MANUAL

Culturally Sensitive Pregnancy Kit

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Preface

I would like to thank a few colleagues and other people who have contributed in some way to the realisation of this culturally sensitive pregnancy kit. Such a project is never the work of any one person.

First, I would like to express a word of gratitude to my direct colleagues: Kato Nackaerts, for her support and fine collaboration; Anggita Soeryanto, for her lovely illustrations; and Harlinde Exelmans, for her support and confidence in the project.

I am also grateful to the Fonds Dr. Daniël De Koninck and the Koning Boudewijnstichting, who have made this project possible.

Special thanks are due to the community health centres: Medikuregem and De Brug – Samira Gharbaoui and Catherine Geypen. Erasmus Brussels University of Applied Sciences and Arts (EhB) – Research group for Brussels Integrated Care – Florence, Katalina and Maaike, Universiteit Antwerp, Child & Family, Le coeur à marée basse, GAMS, Expertisecentrum Kraamvogel, Samen voor Respectvolle geboorte, Paola van der Staak and other partners who have helped either directly or indirectly in the realisation of the Culturally Sensitive Pregnancy Kit.

1. Introduction

Within the span of 10 years, the proportion of people with a migration background in Belgium has increased from one in four to one in three (Statbel, 2021). According to the World Health Organization (WHO, 2021), women account for more than 50% of the migrant population, and they are over-represented in vulnerable groups (80%). This has made Belgium, and particularly Brussels, into an international and ultra-diverse country and city. With 182 different nationalities, Brussels is the second most cosmopolitan city in the world (Venegas, 2021).

Belgium is regarded as a country with good social protection and high-quality healthcare. Nevertheless, not everyone has the same access to these services. Ethnic inequality in obstetric care is a reality in Belgium. Vulnerable pregnant women with a migration background experience greater health risks, due to less adequate prenatal and postnatal care, ignorance, language barriers and low socio-economic status. They are seldom able to find their own way within the healthcare system. With the Culturally Sensitive Pregnancy Kit, we aim to improve the quality of life and health skills during pregnancy (Ben Abdeslam, 2018; Schoenborn, C., De Spiegelaere, M. & Racape, J., 2021).

The unifying theme for the culturally sensitive pregnancy kit consists of the following:

- ✓ Health literacy (*Gezondheidsgeletterdheid*)
- ✓ Woman-centred care
- ✓ The 1001 critical days
- ✓ Health equality & culturally sensitive care
- ✓ Respectful birthing
- ✓ Every life matters: No discrimination at birth
- ✓ Empowering women & men in birthing

1.1 Vision

The Expertisecentrum Kraamzorg [Centre of Expertise for Maternity Care] Volle Maan is dedicated to providing information to vulnerable groups with regard to pregnancy, childbirth and the beginning of the post-partum period, thereby helping them to make conscious and well-informed choices for themselves and their families, regardless of origin, religion or background.

The first 1001 critical days are crucial in the development of a young child. The development of a baby's brain is influenced by mental, emotional and physical experiences that take place between mother and child from the beginning of pregnancy until the age of two years. These experiences have a life-long influence on the child's physical, mental and psycho-emotional health.

To this end, and based on the right to basic information, the Centre of Expertise aims to contribute to preventive health literacy and accessible information about the course of pregnancy, labour and the start of the post-partum period, taking into account the target group and language. This is accomplished within a safe group dynamic in order to achieve dialogue, to break through taboos and myths and to promote networking.

An additional goal is to increase the resilience of vulnerable women, men and young people towards their surroundings and caregivers, as well as to empower them so that they will be able to stand up for themselves and realise a respectful experience throughout pregnancy and birthing.

1.2 Objective

This protocol was developed for vulnerable target groups who have less developed language skills and who need to be supported with the use of visual figures reflecting the reality of perinatal care.

***Hanan**: I am extremely interested in and motivated to create a follow-up to the culturally sensitive contraception kit. I have been working on the development of a pregnancy kit that is accessible, visual and tangible, that takes societal developments into consideration and that is sensitive to diversity. In my experience as a midwife, I was often confronted by the many vulnerabilities of expectant mothers. The decisive factor that led me to develop the pregnancy kit was the research that I conducted for my Master thesis on the needs and requirements of mothers with a migrant background in Brussels. In the process, I was confronted with so many studies that repeatedly confirm the needs of vulnerable women and highlight the difficulty of translating them on the ground.*

***Quotes from interviews with mothers in Brussels (from the Master thesis)**:*

***Mother 5**: I would like to have had more information. I had questions, but I didn't have the courage to ask them. This was because I wasn't able to formulate the questions. I didn't really understand what the midwife had explained to me. I went to my check-up, but when I left, I didn't understand anything about it. It was purely a medical check-up.*

***Mother 3**: Things were not going well either physically or emotionally. I felt alone and abandoned! Pregnancy is the worst of all my memories…I have crossed the desert and sailed across the sea, but pregnancy is truly the worst thing I have ever encountered!! Pregnancy, no, that was much worse! The fear of losing my life or dying during the trip—I experienced that during my pregnancy as well. I was afraid of dying during the pregnancy, because I was losing blood the whole time!*

***Mother 6**: During the sixth month of my pregnancy, I went to the emergency department, and it turned out that I was under-nourished, and that was why I did not feel good. I did not have any food, and I couldn't pay for it. If the person with whom I was living had food on the table, I could eat too, but if there wasn't any food, I didn't eat. In the hospital, they gave me food and a bag of clothing for after the baby was born. They treated me, and I went home with vitamins the same day. I did not really have a problem, thank God. I was only hungry and hadn't eaten anything, so I was weak.*

Vulnerable pregnant women with a migrant background are at increased risk of perinatal morbidity and mortality, and they are more likely to experience adverse pregnancy outcomes and health risks. This is due to less adequate prenatal and postnatal care, ignorance, language barriers and low socio-economic status. They are seldom able to find their own way within the healthcare system. This has been confirmed in numerous studies, as well as in the practical experiences of our partners. These women need clear information that corresponds to their own reality and in which language does not pose a barrier. With the Culturally Sensitive Pregnancy Kit, we hope to respond to this need, thereby improving the quality of life and health skills during pregnancy and empowering vulnerable target groups (Ben Abdeslam, 2018; Venegas, 2021).

Changing behaviour requires more than providing information alone (education alone generates a behavioural change of only 20%). The manner in which information is presented makes a major difference. The following three adjustments can help to achieve a behavioural change of 60%: make the information tangible, personalise it, and include interaction.

It is also important to make a connection with the personal values underlying the behaviour. These

values can vary according to the audience. Social values are a major motivator, as are the enhancement of 'skill power' (knowledge, personal skills) and social motivation (Expertisecentrum Kraamzorg Volle Maan, 2021).

The kit is intended to make three contributions to education and behavioural change:

Knowledge: To impart **health literacy** in a comprehensible manner, **adjusted to the target group**: To use illustrations and demonstration resources to inform and empower women and raise their awareness with regard to the course of a pregnancy.

The kit contains information for **referrals**: Where can women go if they have questions or concerns, even after the information session? Pamphlets included in the kit provide information on specific organisations.

The third aspect involves encouraging the **exchange** of experiences, asking **questions**, discussing and **breaking through taboos**, and entering into **dialogue**. Briefly stated, it involves raising awareness and enhancing communication and social skills.

All three of these components are equally necessary in order to ensure that women have the confidence to make conscious for themselves and their families.

1.3 Delineation of the target group

We are living in an 'ultra-diverse' society. In addition to diversity in terms of origin, this refers to a high level of diversity within that diversity. There are 182 nationalities in Brussels alone. For this reason, the target group for this kit is difficult to define. Given the visual character of the Culturally Sensitive Pregnancy Kit, they can be used for a very broad audience.

We intend to reach roughly two target groups:

- Primary target group: Vulnerable pregnant women with language barriers and limited health literacy, as well as young people and people with mental disabilities, visual impairments and hearing impairments.
- Secondary target group: Professionals who are in contact with vulnerable women (and especially pregnant women). We provide them with visual, tangible and culturally sensitive materials that can be used globally and that pose no language barriers. Examples include various group sessions, schools, universities of applied sciences, community health centres, women's organisations, centres of expertise for maternity care, NGOs, refugee centres, Doctors of the World, midwifery practices, health professionals and all other first-line and interested parties.

2. Culturally sensitive approach

2.1 What is cultural sensitivity?

Culturally sensitive care is defined as ‘care that extends beyond the physical, social and psychological dimensions of the request for help to address cultural and ideological dimensions as well’.

Knowledge, skills and attitudes that are important to culturally sensitive care include:

- The importance of a common language
- Awareness of transference and counter-transference
- Awareness of the client’s own cultural background and social support system

Culturally sensitive care consists of being aware of the cultural colouring of social and healthcare services. This type of care in thus less a specialisation than a basic attitude. This attitude is just as important as the possession of knowledge or skills. Such an attitude and perspective are at the heart of culturally sensitive working methods (Thiers, 2019).

In addition to their cultural background, people are also shaped by various characteristics (e.g. age, social class, gender, sexual orientation, family situation, migration background, ethnicity, physical and mental abilities, education, geographic location, media use, residence status, language, health, religion, property, social development, nationality, skin colour). These are not simply ‘details’. They are axes of identity formation. They help to shape who we are and which positions we are assigned and can assume within society. Each individual is standing at the intersection of different axes of identity formation. Known as intersectional thinking, this perspective is a way of considering differences and power inequalities. All of these axes are linked to and have an influence on each other. Together, they determine our position, our behaviour and our thinking. The opportunities that we receive also depend on these axes. This is because society values certain characteristics more highly or considers them more as the norm than others (Expertisecentrum Kraamzorg Volle Maan 2021).

With the Culturally Sensitive Pregnancy Kit, we try to reason from the perspectives of different cultures and religions, with the sole objective of clarifying content and not to assign any stigmas. By no means a generalisation, it is intended to open the sensitivities that are at play in different groups to discussion through the exchange of knowledge, dialogue and mutual respect.

2.2 Culturally sensitive communication

Good care services depend on effective and appropriate communication. Moreover, communication is the most important key to working with people who are illiterate or with women whose native language is not the official or most commonly spoken language of the country in which they are living. When language barriers exist, the providers and recipients of care understand each other poorly, if at all, such that information is understand or transferred only in part. For this reason, migrant women are unable to express their needs, and care providers are incapable of making an accurate determination of the medical backgrounds of these women. Although it is easy to use relatives as interpreters, this is far from ideal. Professional interpreters and intercultural mediators, family assistance workers and supporting e-tools are necessary conditions for proper communication and care. Adapted models of care are advisable in this regard (El Bouazzaoui & Peters, 2017; Venegas, 2021; Ben Abdeslam, 2018).

Culturally sensitive communication involves more than merely trying to communicate verbally. It also entails considering the non-verbal communication, behaviour and attitudes of the participants. In various cultures, wisdom and knowledge are passed from grandparents to grandchildren either orally or through drawings. Stories and rituals occupy an important place within many Eastern and African cultures.

Non-verbal behaviour and communication with gestures should not be underestimated, and is important to take them into account, especially when working with people who are illiterate. Is the information that you are transmitting clear to the participant? Is interaction occurring, or is the participant merely nodding or not responding at all? These are important points to consider. Is accessible language being used and supported by visual materials? Anyone who will be counselling a group that may be facing language barriers should prepare well in this regard. Such preparations could include finding guest speakers who know the language, bringing in colleagues to help with interpreting or using e-tools. Matchen has developed a detailed pamphlet on e-tools that care providers can use to support communication with non-native speakers. Additional information is available through the following link:
https://drive.google.com/file/d/1pZpRCjrosg4lLo6cfirJQDPTDc6YF2nP/view

As health professionals, we often appear to be largely focused on protocols and not overly familiar. Our educational programmes have taught us to present ourselves as professionally as possible. With regard to developing a bond of trust, however, this could be less advantageous. The need to pay sufficient attention to the emotional aspect should not be underestimated—as we often do during informal conversations in the corridors or during break times. This is an important piece of information to consider when providing counselling services. Without allowing the emotional aspect, professionals are likely to come across as indifferent, and can make the care recipient feel unsafe, thereby making it impossible to create a bond of trust.

Emotions and storytelling—the narrative portion that is expressed through the non-verbal—should also not be underestimated. For example, this can also be experienced when wearing a face mask during the COVID-19 period. Our non-verbal facial expressions and communication are limited, resulting in a quite different form of interaction between the recipients and providers of care.

3. Using the pregnancy kit

The objective of the Culturally Sensitive Pregnancy Kit is to eliminate the need for a manual to use it. The kit is designed in a simple, modular fashion, and it can be used in accordance with the time that is provided for a group session. The figures are divided into the first, second and third trimesters, with accompanying tangible materials.

In the following section, we focus primarily on culturally sensitive topics/figures, as they often raise many questions out of ignorance. Care providers who will be using the kit are expected to possess the background knowledge concerning pregnancy and birthing that is needed to conduct a group session.

There are many methods and models for leading group sessions. Whichever method or model you use, the most important thing is to create a respectful framework and a group dynamic of exchange and dialogue. The facilitator/leader plays an important role in this regard. In collaboration with the Centre of Expertise for Maternity Care, Expoo has developed a protocol for facilitating perinatal group sessions that includes a variety of theoretical frameworks and methods to support facilitators/leaders during their perinatal group sessions. Additional information (in Dutch) is available at the following website:
https://www.expoo.be/train-the-trainer-draaiboek-perinataal-groepsaanbod.

3.1 Practical agreements for culturally sensitive group sessions:

Safety and trust in a group are the most important conditions for making it possible to have effective conversations about highly personal topics.

Given the importance that many people attach to hospitality, it is always a good idea to provide **catering**, with cookies or sandwiches (adapted to the group, as needed). This is a good way to attract participants.

It is also advisable to provide **childcare** whenever possible.

Care providers regularly report that members of vulnerable target groups often do not turn up for training sessions. It is important to bear in mind that most women in these groups were **not raised in a calendar-focused culture**. The best solution is to call or text them the day before the training to remind them.

Presenting yourself in an empathetic manner towards others and accepting them within an authentic and sincere attitude can create an atmosphere that allows open, honest communication.

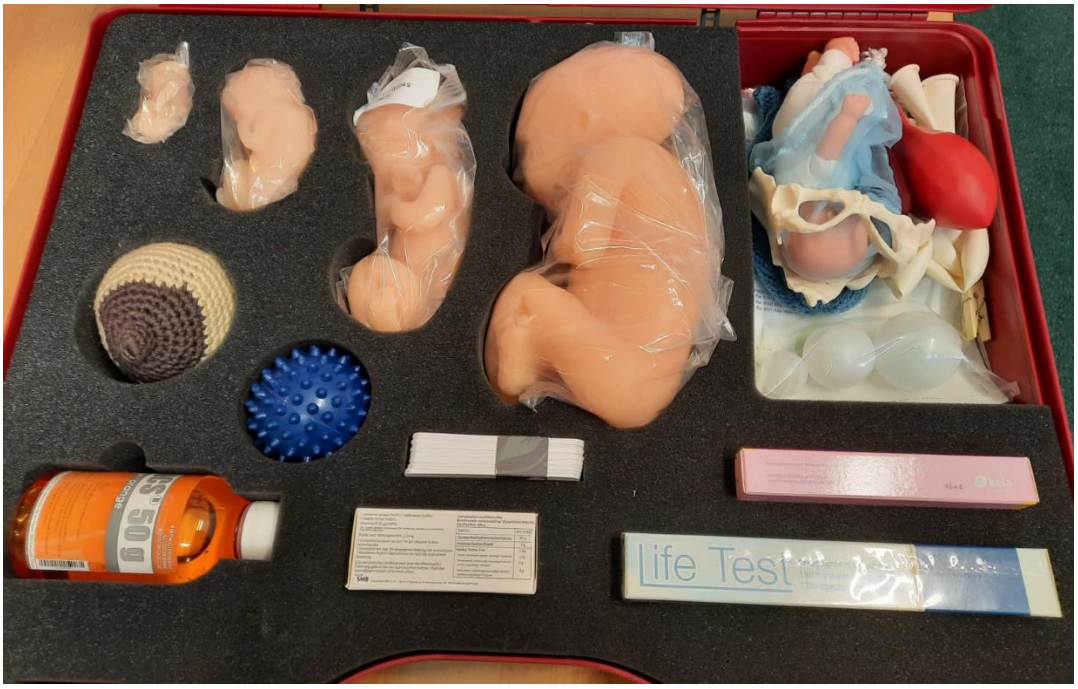
With **taboo-sensitive topics**, it is particularly important to pay attention to the group's **non-verbal communication** as well, in order to respect the boundaries of the participants. As a facilitator, this will make it possible for you to ask the group a question if you do not understand something that someone has said (e.g. 'I see that they do not agree with this statement or explanation. Is what I am saying right? Can someone explain it to me?') and allow the group to speak.

It is important to **be open to** dialogue and to listen carefully to what participants have to say.

Although a facilitator does not need to know everything about another culture or religion, be **curious** and to **ask questions**.

3.2 Tangible materials

Below, we present an overview of the materials in the kit, with reference to the accompanying illustration figures. A complete overview of the contents of the kit, including pamphlets and illustrations is provided in the appendix at the end of this document.



- Life Test pregnancy test (Figure 1)
- Folavit folic acid (Figure 2)
- Vitamin D (Figure 3)
- Foetal models (Figures 4 & 16)

  Indicate the size of a foetus at four different stages of pregnancy:

  1. 12 weeks (1st trimester)
  2. 16 weeks (2nd trimester)
  3. 22 weeks (2nd trimester)
  4. 30 weeks (3rd trimester)

- Clothes pegs and balloons (Figure 11 and the scale of emotions)

  The women can use the clothes pegs to indicate how they are feeling according to the scale of emotions. At the beginning of the group session, each participant receives a clothes peg. If they wish, they may write their names on the clothes pegs. Each woman may affix her clothes peg to the number on the scale of emotions that corresponds to how she is feeling at that time. Once all of the clothes pegs have been affixed to the scale of emotions, the conversation and exchange can begin.

  The balloons are another method for talking about emotions. The white balloons represent emotions that are experienced as positive or neutral. The red balloons represent emotions that are experienced as negative. Each woman chooses a balloon and inflates it to show the intensity with which the emotion is being experienced. If she likes, she may write the emotion on the balloon. The conversation follows. The following is an example: Samira chooses a red balloon and inflates it until it is almost ready to explode. She writes 'frustration' on it. You ask questions like: 'What is making you so frustrated?' 'What might help to keep you (and your balloon) from exploding?' 'Who or what could help you to let off steam?' Ask Samira to show how much this would help her by literally letting some air out of the balloon (make sure that the balloon has not been tied off). At the end of the conversation, you could ask whether she (and her balloon) are already feeling somewhat less tense for having talked about it for a while.

- Relaxation ball (Figure 12)

  This relaxation ball can be used to reduce the level of stress during pregnancy. The ball has spikes that stimulate mental peace when pressed against the pressure points on the hand. This ball can be used as a tool for reducing stress and coping with pain both during pregnancy and during labour.

- Glucomedics sugar drink (Figure 17)

- Breast model (Figures 25–27)

- Belly balls (Figure 26)

  Indicate the size of a newborn infant's stomach:
  1. Day 1
  2. Day 3
  3. Day 5

- Miniature model of baby, uterus and pelvis (Figures 37–38)

- Birthing plan card set (Birthing plan figure and dialogue)
  These cards can be used to start a conversation about choices and options during labour and delivery.

3.3 Illustration figures

In the following section, we provide details on several figures, along with additional background information, paying particular attention to the figures that touch upon culturally specific topics.

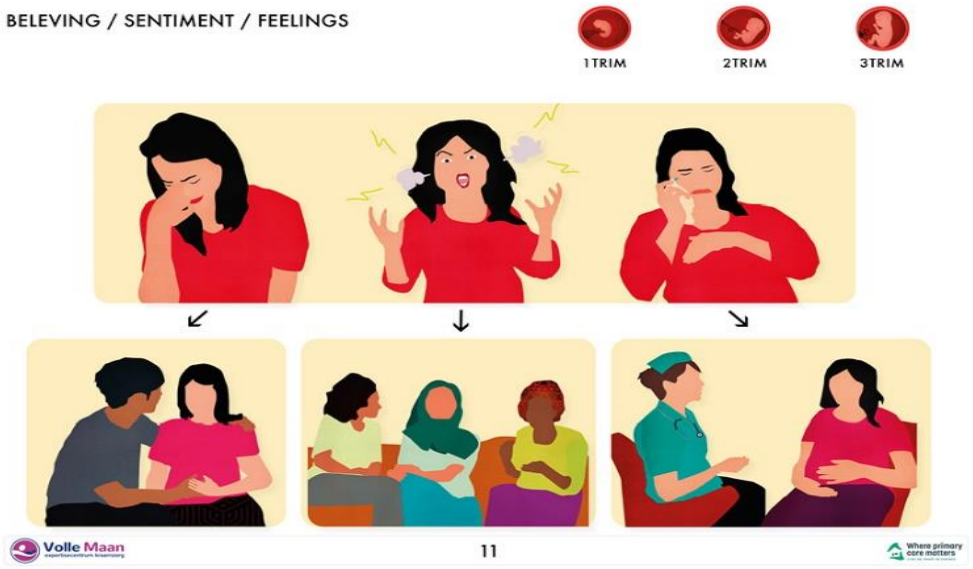
3.3.1 Emotions and experience

Scale of emotions

The first figure in the kit is the scale of emotions. This figure is quite useful as an icebreaker to create a group dynamic after a round of introductions. The emotional scale is used to address how pregnant women/participants feel with regard to emotions. This provides a good foundation for building a relationship and a bond of trust. Participants can use the enclosed clothes pegs to indicate numbers on the emotion scale, or they can express them in words.

The scale can be used throughout the kit to assess how the participants are feeling with regard to certain sensitive topics (e.g. fear of childbirth or traumatic experiences with genital mutilation). One condition is the creation of a safe atmosphere, and the facilitator/leader plays an important role in this regard.

Figure 11: Experience



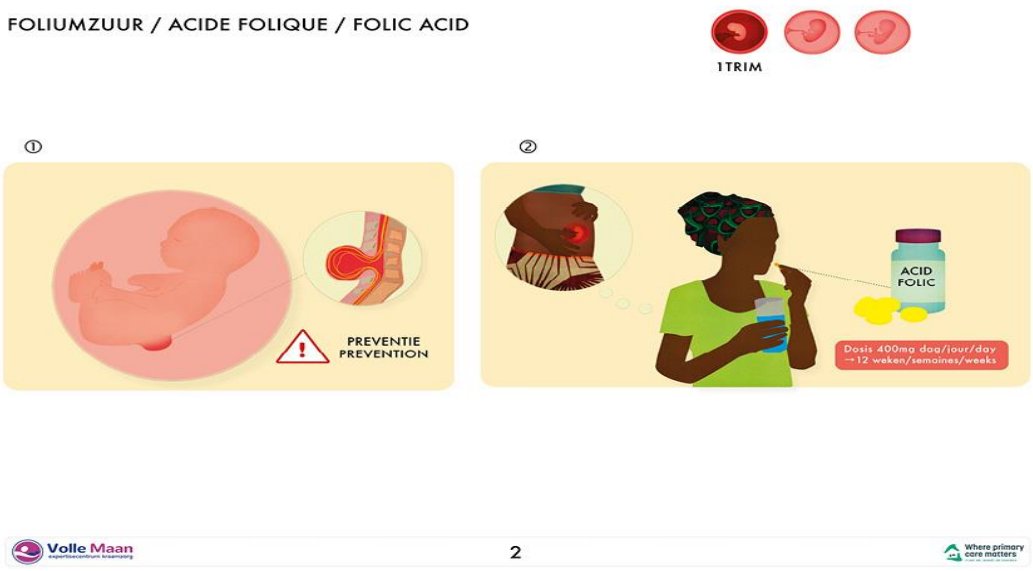
It is very important to pay sufficient attention to the woman's experience during pregnancy, especially in the case of psychological and socio-economic vulnerabilities. Hormones during pregnancy do not make things easier, as they tend to make women even more sensitive and vulnerable. Any additional physical and mental stress can have both short-term and long-term repercussions on the health of both mother and child (Rooseboom, 2018). This is precisely why it is so important to sufficient attention to these aspects, possibly using the scale of emotions.

Talking to a counsellor can be different for everyone. In Western societies, there is a lower threshold to talking with a partner or counsellor about troublesome matters. In a group-based culture, as found in many Eastern and African cultures, people are more likely to share emotions/experiences with women and relatives or acquaintances than they are to discuss them with their partners of care providers. Group-based information sessions create a dynamic that mimics the family, especially when like-minded people are present and a confidential setting is created. Figure 11 displays several options for discussing feelings and highlights the importance of taking the 'I culture' or the 'we culture' into account, depending on the group to be facilitated.

3.3.2 Self-care during pregnancy

We deliberately developed multiple figures on self-care in order to direct sufficient attention to this topic. Vulnerable women are sometimes more occupied with solving problems related to basic needs than they are with caring for themselves and their pregnancies. Given that the long-term physical, mental and cognitive health of a child is determined by the first 1001 critical days, the importance of self-care during pregnancy should not be underestimated. Migrant women are vulnerable to a variety of conditions that are not common in the indigenous population. This is reflected in the following figures.

Figure 2: Folic acid

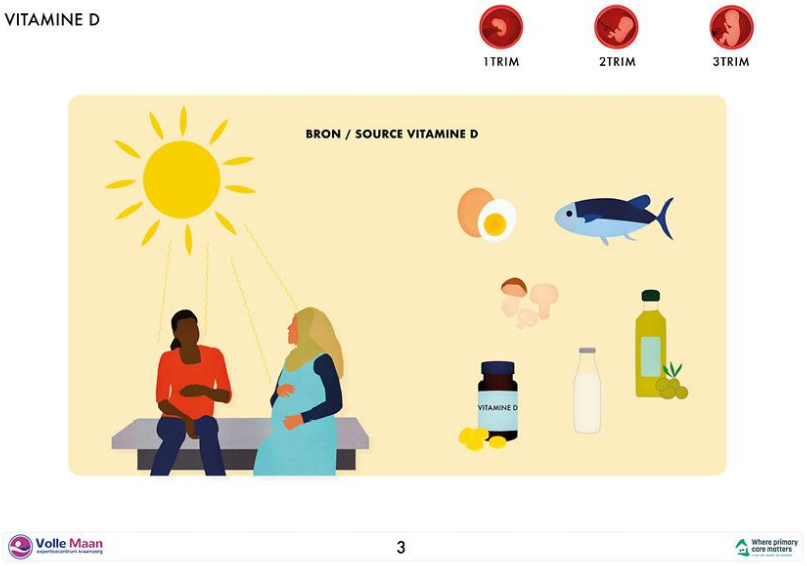


Folic acid is an important vitamin that should be taken by women wishing to have children and by women in the early stages of pregnancy in order to prevent neural tube defects. In order to build up a sufficiently high concentration, it is advisable to start taking folic acid one month before pregnancy occurs.

It is best for a woman to take folic acid (0.4 mg) every day from the moment at which they decide that they want to have children and discontinue their contraception until the third month of pregnancy. For additional information on this point, see the information pamphlet in the pregnancy kit and (in Dutch) at www.gezondzwangerworden.be/foliumzuur (Agentschap Zorg en Gezondheid [Flemish Agency for Care and Health], 2021).

High-risk groups, including women with haemoglobinopathies (e.g. thalassaemia and sickle cell anaemia) should take additional folic acid. This underscores the importance of information. It is best to refer women whom might have thalassaemia or sickle cell anaemia to refer to the general practitioners or gynaecologist.

Figure 3: Vitamin D



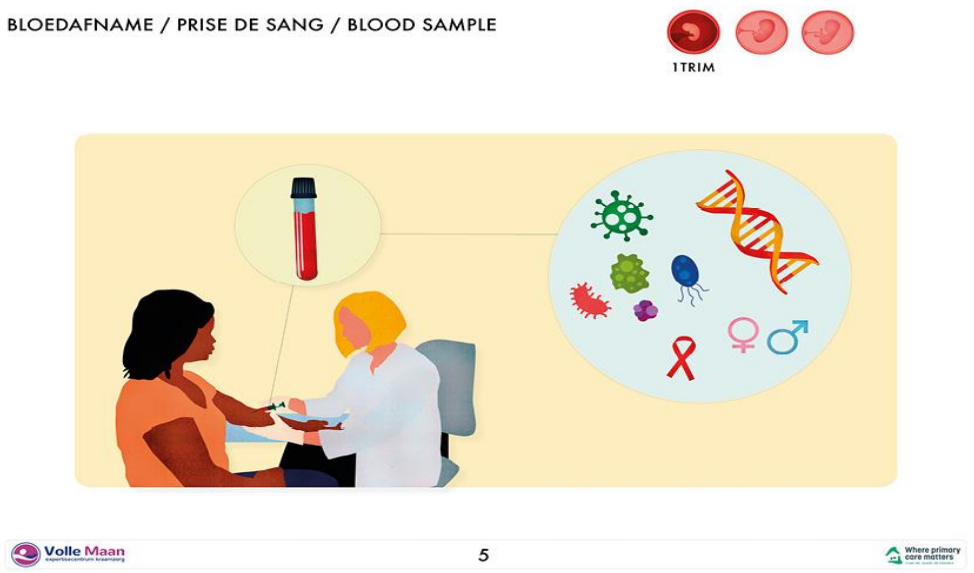
Women from the Middle East and of South Asian, African or Caribbean origin belong to high-risk groups for vitamin D deficiency, as do vegans, obese people and people with very little exposure to sunlight.

Vitamin D stimulates calcium absorption in the intestine and thus the retention of bone mass. Chronic vitamin D deficiency leads to weak bones, as well as to muscle and joint pain.

The recommended daily allowance (RDA) of vitamin D for pregnant women is 20 µg (800 IU). Vitamin D supplementation during pregnancy can reduce the risk of symptomatic neonatal hypocalcaemia. It might also improve the pregnancy outcomes of low-risk women as well (Agentschap Zorg en Gezondheid, 2021).

During the information session, try to emphasise the importance of prevention through sufficient exposure to sunlight and go sufficient intake of foods such as fish, meat, eggs, mushrooms, olive oil, fish oil and milk, with vitamin D supplementation, if necessary.

Figure 5: Blood samples



Blood samples are part of basic care for pregnant women. During pregnancy, blood samples are taken in order to test for many things, including blood type, rhesus factor, hepatitis B, rubella, syphilis, HIV, anaemia, haemoglobin, iron content, ferritin, complete blood formula and glucose.

Anaemia or haemoglobinopathies (e.g. **thalassaemia** and **sickle cell anaemia**) are common in women with a migration background. This matter also deserves due consideration when explaining blood analyses.

What is the difference between sickle cell anaemia and thalassaemia?

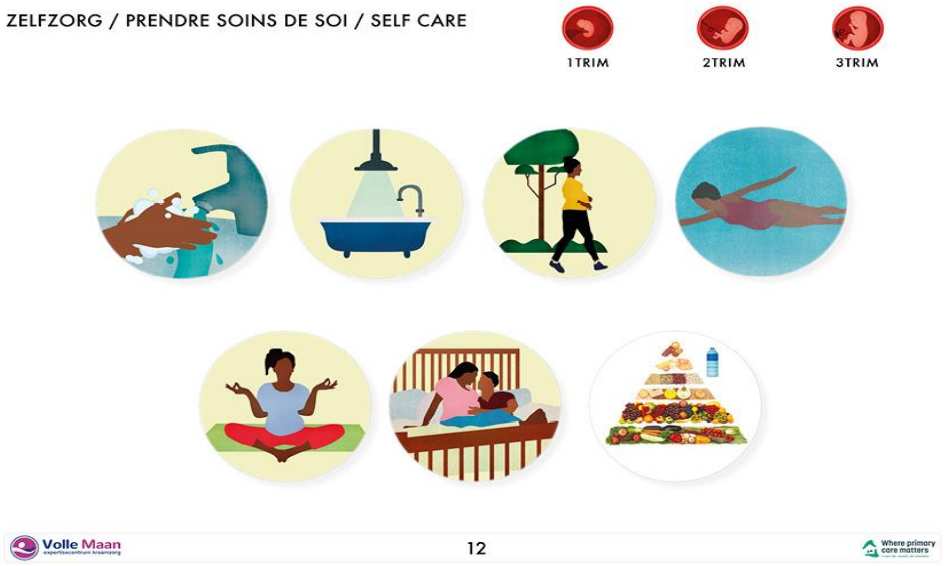
Thalassaemia is a condition characterised by anaemia and its consequences for growth and development. This can be improved with blood transfusions. Without such transfusions, children will experience poor development and poor growth. **Sickle cell anaemia** is accompanied by many other, more acute complications (e.g. pain complications, organ complications) that cannot always be resolved with transfusions. Thalassaemia is thus a transfusion-dependent disease, while sickle cell anaemia is a chronic condition that certainly not always be resolved with transfusions. It occurs primarily in people from Africa, Asia or Mediterranean countries (Artsen voor Kinderen, 2021; Simpto, 2021).

Women with **thalassaemia** are advised to take higher doses of folic acid throughout the **entire pregnancy**. Increased folic acid intake is advised **for life** in case of **sickle cell anaemia**. Referral to a specialist (i.e. haematologist, possibly together with gynaecologist) is indicated (Agentschap Zorg en Gezondheid, 2021).

Sufficient consideration and **information** should be devoted to pregnant women (or women wishing to become pregnant) with regard to what will be examined in the blood samples, so that the proper (and customised) **lifestyle recommendations** can be made (e.g. in case of

toxoplasmosis, anaemia), as well as further referrals, if necessary.

Figure 12: Self-care



As mentioned earlier, vulnerable pregnant women are sometimes more concerned with solving problems related to their socio-economic situation and their basic needs than they are with themselves. The chronic stress associated with this situation can have a wide range of health consequences for both mother and child. If a woman is experiencing stress due to her socio-economic situation (e.g. lack of shelter, food, income), it is important to know the local facilities in order to make targeted referrals.

During an information session, take time to talk about self-care, self-respect, empowerment, network and similar matters. It is important to help women learn to know and set their boundaries, as that is also the foundation of self-care. Brainstorm together with women about what they like to do to relax, thus helping them to become aware of their self-care tools.

Figure 12 supports this conversation with images about hygiene, hiking/nature, swimming or other forms of light exercise, meditation/relaxation/mindfulness, intimacy, healthy food and similar topics.

Figure 14: Self-care

This figure demonstrates how **environmental factors** can have an influence on the health of mother and child. These factors include **smoking**, including passive smoking (e.g. from a partner or shisha (smoking tobacco through a water pipe), **alcohol**, **drugs**, **X-ray**, **medication** and **violence**.

Partner violence in the perinatal period

The drawing in the lower right of Figure 14 addresses partner violence. In order to talk about partner violence, it is especially important to create safety within the group. Start by framing the topic properly by announcing that it will be a difficult topic. Tell the participants that they are free to share what they would like to share, but that they are not obligated to share anything. 'We respect our own boundaries and those of others'. It is also advisable to agree that everything that is said is confidential and will stay within the group. As a digital tool, use videos from https://www.we-access.eu about forms of violence and referral to counselling (see also poster in the pregnancy kit).

What is partner violence? A definition.
Partner violence: A set of behaviours, actions, attitudes, or threats thereof, by partners or ex-partners, that could potentially or that actually do harm to the other partner (physically, psychologically, economically and/or sexually).

Which forms of violence are there?

1. Physical violence: the intentional use of physical force by acts that could result in damage, injury, disability or death (e.g. scratching, pushing, biting, burning, binding with rope).

2. Sexual violence: using physical force to compel the other to engage in sexual activity; trying to engage in sexual activity with someone who cannot understand (e.g. someone under the influence of drugs, someone with a disability); or abusive sexual contact.
3. Gender-related violence (e.g. female genital mutilation)
4. Psychological/emotional/verbal violence: causing psychological damage through coarse language, threats or coercion (e.g. humiliation, controlling, belittling, isolation, withdrawing access to money).

A few interesting facts

- Women are not only victims. One in every 10 men is a victim of partner violence. In many cases, both partners use violence, each reacting to the other.
- Although violence occurs in segments of the population, low income is a risk factor, increasing the likelihood of being a victim of violence by 3.5%.
- Physical violence often declines sharply during pregnancy, while psychological violence continues.

Consequences of violence for pregnancy

The direct consequences of partner violence are well known (e.g. wounds, bleeding, fractures). Violence can also have important indirect consequences, however, including an enormous increase in stress and unhealthy coping strategies (e.g. junk food, drugs), even in the case of 'mild' forms of violence.

This causes a wide range of e.g., negative consequences for the foetus/child. Examples include poor weight gain, miscarriage, prematurity, infections, unwanted pregnancy, placental abruption and maternal death. The woman's stress hormones enter the placenta and affect the brain of the foetus. This can lead to attention problems, anxiety, psychopathology and other problems for the child.

Where can people go for help?

- The police or the general practitioner
- https://www.we-access.eu - Videos on types of violence and referral to counselling (see also the **poster** in the pregnancy kit).
- 1712 > Home - Professional assistance line for questions about violence, abuse and child abuse.
- https://www.caw.be/ - Victim assistance services
- https://www.tele-onthaal.be/ - Help line for a listening ear in an anonymous conversation
- https://www.seksueelgeweld.be/ - Reporting of and assistance after sexual violence

(Van Parys, 2020; Van Cauwelaert, 2019)

3.3.3 Ramadan and pregnancy

Situation

Ramadan or fasting entails the obligation to refrain from eating and drinking from sunrise (Suhur) until sunset (Iftar) for a month. Ramadan is one of the five pillars/commandments of Islam, in addition to pilgrimage, prayer, alms and profession of faith. During this month, fasting is compulsory for all Muslims who are in good health.

Some are exempted from fasting, however, including elderly people, sick people (either physically or mentally), travellers, pregnant women, nursing mothers, children and menstruating women, including those with postnatal bleeding. Any days that are missed are made up later, once the person is able to do so. If the person is unable to do so, a charitable donation can be made to the poor to make up for the missed fasting days.

For Muslims, the purpose of fasting is to reflect spiritually, purify the body, control the self, empathise with the lives of the poor and take action in this regard.

Care providers and practice

Health professionals are increasingly confronted with pregnant women who wish to participate in Ramadan, but who do not always know how to answer their questions, due to ignorance. Studies have also indicated that pregnant women do not always dare to ask for advice, for fear of rejection or disagreement between the pregnant woman and the care provider.

Is Ramadan healthy?

The scientific community has already examined the possible risks of fasting during pregnancy. Some studies indicate a risk of low blood sugar, low blood pressure, nausea, acidification of the blood, lower birth weight and reduced lactation. Other research has shown that fasting has no demonstrable negative effect on birth weight and that more research is needed to determine the perinatal effects (Glazier et al., 2018).

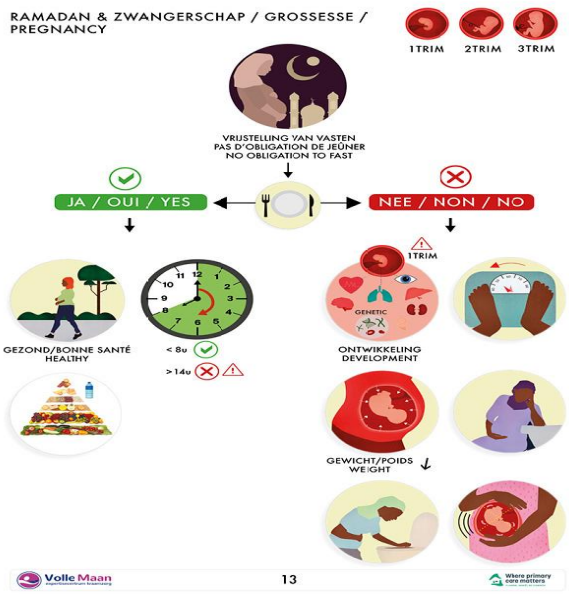
Pregnant and lactating women are exempt from Ramadan. In reality, however, pregnant women are often observed participating in Ramadan, despite knowing that about this exemption. This is not always without risks.

Is it or is it not advisable for a pregnant woman to participate in Ramadan? It depends on the woman's stage of pregnancy and her state of health, both physical and mental. It is also necessary to determine whether the fasting days are long or short, as well as the woman's socio-economic situation and whether there are any stressors. Each case is thus unique, and customised counselling with appropriate advice (including with regard to lifestyle) is important.

For a woman who has fasted for much of her life, it is not easy to refrain from fasting during pregnancy, despite the exemption. It remains an important social event for her. In some communities, there is even a social pressure that can influence the decisions of pregnant women, but this is more of a cultural phenomenon than a religious duty. Health professionals should try

to identify the exact reasons why a pregnant woman wants to fast and which feelings or needs are behind her motivation, and then provide guidance/coaching in this regard. Figures 13 and 28 can provide support in an information session.

Figure 13: Ramadan and pregnancy



The upper circle with the drawing of a woman indicates that a pregnant woman is exempt from fasting in Islam, but if the woman in question still wishes to fast, she should do so. In this case, discuss the conditions 'yes in green' on the left and 'no in red' on the right.

Ja/Oui/Yes

This means that, if the woman still wishes to fast, the following conditions should be met:

- The woman should be in good health and have no pregnancy-related complications.

- The fasting days should be short—less than eight hours. In the winter period, the time between sunrise and sunset is shorter. In recent years, however, the Ramadan period has fallen during the summer, when the days are long. Fasting is therefore not advisable for women who are pregnant or lactating. Fasting for more than eight hours requires an enormous amount of energy from a pregnant woman: the metabolism switches over to burning fat starting with 12–14 hours of fasting, and long periods without fluid intake are not recommended during pregnancy.

- The woman should have a healthy lifestyle and nutrition. It is important to pay sufficient attention to providing pregnant women with lifestyle information, in addition to asking them to describe their meals during a fasting day, and especially whether they are balanced and sufficiently healthy. Stress the importance of fluid intake, nourishing soups, a few dates and healthy, light meals between sunset (Iftar) and sunrise (Suhur). The pregnancy kit includes a nutrition triangle poster that can be used as a support during group (or individual) sessions. After the interview, if it appears

that the mother does not have a healthy lifestyle, there are several possible courses of action, depending on her socio-economic situation. Poverty can also be a cause of malnutrition, in which case referrals can be made to actors who distribute food parcels. If poverty is not involved, one option could be to involve a dietician to help her further, taking into account that the dietician in question has affinity with various groups.

- The mother should be made aware that she should listen to her body and end the fast if she does not feel well.

Nee/Non/No

- Fasting is not recommended during the first trimester of pregnancy, as these moments are essential to the development of the foetus (e.g. organ development, neurological development), and fasting could therefore have long-term effects, including an increased risk of diabetes, obesity, vascular and heart diseases.

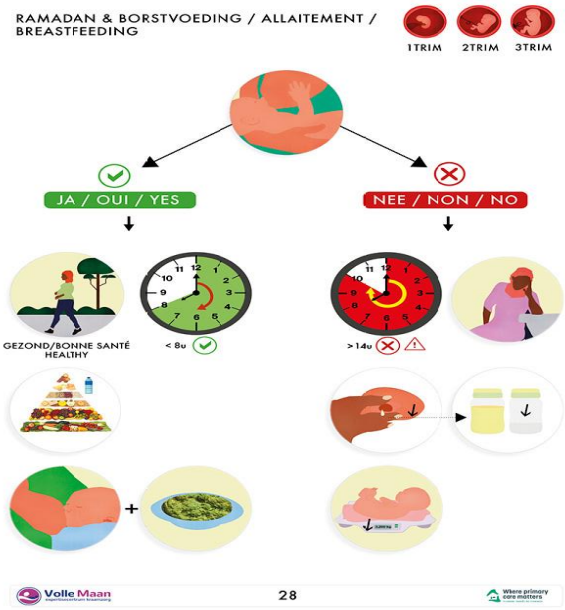
  One example that is familiar to many is the Hunger Winter of 1944/1945, a period of extreme famine in the Netherlands. Studies on the Hunger Winter have demonstrated that malnutrition during pregnancy has lasting effects on the health of the child, and even on the health of her grandchild (epigenetics). The effects of hunger were greatest when malnutrition occurred in the very early stages of pregnancy. It is during this time that the vital organs (i.e. heart, brain and liver) are being constructed. Decades later, this led to disrupted blood coagulation, higher cholesterol and glucose levels, poorer performance on memory tests, more cardiovascular diseases, higher mortality and even higher stress sensitivity during life events, with consequences including reducing employment opportunities.

  Recent studies have also shown that babies who were smaller at the first 12-week ultrasound scan after conception—without this being reflected in their birth weight—have higher blood pressure later on and are more likely to be obese. In addition to extremely poor conditions, even normal variations in earlier development can affect the health of the child (Rooseboom, 2018; de Koning, 2021).

- For long fasting days of more than 12 hours.

- In case of physical or mental complaints:
  - Weight loss in both mother and child due to malnutrition
  - Fatigue a feeling of unwellness
  - In case of nausea/hyperemesis gravidarum, gestational diabetes, hypertension and hypotension, intrauterine growth restriction (IUGR) and other complications during pregnancy
  - Decreased movement of the child

Figure 28: Ramadan and lactation



Like pregnant women, lactating women are exempted from fasting. If they nevertheless wish to fast, Figure 28 can be used to help discuss the conditions with them.

Ja/Oui/Yes

If a woman nevertheless wishes to fast, it is important to discuss certain conditions:

- The woman should be in good health and have no complications.

- The fasting days should be short—less than eight hours.

- The woman should have a healthy lifestyle and nutrition. It is important to pay sufficient attention to providing information on lifestyle of both mother and child (see also above for healthy lifestyle suggestions during pregnancy).

- Breastfeeding should be combined with solid food starting at six months.

- The mother should be aware that she should listen to her body and stop fasting if her milk production decreases or if her physical or mental condition deteriorates.

Nee/Non/No

- For long fasting days of more than 12 hours.

- Physical and/or mental complaints, or if there are signs of dehydration on the part of either mother or child. If the mother's or child's urine is dark or has a strong odour, this is a sign of insufficient fluid intake. In that case, the recommendation is to discontinue fasting.

- Decreased or difficult milk production.

- Weight loss in the child.

(Kridli, 2011; Glazier et al., 2018; Oosterwijk, Molenaar, van Bilsen, Kiefte-de Jong, 2021; Zoukal & Hassoune, 2019).

3.3.4 Diabetes and pregnancy

What is gestational diabetes?

The body undergoes many changes during the period of pregnancy. Many hormones are released that reduce the effect of insulin in the body. Under normal circumstances, the pancreas would produce additional insulin. In the case of gestational diabetes, however, this does not happen, thereby causing the blood glucose level to rise.

Gestational diabetes disappears after pregnancy due to the loss of the placental hormones. Gestational diabetes is usually temporary and disappears once the hormonal situation returns to normal after the baby is born. This is because the body produces fewer hormones again after pregnancy.

Although prevalence figures in the literature vary widely (from 1% to 14%), the prevalence in Flanders has been reported to be approximately 9.5% (Vandenhaute, 2018; Diabetes Liga, 2021).

When is it diagnosed?

Between 24 and 28 weeks of pregnancy, a challenge test is conducted with 50g of glucose (non-fasting) or, in case of high risk, an oral glucose tolerance test (OGTT) is carried out immediately with 75g of glucose (fasting). See Figures 17 and 18 for the values and to prepare a pregnant woman for the test.

Treatment for high values

- Doctor's recommendations
- Follow diet and exercise
- Measure glycaemia
- In some cases, insulin or medication
- Follow-up by physician, diabetes nurse and dietician

Complications for mother and child

- Large or too small baby
- Prematurity or miscarriage
- Excessive amniotic fluid
- Pre-eclampsia
- Obesity
- Greater chance of artificial delivery or caesarean section
- Hypoglycaemia in the baby
- Greater chance of Type 2 diabetes
- Shoulder dystocia

Who is at greater risk of gestational diabetes?

- Women who have previously had gestational diabetes
- Women who have previously given birth to a child weighing more than 4kg
- Women with obesity or an unhealthy lifestyle
- Women older than 35 years
- Women with a father, mother, brother or sister with Type 2 diabetes
- Women from the Middle East, North Africa, Turkey and Hindustan
- Women with high cholesterol or high blood sugar

Origin and diabetes

Studies have indicated that **migrant women are at higher risk** of **gestational diabetes** than are indigenous women, with unfavourable pregnancy outcomes. This once again emphasises the importance of health literacy and targeted diversity-sensitive campaigns for both health professionals and the target group itself (Al-Rifai et al., 2019; Kragelund Nielsen, Andersen, Damm, Andersen, 2021).

Figure 17: Diagnosis of diabetes

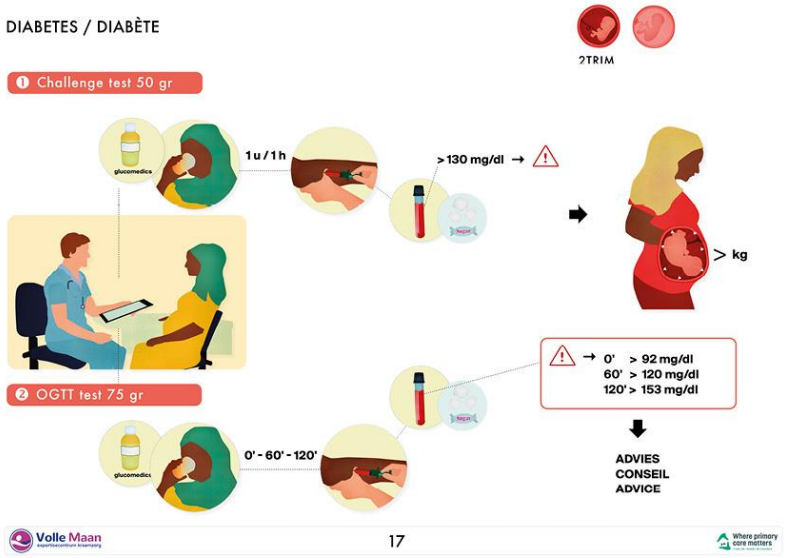


Figure 18: Treatment of gestational diabetes

Figures 17 and 18 can be helpful for providing information on the diagnosis of diabetes and on treatments for gestational diabetes. It is important to detect possible risk factors for gestational diabetes as early as the first trimester. This makes it possible to make timely referrals and, above all, to provide preventive lifestyle advice based on the nutrition triangle, the exercise triangle and the *Zoet Zwanger* [Sweet Pregnant], all of which are included in the Culturally Sensitive Pregnancy Kit.

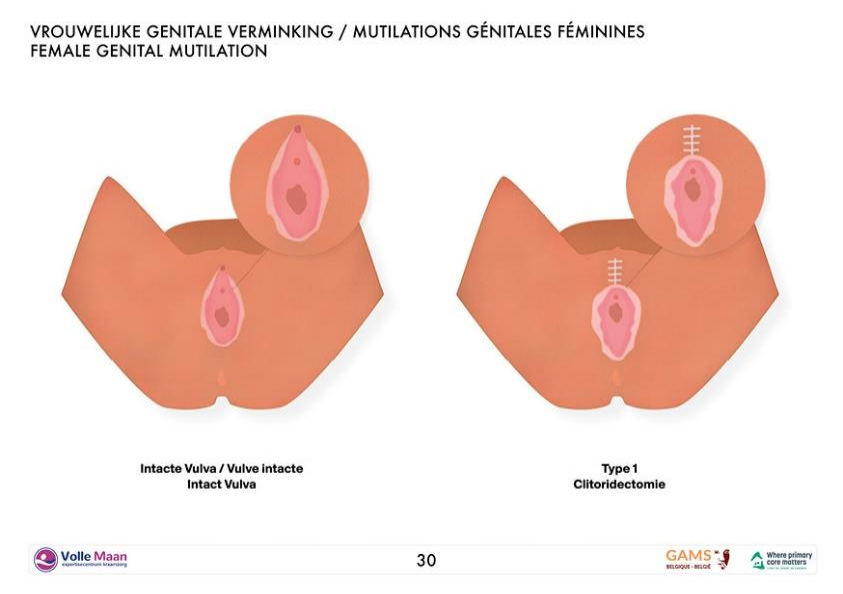
3.3.5 Female Genital Mutilation (FGM)

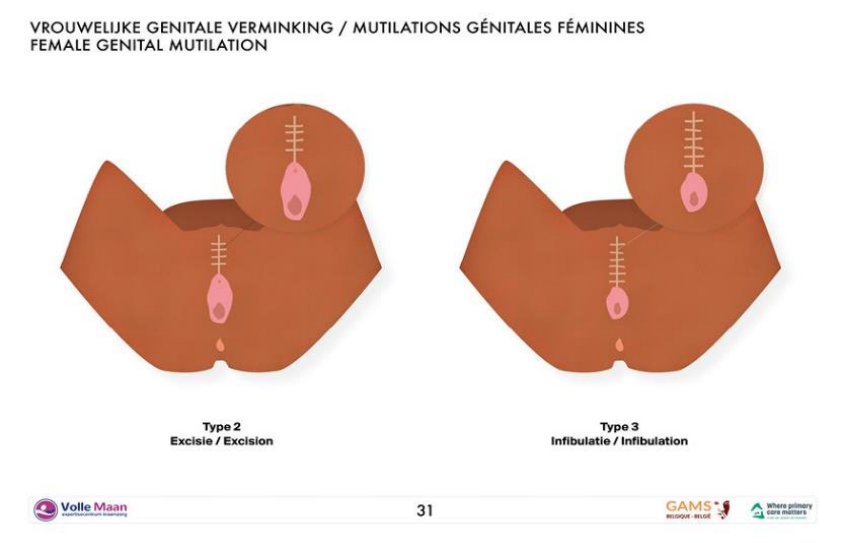
Situation

According to the World Health Organization, 'female genital mutilation (FGM) comprises all procedures that involve partial or total removal of the external female genitalia, or other injury to the female genital organs for non-medical reasons' (WHO, 2008).

At the end of 2016, there were more than 17,000 circumcised women in Belgium, and 8,000 girls were at risk. Each year, more than 1,400 circumcised women give birth in Belgian maternity hospitals (Dubourg & Richard, 2018; GAMS, 2019).

Figures 30 and 31: Types of FGM





The various forms of FGM have been grouped into four types, as presented in Figures 30 and 31. This classification was adjusted in 2007 (GAMS, 2019).

- **Type 1** or clitoridectomy is the partial or complete removal of the clitoris and/or the foreskin of the clitoris.
- **Type 2** or excision is the partial or complete removal of the clitoris and the labia minora, with or without removal of the labia majora.
- **Type 3** or infibulation is the narrowing of the vaginal orifice by removing the labia minora and/or labia majora and suturing the remaining tissue shut, with or without removal of the clitoris.
- **Type 4** comprises all other harmful procedures to the female genitalia for non-medical purposes (e.g. pricking, piercing, incision, scraping and cauterisation).

Figure 32: FGM and pregnancy

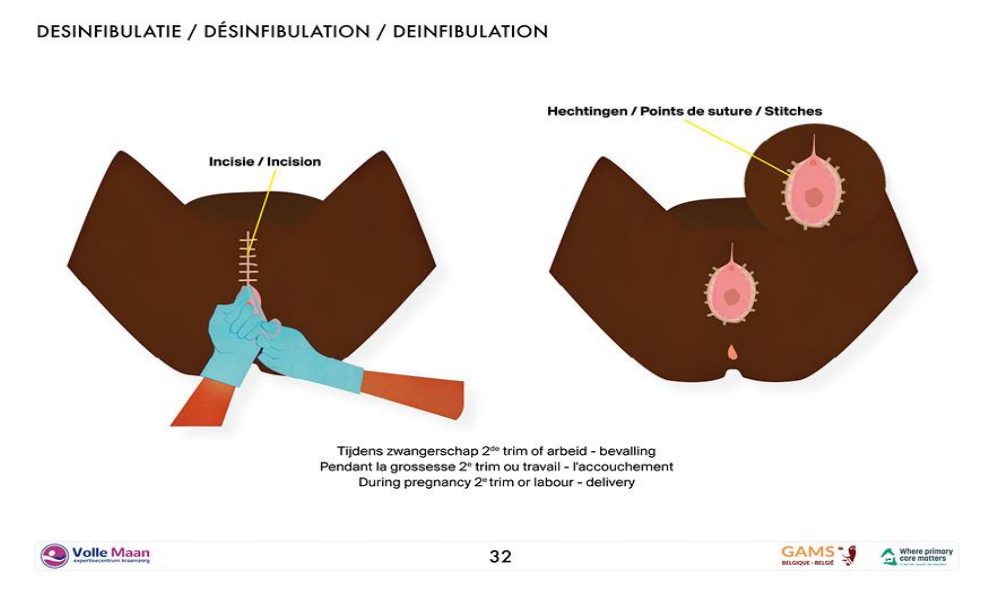


Figure 32 indicates how and when disinfibulation can be performed. It is advisable to start talking about FGM as soon as a woman has decided that she wants to have children or in the first trimester of pregnancy. In the first trimester, vaginal examination should be done to diagnose the type of mutilation, for possible referral, or to prepare for disinfibulation during the second trimester or during delivery. It is important to ensure timely follow-up with the woman, given the physical consequences and psychological traumas that may surface.

For comprehensive information on FGM and pregnancy, read the attached GAMS protocol for counselling pregnant women with genital mutilation.

Case discussion of pregnancy and FGM

A 16-year-old girl comes to the practice in preparation for her delivery/post-partum period. The hospital has indicated that she knows little about what to expect. She speaks mostly Somali, so I get a Somali interpreter to make sure she understands all the information.

In addition to her questions and basic information, we also discuss FGM. We use the figures from the Culturally Sensitive Contraception Kit to discuss the various types of FGM, and I ask her if she knows which variant has been performed on her.

She cannot tell me, but this is obviously very important for her partus. Given that she will be having another consultation soon, I prepare her by letting her know that I would like to do a vaginal examination. She agrees to this.

The next time, I see that she has a circumcision between Type 2 and Type 3, with partial pseudo-infibulation towards the vagina. I then contact the hospital that is monitoring her. The reference gynaecologist has no place for her delivery and does not reply to emails. The social assistant

reports, 'She became pregnant spontaneously, despite using a condom. There has thus been some form of penetration. It is therefore unnecessary to do anything before the partus'.

The gynaecologist to whom I normally refer, Dr X, is not allowed to accept clients who do not need urgent medical attention at that time, due to COVID-19 (beginning of the coronavirus pandemic in 2020). As a result, this lady unfortunately had no proper consultation concerning her FGM before giving birth.

She then gave birth with a ventouse (due to maternal exhaustion), without any clipping of the pseudo-infibulation or partial infibulation. She also did not have an episiotomy, which is common for a ventouse. The father indicated that it was not going to fit, and asked if they should not clip it. This was not done. Subsequently, a total rupture occurred. The stitches also caused a considerable amount of infection afterwards.

Although discussions were held after the delivery, they were aimed primarily at prevention, and the woman in whom the FGM had already been carried out did not receive the proper discussions or counselling. After a period of recovery, she did go to see Dr X, and she did have the necessary conversations with another GAMS employee. The hospital also paid more attention to the client's minority (suspicion of forced marriage) than it did to any mistakes that might have happened during the monitoring of the woman.

It should have been considered earlier whether disinfibulation would have been useful before or during partus. (Van der Staak P., P.C., September 2021)

Questions to discuss in the group:

- When you read this case, what effect does it have on you as a health professional?
- Have you ever encountered a case of FGM?
- How did you address this, or how would you address it as a health professional?
- Is the service for which you work as a health professional sufficiently prepared for women with FGM?

For answers, be sure to read the attached GAMS protocol for professionals on counselling pregnant women with genital mutilation. A few more interesting links:

https://gams.be/nl/
https://gams.be/nl/de-dialoog-over-desinfibulatie-tot-stand-brengen/
https://www.we-access.eu/nl/videos

3.3.6 Birthing plan

Birthing plan and dialogue

The 'birthing plan' and 'dialogue' figures were developed in cooperation with *Samen voor respectvolle geboorte* [Together for respectful birthing] and *Le coeur à marée basse* [The heart at low tide]. These figures are intended to prepare women for labour and delivery in a respectful way and with as much dignity as possible. Above all, we would like to help them to make conscious choices and to experience as little anxiety and stress as possible, depending on the context and environment within which they will be giving birth.

Studies have indicated that women of lower socio-economic status, migrants or women with low

levels of literacy from ethnic minority groups often encounter less adequate care, as well as discriminatory and denigrating remarks. (Ben Abdeslam, 2018; Van Cauwelaert, 2019; Schoenborn, De Spiegelaere & Racape, 2021).

Discussing birthing plans in group sessions makes the conversation stronger, as it creates group awareness and exchange amongst women. They can discuss what they take away with their health professionals during subsequent medical examinations. The figures and birthing cards in the pregnancy kit can be used to make women aware of their rights and choices during labour and delivery.

What is obstetric violence?

At this point, we would like to devote some space to obstetric violence. By acknowledging that this exists, we can empower women and point out their rights.

Obstetric violence is an umbrella term for various forms of violence and abuse by health professionals towards women during the perinatal period. It involves disrespectful behaviour and abuse, inhumane care and ill treatment of women. These forms of violence can occur at the interpersonal level through inappropriate attitudes towards women or through the policies and culture of a health institution. Women who experience obstetric violence often experience their deliveries as traumatic, which can have an impact on their self-image and psychology, as well as on their attitude towards subsequent pregnancies.

Physical violence
There have been several cases of women being beaten while pushing. Another practice that is still often used is that of fundus pressure, which also falls under the heading of physical violence. One major difference between beating and applying fundus pressure is that the latter is acceptable under certain circumstances.

Verbal violence
In addition to physical abuse, verbal abuse can also occur during labour and delivery. The term ‘undignified care’ is used to refer to care that is accompanied by deliberate humiliation, blaming, rough treatment, berating, disclosure of personal information and negative perceptions of care. It also involves harsh or coarse language, blaming or accusing, threatening to withhold care and assigning blame for a negative outcome. Coarse language occurs in high-income, middle-income and low-income countries. It is a factor that regularly produces a negative tint to the childbirth experience. For example, there is a link between ‘verbal abuse’, ‘stigma and discrimination’ and a ‘poor relationship between women and health professionals’. Women with lower socio-economic status, migrants and women from ethnic minority groups are often confronted with derogatory remarks. Women who do not conform to traditional gender stereotypes are also likely to experience poor care as punishment. The health professionals are often under time (or other) pressure, which can lead to confrontations. One possible reason could be that the health professionals are simultaneously involved in other stressful situations and need to divide their attention (Van Cauwelaert, 2019).

***Samen voor respectvolle geboorte* [Together for respectful birthing]**

Samen voor respectvolle geboorte is committed to providing birthing care that is centred on the pregnant woman, with open, respectful communication and family-centred care. The basic values of respectful birthing are as follows: Cooperation – High-quality care – Respect – Autonomy – Dignity. Additional information (in Dutch) is available at https://www.respectvollegeboorte.be

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5. Appendix

Contents of the Culturally Sensitive Pregnancy Kit

The substances in the kit are **not** suitable for use. They are placebo materials of materials for use only for purposes of training or demonstration.

Materials

• Foetal models (4)	☐
• Miniature model of baby, uterus and pelvis	☐
• Balloons and clothespins	☐
• Belly Balls	☐
• Relaxation ball	☐
• Breast model	☐
• Baby powder	☐
• Glucose drink	☐
• Vitamin D (D-cura tablet)	☐
• Birthing plan card set	☐
• Folic acid (Folavit Start)	☐
• Pregnancy test	☐

Illustrations

- Illustration Figures 1–41
- Illustrations of respectful birthing: Birthing plan and dialogue
- Progress in labour: Cervical dilation
- Road Map of Labour
- Positions for Labouring out of bed: Birthing positions

Publications

- Vrouwelijke Genitale Verminking/Vrouwenbesnijdenis [Female Genital Mutilation/Female circumcision] (GAMS Belgium)
- Geen besnijdenis voor mijn dochter [No circumcision for my daughter] (GAMS Belgium)
- Zwanger? Beperk hormoonverstoorders [Pregnant? Limit hormone disrupters] (Gezinsbond)
- Gezond zwanger worden? Neem foliumzuur in voor je zwanger bent! [Healthy pregnancy? Take folic acid before you become pregnant] (Kela)
- Geluksdriehoek [Happiness triangle] (VIGL)
- Wat met alcohol voor, tijdens en na de zwangerschap? [What should you do with alcohol before, during and after pregnancy?] (De druglijn)
- Alcohol, tabak en drugs tijdens de zwangerschap [Alcohol, tobacco and drugs during pregnancy] (De druglijn)
- Wat na… zwangerschapsdiabetes [What to do after...gestational diabetes] (Diabetes Liga)
- Postpartum depressie [Post-partum depression] (VVGG)
- Fiche voedingsdriehoek, bewegingsdriehoek en geluksdriehoek [Information sheet: Nutrition triangle, exercise triangle, happiness triangle] (Gezond Leven)
- Posters: Nutrition, exercise and happiness triangles: 2 each (Gezond Leven)
- Doorbreek nu de stilte omtrent gendergerelateerd geweld [Break the silence about gender-related violence now] (Access)
- Kind in Beeld: Zwangerschap [Child in View: Pregnancy] (Kind & Gezin)
- Road map of labour handouts: 3
- Positions for labouring handouts: 3
- Breastfeeding guide (Kind & Gezin)