamah, states "Allah has not placed a cure for your disease in things that He has forbidden for you" (Khan & Shaharuddin, 2015). Another hadith, reported by Abu ad-Darda, says that "Allah has sent down both the disease and its remedy. For every disease, He has created a cure. Hence, seek medical treatment, but never with something, the use of which Allah has prohibited" (Khan & Shaharuddin, 2015). For a Muslim patient to follow the hadith and sunnah, all medications must be halal (Khan & Shaharuddin, 2015).

Ramadan: The Holy Month of Fasting

During the ninth month of the Islamic calendar, a month of fasting called Ramadan is observed, beginning and ending with the appearance of the crescent moon (Merits et al., 2018). During this one-month time, there are certain things to be avoided from sunrise until sunset, including food, drink, tobacco, and sexual intercourse. Alcohol is always prohibited, regardless of the time of year. In addition, certain types of medication are also not allowed to be consumed during the Ramadan fast, including tablets, drops, and inhalable medications (Merits et al., 2018). However, medication that is administered through injection and mouth rinse is permissible.

Pregnant women and breastfeeding women are exempt from these obligations according to the Quran (Merits et al., 2018). However, after Ramadan, the women must make up the fasting

days. This is why many women still choose not to eat or drink during the day (Merits et al., 2018). One cross-sectional study done in the US, which surveyed thirty-seven Muslims with active obstetric records, reported that of the women surveyed, 70% did not fast during Ramadan and 62% stated that they considered fasting harmful to either themselves and/or the fetus (Lou & Hammoud, 2015). Another cross-sectional study of 187 pregnant Muslim women in Indonesia found that, during Ramadan, for every week increase in gestation age, the odds of adherence to fasting were reduced by 4% (Van Bilsen et al., 2016). In addition, the same study found that fasting during pregnancy was not affected by age, income, employment, or education. In this study, 80% of women chose to fast during pregnancy, believing fasting not to be harmful to themselves or their unborn baby during pregnancy (Van Bilsen et al., 2016).

The Islamic Dress Code

Not only is Ramadan a central part of Islamic culture, but the Islamic dress code is another key component that also affects maternal care (Merits et al., 2018). The Quran, the Islamic sacred text instructs, “And say to the believing women that they should lower their gaze and guard their modesty; and that they should not display their beauty and ornaments except what appear thereof; that they should draw their veils over their bosoms and not display their beauty save to their husbands, or their fathers or their husbands' fathers, or their sons or their husbands' sons, or their brothers or their brothers' sons, or their sisters' sons, or their women, or the slaves whom their right hands possess, or male servants free of physical desire, or small children who have no sense of sex; and that they should not stamp their feet in order to draw attention to their hidden ornaments…” (Quran 24:31). Because dress code is such a key aspect of Muslim culture, it should be understood and respected by healthcare providers in the US.

Islam requires modest dress for all women. These strict regulations for dressing require every part of a woman's body to be covered, except for the hands and face (Merits et al., 2018). In certain regions, including Afghanistan since the recent Taliban takeover, the hands and face are required to be covered as well (Cambridge University Press, 2021). An Afghan woman refugee's dress upon entering the US will be dictated by her family's beliefs, depending on the school of thought the family most closely align with. There are four major schools of Islamic jurisprudence, each interpreting the teachings of Muhammad differently (Islamic Jurisprudence and Law, n.d.) The most conservative of the four different schools, the Hanbali and Shafii schools, require women to cover their face and hands, in addition to the rest of their body (Islamic Jurisprudence and Law, n.d.) According to a cross-sectional study conducted in the US of twenty-seven Muslim women, 93% of the participants reported through a written survey that it was extremely important to maintain Muslim dress code in the healthcare setting (Hasnain et al., 2011). In the same study, 100% agreed that a Muslim women's need for modesty is justified, 93% of providers surveyed agreed with the same statement (Hasnain et al., 2011). However, this survey was conducted with a convenience sample of healthcare providers and Muslim women at a conference titled 'Patient-Centered Health Care for Muslim Women' in the US. In survey with a random sample of healthcare providers in the US, the results may not as supportive of a Muslim women's need for modesty. This strict dress code comes with challenges for healthcare providers, including identifying signs of abuse and anemia, among other problems.

Male Influence on Maternal Care

Because of cultural beliefs about modesty, men are not allowed to be in the room with a woman giving birth (Merits et al., 2018). Typically, the only people allowed in the room are female relatives and female healthcare providers. However, the husband or other male relatives

dictate who can be in the room as well as the location of childbirth, which can limit the help a woman receives (Merits et al., 2018). In addition, men limit access to health care in general. One woman from the ethnographic study of fourteen Afghan women stated, "I don't know where the local clinic is; when I want to go out even for treatment, I must get permission from my father-in-law" (Amiri et al., 2019, p. 50). If the husband of the pregnant woman or other male figures in her family are not supportive of prenatal care, medical assistance during childbirth, or health care in general, women do not receive the medical help they need (Merits et al., 2018).

Language Barrier

Not only are there many cultural barriers to overcome when providing health care to pregnant Afghan refugees in the US, but there is also a language barrier. Shafiei et al. (2012) mentions a research study of forty-seven Afghan women investigating women's views and experiences of maternity care. Refugee women were interviewed who had recently given birth in Melbourne, Australia. When asked about their birth experiences, one of the issues the women mentioned was not having an interpreter. One woman, Leila, who had been in Australia for 12 years, she did not understand the medical terminology her doctor used in conversation. In this instance, the doctor told the woman that she needed a hysterectomy, and her husband signed the consent form unaware of what the procedure entailed, leading to the husband being very upset. This woman stated that "In the serious situation, it's better to have an interpreter" (Shafiei et al., 2012, p. 201). Interpretation is a key element of caring for refugees, especially when it comes to maternal care.

Prenatal Care in Afghanistan

Not only is understanding the Islamic religion and culture important, but understanding maternal care practices in Afghanistan and the context these women are coming from is also vital

to providing culturally competent care. Prenatal care is a major component of maternal care, as prenatal care often determines the health of the baby and the mother (Merits et al., 2018). Based on a study of nine Afghan midwives in Estonia through focus group interviews, prenatal care is often not viewed as an essential component of the pregnancy process (Merits et al., 2018). Since healthcare workers in the US understand the importance of antenatal care and are charged with caring for expectant Afghan mothers, they should understand that pregnant Afghan women often do not receive adequate prenatal care in Afghanistan. Reasons include modesty concerns, lack of family support, and lack of female healthcare workers (Merits et al., 2018). For women who do value prenatal care, lack of access and lack of resources are significant barriers to acquiring prenatal care (Van Egmond et al., 2004). In addition, home birth is sometimes more highly valued in comparison to birth at a hospital or clinic (Merits et al., 2018).

Reasons for not Seeking Prenatal Care

Lack of familial support is one of the reasons pregnant Afghans do not seek prenatal care. In the Muslim collectivistic culture, pregnant women are typically surrounded by female family members (Merits et al., 2018). These women, typically the mother of the pregnant woman, mother-in-law, sisters, and aunts, will provide support to the pregnant women, encourage her, and give her advice. Because of the supportive roll relatives play in the entire pregnancy, women do not feel it necessary to receive additional care throughout their pregnancy (Merits et al., 2018). In addition, men are typically excluded from the prenatal process, but do dictate whether their wives receive prenatal care. Lack of female healthcare providers and fear of exposing themselves to a male also is a major reason for not seeking prenatal care (Merits et al., 2018). If the provider is male, most Afghan women will be ashamed by the type of medical examination required for a prenatal appointment. In a cross-sectional study conducted in the US of twenty-

seven Muslim female patients, 80% of those surveyed said that it was important for Muslim women not to be examined by male providers (Hasnain et al., 2011).

Barriers to Prenatal Care in Afghanistan

While most traditional Afghan families consider the care given by female family members to be sufficient for prenatal care, there are some who value prenatal care as important for the healthy development of their unborn children (Dadras et al., 2020). In the population of Afghan refugees in Iran, which is approximately 96% of all Afghan refugees, half are women capable of childbearing. Four hundred twenty-four Afghan women from health centers in the Tehran province in Iran were interviewed regarding prenatal care, particularly the concerns and obstacles experienced. In addition to discrimination and cultural concerns, the two primary themes that emerged were lack of financial resources and lack of access (Dadras et al., 2020).

Lack of Financial Resources

The pregnant women expressed that government hospitals were significantly more expensive than community health centers (Dadras et al., 2020). Even women without financial struggles preferred to go to the community clinics. At these local clinics, however, diagnostic and screening tests were not provided, which is an essential part of prenatal care. Many of the pregnant Afghan refugees in the study were not able to afford these services at the government hospitals. A concerning finding of this survey is that most of the women interviewed did qualify for public health insurance in Iran, they were simply unaware of their eligibility (Dadras et al., 2020). Of the women who had insurance, they were not educated on services they qualified for.

Lack of Access

The second problem mentioned by the women interviewed was lack of access (Dadras et al., 2020). While some women lived closer to the city and could either walk or use public

transportation to receive prenatal care at the local clinics, others living in more rural areas struggled to find transportation for their appointments (Dadras et al., 2020). This is a common problem in Afghanistan, with a significant percentage of the population living in rural areas, and is also a shared problem in the US. Distance caused women to miss appointments, making prenatal care inconsistent at best (Dadras et al., 2020).

Childbirth in Afghanistan

The infant mortality rate in Afghanistan is currently 44.6 deaths per 1000 live births (*Afghanistan Infant Mortality Rate 1950-2023*, 2023). Although this number is lower than the previous year by 3.08%, it is still much higher than the world infant mortality rate, which is currently 26.1 deaths per 1000 live births (*World Infant Mortality Rate 1950-2023*, 2023). Clearly, childbirth in Afghanistan can be a devastating experience for many families, leading to the question of what factors contribute to these high mortality numbers. Education of midwives is also a significant factor influencing the birth experience of women in Afghanistan. Prior to the 1996 Taliban takeover of Afghanistan, there was a system of educating midwives (Thommesen et al., 2020). However, when education for women was outlawed, this led to a major deficit in the country of only 467 educated midwives in 2002 (Thommesen et al., 2020). Through many programs and international support, midwives began to be educated again. However, there is still a lack of skilled maternal caregivers, which has devastating effects on the infant mortality rate (Thommesen et al., 2020). In 2000, only 12% of Afghan births were attended by skilled health staff (*Births attended by skilled health staff*, 2020). Thankfully, in 2020, that percentage rose to 62%; however, there is a significant percentage of women who give birth without trained staff (Merits et al., 2018).

Factors Influencing Location of Birth

In Afghanistan, it is very common to give birth at home, especially if the pregnant woman lives in a rural area (Merits et al., 2018). There are several factors that contribute to the decision of whether a woman should give birth at home or in the hospital, including perceived or experienced abuse, safety and transportation, education level, and preference of the husband or family members (Arnold et al., 2019). Many studies have shown that poor care, neglect, and abuse are common in Afghanistan and influence a family's decision on where the woman will give birth (Arnold et al., 2019).

Abuse During Maternal Care

One ethnographic study of 19 Afghans and 22 non-Afghans showed that Afghan women were often mistreated by staff due to understaffing, lack of supplies, and poor management (Arnold et al., 2019). While abuse does occur in Afghan hospitals regularly, most staff respond to patients negatively due to poor working conditions and burnout. Throughout hospitals in low and middle-income countries in Afghanistan, healthcare workers are unable to provide quality care to patients. One midwife reported that while new midwives desired to treat patients kindly, the experienced staff does not allow them to show compassion to the women because it is against the behavioral norms. The system is not conducive to quality care even if healthcare workers desire to treat patients with dignity (Arnold et al., 2019).

Transportation as a Barrier

Not only does a poor system inundated with abuse contribute to a lack of care for women in labor, but transportation can be a significant issue (Merits et al., 2018). Lack of access to hospitals or clinics as well as lack of transportation for midwives leads to a lower percentage of women seeking medical help during childbirth. A reproductive-health knowledge, attitudes, and practices survey in the capital of Kabul found that 14.2% of the population residing in the city

experienced problems finding transportation to a medical facility (Najafizada, 2017). An additional 18.2% of the residents of Kabul thought that the healthcare facility was too far away (Najafizada, 2017). An exploratory case study of 39 women in the rural province of Kunar found that, because of the mountainous area, transportation had to be on foot, on pack animals, or motorized vehicles (Thommesen et al., 2019). Walking was the default method of transportation, with the nearest access to medical resources for the women in this region being an hour away (Thommesen et al., 2019).

War, Conflict, and Weather in Afghanistan

Due to instability, safety in Afghanistan is also a concern when it comes to deciding the location of a woman's birth (Thommesen et al., 2019). Insecurity influences the family's decision to travel to a clinic for childbirth due to immense risks, especially at night. One midwife interviewed stated that "When going to the clinic we use the same road as the bombers…It makes moving from one place to another very dangerous and difficult" (Thommesen et al., 2019, p. 9). Unrest in the streets is prominent in Afghanistan, making any travel dangerous. Another aspect of safety has to do with the climate of Afghanistan. During the long winters, large amounts of snow fall, making the roads treacherous. Lack of infrastructure throughout the country can also make travel dangerous (Merits et al., 2018). Safety, then, is a huge factor in families considering where childbirth should occur (Thommesen et al., 2019).

Education of Family Members

The education level of the family plays a huge role in determining the location of birth (Merits et al., 2018). If the husband or other family members have a higher level of education, they will understand the importance of medical care during childbirth and are more likely to choose to have assistance during birth (Merits et al., 2018). Education of the pregnant woman

herself also plays a role as well as previous experiences with childbirth. Many women from rural areas in Afghanistan expressed that they did not desire help during labor and childbirth because they had previously had successful home births (Thommesen et al., 2020). Some women interviewed believed that going to a clinic to have a baby was a waste of time, indicating that they may not fully understand the potential risks involved with childbirth (Thommesen et al., 2020).

Post-Partum Care

There are several cultural customs to be aware of when providing postnatal care to Afghan refugee women (Merits et al., 2018). First, it is a common custom to keep the placenta and bury it for good luck. In the hospital setting, patients might ask to take home the placenta. Additionally, burying the umbilical cord is a tradition. Having the Quran near the mother and child and wearing blue beads are supposed to keep the recovering mother and baby from evil (Merits et al., 2018). A holiday of 40 days is required after the woman gives birth, during which time the woman does not leave the home, does not engage in physical labor, and receives help caring for her newborn baby from family members (Merits et al., 2018). A ritualistic washing is done immediately after birth. After the washing, the baby is placed in a yellow sheet and olive oil, coffee grounds, and tar are put onto the stump of the umbilical cord (Merits et al., 2018).

Another cultural custom to be aware of for healthcare providers is the importance of prayer in the birthing process (Merits et al., 2018). During the birthing process, the pregnant woman has other women pray for her, in order that God might fulfill the prayers as a reward for the suffering that the woman had to endure during labor. In addition, during childbirth, the relatives of the laboring woman might need a private room in which to pray for the woman in labor (Merits et al., 2018). Finally, right after the baby is born, there is a ritual traditionally

performed where the father of the baby whispers a prayer first into the baby's right ear and then the left. This is to remind the baby of his Muslim heritage, in order that the baby would never sway from the Islamic faith. Healthcare providers need to be aware of unique customs of religious and people groups to accommodate them in the postpartum period.

Adverse Pregnancy Outcomes

Adverse pregnancy outcomes in Afghanistan are primarily due to lack of attentiveness by healthcare providers and the patients' fear of the staff. One experienced midwife discussed the lack of care given in Afghanistan hospitals when she said of her co-workers that "after women deliver, they (the midwives) have to check their blood pressure, their bleeding, everything – but they are not checking these things" (Arnold et al., 2019). Fearful of staff, Afghan women are often too scared to verbalize that something is wrong. One interviewee recalled a time when a woman was found dead in her bed due to a postpartum hemorrhage that had gone unnoticed by the staff (Arnold et al., 2019). Lack of healthcare workers and lack of attentiveness to patients contributes to the number of adverse pregnancy outcomes in Afghanistan.

Lack of Postnatal Education

Another factor heavily influencing the adverse pregnancy outcomes is lack of education among Afghan women. The mixed-methods study of forty Afghan refugee women in Iran revealed that the highest postnatal information needs were about postnatal complications and postnatal self-care (Sharifi et al., 2019) A lack of maternal health education was rampant among pregnant refugees as well as illiteracy or low literacy among the women. Other results showed that "age and routine pregnancy care are predictive factors of postnatal information needs in Afghan women" (Sharifi et al., 2019, p. 237). Another study of 424 Afghan women refugees in the Tehran province had the exact same results: women were more likely to have adverse

pregnancy outcomes if they were illiterate, undocumented, and unemployed with a lower socioeconomic status (Dadras et al., 2021).

Other Factors Influencing Adverse Pregnancy Outcomes

Other factors associated with adverse pregnancy outcomes include intimate partner violence, food insecurity, and poor mental health (Dadras et al., 2021). More than half of the 424 women who filled out questionnaires reported one or more pregnancy complications in their most recent pregnancy. Of those women, fifteen percent of the women reported being abused during their recent pregnancy and fourteen percent of the women reported food insecurity (Dadras et al., 2021). Finally, more than sixty percent of women reported depressive symptoms during the last year (Dadras et al., 2021). The results determined that food insecurity significantly and directly influenced the occurrence of adverse pregnancy outcomes.

Stillbirth in Afghanistan

Stillbirth is an adverse pregnancy outcome that is addressed very poorly in Afghanistan. Interviews of 55 Afghan parents and healthcare providers in the capital of Afghanistan, Kabul, explored the experiences of the parents of babies that were stillborn and providers caring for parents of stillborn children (Christou et al., 2021). Several themes that emerged from this study paralleled Afghan women's frustrations with their perinatal care, including lack of information and insensitive communication. Failure of healthcare professionals in Afghanistan to inform parents of the status of their baby resulted in frustration and regret. The parents involved in this study desired to make memories with their baby before their stillborn child was taken away. However, this did not occur because the parents were not informed, and the baby was taken away before the parents knew what had happened to their child. In addition, lack of psychological support left the women confused and hurt. While the challenges and experiences described above

are in the Afghan context and their health care personnel and system need improvement, when the refugees arrive in the US, it is important to provide optimal care to them and treat them with the same level of dignity and respect as all other patients, communicating with them and providing culturally appropriate care (Christou et al., 2021).

Application to Healthcare Workers in the US

To provide culturally competent care to pregnant Afghan refugees, healthcare providers should educate themselves on the basic principles of care in the Muslim culture and the Islamic religion as well as the background and experiences these women are coming from. In addition, healthcare workers should understand how this knowledge applies to their care of pregnant Afghan women daily. Liminality, which is the process of transitioning between two places and describes the "in between" feeling, is what these women are experiencing when they migrate from their homes to a foreign culture (Pangas et al., 2019). Providing culturally competent care to these women will help them to feel more at home while also giving the excellent maternal care these women need. This is why culturally informed education of healthcare workers is essential to improve patient satisfaction and results.

Application Regarding Food Restrictions and Ramadan

There are several takeaways for healthcare providers regarding culture, religion, and background. First, hospital systems should offer halal foods, should have a method of guaranteeing to patients that the food provided is halal, and should have separate sections in the kitchen to prepare halal and haram foods. This will allow Muslim patients the freedom to consume foods during their stay, which will promote healing. If a woman is not consuming the food provided, healthcare providers should consider asking if the woman would like alternative foods, since what the patient was offered could be considered a 'cold food'. Because halal is a

critical component of the Islamic belief system, healthcare providers should make every effort to accommodate Muslim patients as they seek health care, including medications. Healthcare providers should have the knowledge and ability to prescribe halal medications and inform patients of the halal status of the medications to promote patient adherence, which is especially important during pregnancy. Healthcare providers should consider fasting during Ramadan not only when giving nutritional advice, but also when giving Afghan women prescriptions (Merits et al., 2018). For example, if a healthcare provider gave instructions to an Afghan woman to take medication at lunchtime with food, the woman may or may not be able to take the medication. Therefore, asking specific questions and adjusting orders could be beneficial when it comes to medication adherence. Healthcare providers should work to accommodate these requirements in order that these women have the medication and nutrition requirements met.

Applications Regarding Modesty and Language Barriers

The number of Muslims in the US continues to increase, creating an increased demand for healthcare workers to understand Islamic customs, including modesty standards. Medical examinations for prenatal appointments, childbirth, and postnatal checkups typically require women to uncover areas of their body that would normally be covered, presenting a challenge for healthcare workers. It is vital to preserve the modesty of Afghan women, while at the same time providing excellent care, which will require creativity and patience from healthcare workers. In addition, making sure the woman does not encounter a male healthcare worker if she is uncomfortable will help with providing culturally informed care to the patient. Helping preserve the woman's modesty is one way to make them comfortable. Additionally, it is essential to provide a translator for all communication. Even if a refugee speaks English, the assumption that

refugees can understand all medical terminology in English can be dangerous. Most hospitals pay for translator services, which should be used when providing care for all refugees.

Application Regarding Male Influence on Childbirth

According to an interview with a midwife, the proximity of men to the delivery room could impact how women act during birth. One midwife mentioned that women "mostly try to be quiet, because…of their husbands. Perhaps their husbands are outside, and they can hear your voice" (Merits et al., 2018, p. 17). Healthcare providers in the US must understand how men impact the behavior of their pregnant wives during delivery. If women do not act like they are in pain and do not request pain medication because their husband is nearby, they could not get the care they need. In addition, signs of pregnancy complications could be missed if women do not express pain or emotions during childbirth.

Application Regarding Education

Education empowers people to make autonomous decisions. One aspect of education that is essential to explain to Afghan refugees coming into the US is how to access, apply for, and properly use public health insurance. This could increase the number of refugee women receiving access to prenatal care, resulting in fewer adverse pregnancy outcomes and an overall healthier refugee population. In addition, educating and working with these women to find consistent transportation is essential for their own health and the health of their babies. A study of four hundred sixty-eight Afghan woman of reproductive age found that, "the use of antenatal health services was significantly associated with the educational level of the woman" (Van Egmond, 2004, p. 273). The same study found that the woman's schooling is associated not only with antenatal care, but also significantly associated with institutional delivery and use of skilled

attendance at birth. Education is a tool that promotes increased patient satisfaction and decreases adverse pregnancy outcomes.

Application Regarding Adverse Pregnancy Outcomes

Understanding what pregnant Afghan women have gone through in previous birthing experiences and the culture surrounding childbirth in Afghanistan can significantly help healthcare providers in the US better care for their Afghan patients. Intimate partner violence, food insecurity, and poor mental health are highly prevalent in refugee populations due to the traumatic events experienced and the relocations. Therefore, healthcare providers should be more vigilant to observe adverse pregnancy outcomes in Afghan refugee women. Providers in the US should be especially compassionate and caring to Afghan women who experience adverse pregnancy outcomes such as stillbirth and communicate what has happened to their child, giving them adequate time to grieve before the baby is taken away. Communication between patients and providers could significantly decrease adverse pregnancy outcomes and promote trust in the healthcare system by Afghan women.

Expectations of Afghan Women During Maternal Care

Much research has been done regarding nonrefugee women's satisfaction with maternity care, highlighting the areas the healthcare system can improve to provide better satisfaction (Shafiei et al., 2012). While maternity care satisfaction in women has been explored, fewer studies have emphasized the experiences of refugee women specifically due to difficulties with performing cross-cultural research. One mixed-methods study of forty Afghan refugee women in Melbourne, Australia however, sought to fill this gap by performing phone interviews and face-to-face interviews investigating refugee women's experiences with maternal care (Shafiei et al.,

2012). Two of the themes that emerged were the influences of interactions with the caregivers and the organization of care.

Interactions with Caregivers

All the women in this study mentioned the behavior and attitudes of the staff as an influential factor in their experience (Shafiei et al., 2012). While staff described as caring, patient, and kind provided positive experiences, staff described as unfriendly, rude, or uncaring did not provide positive patient experiences. Of the staff who were perceived as caring, the women mentioned that they appreciated when healthcare workers took time to listen to them and explain things to them (Shafiei et al., 2012). Giving adequate information to the women as well as giving choices was appreciated by these women. One refugee stated, "I'm very happy that I was given an option at 30 weeks; my baby was breech; I had my baby turned instead of cesarean section. I'm very happy to be given the option to choose" (Shafiei et al., 2012, p. 201). In contrast, the providers that were perceived as uncaring did not pay attention to the women's concerns. When healthcare workers did not give enough support during the childbirth process, the women expressed discontentment with the process (Shafiei et al., 2012).

Organization of Care

Interactions with caregivers are important to all women, including refugees (Shafiei et al., 2012). In the Afghan culture, where relationships are highly valued, it is even more important for caregivers to be intentional when attending to patients, listening to them, not appearing too hurried, and speaking kindly to patients. The other interesting theme noted in this study was the organization of care. Several factors the women mentioned were shared rooms, hospital food, busy staff, and staff shortages (Shafiei et al., 2012). Afghan refugee women appreciated the intentionality of the staff and explanations, which was more prominent when the environment

and care were organized (Shafiei et al., 2012). The women also expressed satisfaction with the hospital environment when they had a private room after birth and all female doctors (Shafiei et al., 2012).

Comparison of Experiences in Afghanistan Versus Australia

When Afghan refugees in Australia were asked how their maternal care compared to care back home in Afghanistan, the women were significantly more satisfied in Australia (Shafiei et al., 2012). The decreased satisfaction with maternal care in Afghanistan was primarily due to lack of resources in Afghan medical facilities (Shafiei et al., 2012). One woman mentioned a lack of pain medication during birth as well as a lack of a doctor during birth (Shafiei et al., 2012). In addition, the lack of technology in Afghanistan and the kindness of the nurses in Australia in comparison to Afghanistan was mentioned (Shafiei et al., 2012). This study is a model of how pregnant Afghan refugees have responded to positive maternal care that should be considered by health care providers in the US. Refugee experiences with maternal care in comparison to non-refugee women's experience with maternal care are overall comparable, with views of positive and negative experiences being similar. Healthcare providers should be intentional to provide supportive and kind care to all women, including refugee women.

Discussion

This extensive literature review only addresses maternal care, which is one aspect of women's health. Further research is necessary to investigate other areas of women's health to paint a comprehensive picture of Afghan refugee women's health. There was much research that addressed how culture affects healthcare, but not much research was present to investigate ways to enact change in the American healthcare system to make healthcare workers more culturally competent in their care of female Afghan refugees. Further research should explore the evidence

for culturally competent care to Afghan women and integrate that knowledge in the healthcare setting. The initial question of how healthcare providers in the US can recognize the unique health care needs of pregnant Afghan refugees was answered through the investigation of different aspects of maternal care in Afghanistan as well as an overview of how Muslim religious beliefs and traditions impact maternal care. It is feasible to present a training module to healthcare providers in the US with the purpose of teaching caregivers about Afghan culture in relation to pregnant Afghan refugees. Cultural training to healthcare providers would bring more awareness to the healthcare system and would enhance the experience and healthcare outcomes for pregnant Afghan refugee women.

Conclusion

Pregnant Afghan women refugees are coming from hardship, are not well educated, don't have the ability to seek health care, have past negative experiences with healthcare, and have a distorted perception of healthcare. Not only are their circumstances not conducive to quality maternal care, but the Muslim culture presents many barriers to overcome and navigate when providing health care to Afghan women, including modesty standards, nutrition accommodations, and religious beliefs, among many others. Understanding the background and culture of pregnant Afghan refugees will help healthcare workers provide culturally informed care to their pregnant female patients.

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