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Refugee Women's Health: Reproductive Health Disparities and Best Practice Paradigms

presentation will begin shortly

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Webinar Overview

• Presentation (50 minutes)
• Q&A via Chat Window (20 minutes)
• Slides, webinar recording, Question and Answers, and additional resources will be posted to [http://refugeehealthta.org](http://refugeehealthta.org) after the webinar
• Email [refugeehealthta@jsi.com](mailto:refugeehealthta@jsi.com) if you have any questions after the webinar
Learning Objectives

1. Describe the challenges faced by healthcare professionals in providing culturally competent reproductive health care and family planning.

2. Discuss best practices in refugee women’s health.
Evaluation

• Appears in your internet browser after webinar ends (please stay logged in!)
• Also available via email if you logged in from your RHTAC invitation
• Strongly encouraged for everyone – we learn from the evaluations!
• CECs: Check email ~7 days after webinar for separate evaluation from Baystate Continuing Ed.

THANK YOU!
Presenter

Crista E. Johnson-Agbakwu, MD, MSc, FACOG
Founder & Director, Refugee Women’s Health Clinic, Obstetrics & Gynecology, Maricopa Integrated Health System

Assistant Research Professor, Southwest Interdisciplinary Research Center (SIRC) Arizona State University

Research Assistant Professor, University of Arizona College of Medicine - Phoenix
Refugee Women's Health: Reproductive Health Disparities and Best Practice Paradigms

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Assistant Research Professor, Southwest Interdisciplinary Research Center (SIRC) Arizona State University
Research Assistant Professor, University of Arizona College of Medicine - Phoenix
Objectives

• Refugee Women’s Health within the Context of Resettlement
• Refugee Health Disparities
• Best Practice Strategies
• Future Research Directives
• Health Policy Implications
‘Healthy Migrant’ Paradox

- Immigrants to the U.S. are often healthier than native-born residents in their new countries of residence.
- The migrant health advantage diminishes dramatically over time.
  - Rise in obesity
  - Hyperlipidemia
  - Hypertension
  - Cardiovascular disease

Fuentes-Afflick et al, 1999; Muening & Fahs, 2002; Neria, 2000; Singh & Siahpush, 2001
Evidence suggests the ‘Healthy Migrant’ effect may not be evident.

Refugees often arrive with health deficits due to refugee camp living conditions and may need special care and protections in a new country, particularly in their early stages of resettlement.
Factors Related to the Health of Resettling Refugee Women

Refugee Health Disparities
Conditions Affecting Refugee Women’s Health & Well-Being

- Gender-Based Violence
- Sexually Transmitted Infections
- Emerging Chronic Diseases
- Breast and Cervical Cancer
- Pregnancy-related outcomes
- Female Genital Cutting (FGC)
Interpersonal Violence
Against Women & Adolescents

• Iraqi women (n=55)
  ➢ Controlling (93%), threatening (76%), physical violence (80%)
  ➢ Significant association between IPV and poor physical health (40%), and psychosomatic symptoms (90%)

• Somali women (n=62)
  ➢ Women with greater English proficiency experienced more psychological abuse and physical aggression from partners

• Nepali women (n=45)
  ➢ Verbally insulted (75.6%), seek permission from partners to visit friends/relatives (62.2%)

• Evaluation 25,779 refugees resettled in MN between 2003-2010

• N=18,516 (72%) refugees tested for at least one STI
  ➢ 1.1% (183/17,235) seropositive for syphilis
  ➢ 0.6% (15/2,512) positive for Chlamydia
  ➢ 0.2% (5/2,403) positive for gonorrhea
  ➢ 2.0% (136/6,765) positive for HIV
  ➢ 0.1% (6/5,873) positive for multiple STIs
### Cardiovascular Disease Among Somali Women in the Diaspora

<table>
<thead>
<tr>
<th>Topics</th>
<th>n=50 (% total)</th>
<th>Subcategory</th>
<th>n=50 (% total)</th>
</tr>
</thead>
<tbody>
<tr>
<td>CVD</td>
<td>0</td>
<td>Stress and mental health</td>
<td>12 (24%)</td>
</tr>
<tr>
<td>Risk factors for CVD</td>
<td>21 (42%)</td>
<td>Physical activity</td>
<td>4 (8%)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Tobacco exposure</td>
<td>4 (8%)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Diabetes</td>
<td>1 (2%)</td>
</tr>
<tr>
<td>Other health topics</td>
<td>29 (58%)</td>
<td>Reproductive/maternal health</td>
<td>16 (32%)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Infectious Diseases</td>
<td>6 (12%)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Experiences with healthcare</td>
<td>5 (10%)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Other</td>
<td>2 (4%)</td>
</tr>
</tbody>
</table>

*a Four articles on diabetes in pregnancy were included in this category*

Physical Activity and Nutrition Among Immigrant and Refuge Women

- Socioculturally responsive physical activity and nutrition program using CBPR
- 6 week, 90-minute weekly classes
- Hispanic, Somali, Cambodian, non-immigrant African-American (n=45)

**Exercise**
- Use music and dance from different cultures
- Start slow and gradually increase intensity
- Ensure an exercise space dedicated to women without men nearby

**Nutrition**
- Use food props and visual models
- Focus on portion size
- Emphasize healthy food choices for the family, not just individual
- Do not attempt to change culturally entrenched foods. Suggest modifications instead.

Cervical Cancer Disease Burden

• Foreign-born account for > 50% of cervical cancer deaths in U.S.

• Accounts for 10% of all cancers worldwide (370,000 new cases annually)

• 80% of all new diagnoses and related mortality occur in underserved, resource-poor populations

• Barriers to screening
  - Lack of health insurance
  - Less timely contact with health care system
  - Socio-cultural and demographic variables
  - Lack of knowledge

Burnley, J, Johnson-Agbakwu CE. *Encycl Immigrant Health* (2011)
Population-based cohort 455,864 foreign-born women

Cervical cancer screening rate 53.1% (compared to 64.6% among long-term Ontario residents)

Variables associated with lack of screening (regardless of culture/ethnicity)

- Being outside age range of 35-49 years
- Residence in lowest-income neighborhoods
- Not having a regular source of primary care
- Having a provider from the same region of origin
- Not having access to a Female provider (significant across all regions)

Health Disparities in Breast Cancer

• Women in U.S. < 10 years less likely to have had a mammogram within the last 2 years*

• Barriers to screening:
  ▪ Limited knowledge
  ▪ Racial discrimination
  ▪ Embarrassment
  ▪ Fear of diagnosis
  ▪ Cultural beliefs
  ▪ Lack of insurance
  ▪ Culturally-appropriate health resources
  ▪ Underestimation of risk
  ▪ Socio-demographics
  ▪ Access to care

• Reduced screening rates among refugee communities~
  ➢ Increased breast cancer risk
  ➢ Presentation at later stage of breast cancer
  ➢ Increased mortality/morbidity following diagnosis

Qualitative interviews of 20 Iraqi refugee women

Emergent Themes

- Culturally mediated beliefs about illness and preventive care
- Knowledge about breast cancer screening
- Barriers to obtaining mammography screening:
  - Psychosocial barriers
  - Health consequences of war
  - Religiously influenced concerns

Adverse Pregnancy Outcomes

Somali Women are a HIGH RISK sub-population

- Increased cesarean delivery due to fetal distress
- Delivery after 42 weeks
- Significant perineal lacerations, gestational diabetes, and oligohydramnios
- Poor neonatal outcomes
  - Prolonged hospitalization
  - Lower 5-minute Apgar scores
  - Assisted ventilation
  - Meconium aspiration

N=106 Somali women (1994-2006)
64% vaginal delivery/36% cesarean delivery

Probability of Subsequent Delivery Following Index Pregnancy

<table>
<thead>
<tr>
<th>Time point following index delivery</th>
<th>Cesarean section group estimate (95% CI)</th>
<th>Vaginal group estimate (95% CI)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 year</td>
<td>Group 1: 2.9% (0–8.2)</td>
<td>Group 2: 3.3% (0–7.8)</td>
</tr>
<tr>
<td></td>
<td>2 years: 25.9% (9.8–39.2)</td>
<td>55.4% (40.1–66.8)</td>
</tr>
<tr>
<td></td>
<td>3 years: 58.1% (27.0–72.2)</td>
<td>74.4% (59.0–84.0)</td>
</tr>
</tbody>
</table>

Likelihood of Somali women having a second child after cesarean delivery is lower than after vaginal delivery at 2 and 3 years follow-up.
Risk Factors for Postpartum Depression Among Refugee Women

Migratory Stressors

- Stress due to war/persecution
  - High perinatal anxiety
  - Somatic complaints
- Social isolation/lack of social support
- Loss of family support

Post-Migration

- Housing difficulties
- Discrimination/prejudice
- Limited financial resources

O’Mahony J, Donnely T. J Psych Mental Health Nursing 2010
<table>
<thead>
<tr>
<th>Positive</th>
<th>Negative</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Informal social support</td>
<td>• Mental illness highly stigmatized</td>
</tr>
<tr>
<td>• Partner</td>
<td>• Postpartum depression symptoms more likely to be unrecognized</td>
</tr>
<tr>
<td>• Extended family</td>
<td>• Refugee women less likely to seek help</td>
</tr>
<tr>
<td>• Greater religiosity associated with decreased postpartum depression</td>
<td>• Unwanted emotional support</td>
</tr>
<tr>
<td>• Support during perinatal period needs to be perceived as support by</td>
<td>• Parents-in-law</td>
</tr>
<tr>
<td>mother</td>
<td>• Rituals not viewed as helpful by mother</td>
</tr>
</tbody>
</table>

O’Mahony J, Donnelly T. J Psych Mental Health Nursing 2010
Female Genital Cutting

Tradition

- Cultural ideals femininity and modesty
- Wife/Motherhood is livelihood
- Marriageable
- Frame of reference is other women within the community
Epidemiology

- Affects 140 million women worldwide
- Africa—(28 countries), Middle East, Asia
- Each year, 3 million girls at risk for procedure
- In the U.S. more than 228,000 females have either undergone or are at risk for procedure

FGC Prevalence in Women Age 15-49

Demographic & Health Surveys, UNICEF 2005
A Global Perspective
• Any procedure that involves partial or total removal of external female genitalia or other injury to female genital organs whether for cultural or nontherapeutic reasons”
Female Genital Cutting (FGC)

Type I – Excision of prepuce with/without excision of part or all of clitoris

ACOG. Female Circumcision/Female Genital Mutilation, Clinical Management of Circumcised Women. RAINBO 1999
Female Genital Cutting (FGC)

Type II – Excision of prepuce and clitoris together with partial or total excision of labia minora.
Female Genital Cutting (FGC)

Type III - Infibulation

ACOG. Female Circumcision/Female Genital Mutilation, Clinical Management of Circumcised Women. RAINBO 1999
Defibulation

- Prior to coitus, prior to pregnancy, during 2nd trimester
- Avoids acute problems at time of delivery
- At onset of labor, vaginal introitus adequate for vaginal exams and any interventional procedures
- Avoids excessive blood loss at delivery
- Provide counseling on post-operative expectations (i.e. change in stream of urine/menstrual flow)

Federal Prohibition of Female Genital Mutilation Act of 1995

- Federal crime to perform any medically unnecessary surgery on genitalia of girls < 18 years of age
- Does not address:
  - Women > age 18
  - Reinfibulation after delivery
  - Female minor being taken out of the country for FGC

(The Girls Protection Act of 2010 H.R. 5137 presented before congress 4/26/10)
United States Legislation for Female Circumcision/Female Genital Mutilation

Source: Female Genital Mutilation: A Guide to Laws and Policies Worldwide by Nahid Toubia

NOTES:
CA, CO, MN, NY, OR: Additional provisions for education and outreach to relevant communities.

(Last updated 2/7/2007)

ACOG committee opinion

Female genital mutilation

Number 151 – January 1995

Committee on Gynecologic Practice
Committee on International Affairs
To provide culturally grounded and linguistically appropriate health services to the growing refugee and immigrant communities in the Phoenix Metropolitan area while seeking to reduce/eliminate health disparities and cultural barriers to care.
LOCALLY ACCESSIBLE. GLOBALLY MINDED.

Helping refugee women navigate the healthcare system and increase health seeking behavior
Priorities are community-driven
Hired staff are from the refugee community
Culturally/linguistically appropriate interpreters
In-service cultural sensitivity training for medical staff
Live, In-Person Interpretation in More Than 13 Languages:

- Burmese
- Somali
- Swahili
- French
- Kirundi
- Kinyarwanda
- Arabic
- Chin
- Maay Maay
- Oromo
- Amharic
- Nepali
- Farsi

35 Countries Served

Burma
Somalia
Burundi
Ethiopia
Iraq
Bhutan
Liberia
India
Nigeria
Democratic Republic of Congo
Egypt
Sudan
Central African Rep
Cuba
Libya
Palestine
Sierra Leone

Togo
Vietnam
Iran
Kenya
Russia
Cameroon
Ghana
Albania
Afghanistan
Eritrea
Ivory Coast
Morocco
Guinea
Syria
Rwanda
Pakistan
Palestine
Uzbekistan

Clinic Locations & Hours of Operation:

**MAIN CLINIC**

Refugee Women’s Health Clinic
Comprehensive Health Center
Women’s Care Center, 2nd Floor
2525 E. Roosevelt Street
Phoenix, Arizona 85008

- Mondays 12:30 – 6:00pm
- Wednesdays 1:00 – 5:00pm
- Thursdays 8:00 – 5:00pm

**MARYVALE CLINIC**

4011 N 51st Ave
Phoenix, AZ 85031

- Tuesdays 8:00 – 12:00pm
- Fridays 8:00 – 12:00 pm
OVERCOMING BARRIERS.

Providing culturally sensitive healthcare to a growing refugee & immigrant community
Patient Education Classes
De-Mystifying Labor & Delivery

- Orientation to the room
- IV and why
- Induction process
- Visitation
- Required tests and exams, fetal monitoring and option to walk during labor
- Pain Management options and feelings
- Routine to transfer baby to Nursery
Overcoming Barriers
Patient Education Classes

Postpartum
- Postpartum care of mother
- Newborn care
- Breastfeeding
- Car seat safety measures

Family Planning

Discharge planning
- Baby first well visit with Pediatric clinics
- Mom post partum follow-up with RWHC
Overcoming Barriers

Intensive Care Coordination

- Home visits as needed
- Patients reminders of appointments
- Coordination of transportation services
- Accompanying patients to various services on MIHS campus (i.e. radiology, pharmacy, lab, ER, L&D, etc)
- Insurance coverage assistance
- Advocacy to various social services as needed
- Alternative child care plans for inpatient moms
- Live, in-person interpretation whenever feasible
- Cross referrals from Family Health Centers
- Care coordination with health plans’ case managers
EMPOWERING WOMEN.
Eliminating myths surrounding labor & delivery and preventative health services
Empowerment Tools
RWHC Communication Card

I am receiving care at Maricopa Medical Center
Please, take me there!

2601 E. Roosevelt St.
Phoenix, AZ 85008

Labor and Delivery: 602-344-5451
Refugee Women’s Health Clinic: 602-540-6469

Refugee Women’s Health Clinic
Program Manager: Jeanne Nizigiyimana, MA, MSW
Medical Assistant: Halima Abdirazak

OB/GYN Providers:
◊ Crista Johnson, MD, MSc
◊ Jennifer Baumbach, MD
◊ Susan Yount, PhD, CNM, WHCNP, RN
◊ Lynn Kennedy, CNM

Days of operation: Mondays, Wednesdays and Thursdays

Comprehensive Health Center-Women’s Care Center
2525E. Roosevelt, 2nd floor-Phoenix, AZ 85008
The Refugee Women’s Health Community Advisory Coalition (RWHCAC) is comprised of community stakeholders who are co-equal partners with the RWHC in empowering, mentoring, connecting, and reshaping the lives of refugee women towards improved health and well-being.
The Refugee Women’s Health Clinic
A Patient-Centered Medical Home

This is achieved through:

- Enhanced access to care
- Intensive Care Coordination and Case management
- Continuity of Care
- Integrated team-based approach to health care delivery
- Cultural Sensitivity
- Partnered Community Engagement
- Patient Empowerment and Trust
At RWHC, We Care About Our Patients

Hands-On Patient-Centered Approach

Provide Culturally Sensitive Care in a safe, accessible environment

Meet the Language Needs

Improved Reproductive Health Outcomes

Build trust by engaging patients & their community

Empower Women & Improve Health Literacy
Integration
Clinical Care, Community, and Research

Community Engagement
Community-Based Participatory Research
Clinical Care
Engaging Refugee Communities
Community-Based Participatory Research (CBPR) In Refugee Communities
To Promote Health Literacy in Refugee Communities

- Community Needs Assessment examining reproductive health priorities of Somali and Burundian women

- Train-the-Trainer intervention to increase Breast Health Literacy and build community capacity in the Somali Refugee Community
Promoting Cultural Competency
Culturally Sensitive Care

- Engender Trust
- Continuity of care
- Female Providers
- Structural barriers to health care access
  - Transportation
  - Lapses in Health insurance coverage
  - Long wait-times, rushed through visit
- Involvement of partner/spouse
- Cultural Health Navigators
Culturally Sensitive Care

- Effective use of interpreters
- Respect for modesty
- Understand cultural/traditional practices
- Religious observances — i.e. Ramadan during pregnancy
- Anticipatory guidance
- Coordination of care
- Case management
Encourage Asset-Based Approach to Health & Wellness

- Supportive family/social interactions
- Community-centered values
- Sharing within the cultural unit
- Resiliency
- Maintaining strong cultural beliefs

O’Mahony J, Donnelly T. J Psych Mental Health Nursing 2010
Research Directives

- Distinguish refugees as a unique sub-population of immigrants
- Ethno-cultural specificity
- Need for linguistically-appropriate validated instruments that are culturally relevant
- Validation of measures for working with low literate populations
- Incorporation of Cultural Health Navigators
Will the Patient-Centered Medical Home Transform Health Care Delivery?

- Enhance outreach and engagement of patients
- Better documentation and coordination of care (i.e. use of electronic medical records)
- Increase use of population-based disease management (i.e. use of disease registries)
- Improve quality of care, increase satisfaction with care, and lower cost of care
Health Policy Implications

For Refugee Communities

• Community Engagement
  - Creates bi-directional dialogue/partnership at every juncture
  - Engenders trust, dispels myths/misunderstandings
  - Ensures sustainable capacity-building (i.e. community health workers)
  - Creates social capital which empowers communities in navigating the health care system

• Evidence-based clinical guidelines/protocols
  - Addresses the needs/values of refugee women
  - Involves men as partners in medical decision-making
  - Engage multi-disciplinary team (i.e. providers, social workers, community advocates, interpreters)

• Involve local/national stakeholders

• Design replicable interventional programs that improves the quality of health care delivery
Web Resources

• North American Refugee Healthcare Conference
  - Expanded version of presentation

• Refugee Health Technical Assistance Center
  [www.refugeehealthta.org](http://www.refugeehealthta.org)
  - Tips and Strategies for Culturally Sensitive Care
  - Archived webinars
    [Culturally and Linguistically Appropriate Services](http://www.refugeehealthta.org/webinars/clas/)
Thank You!