Refugee Women's Health:
Reproductive Health Disparities and Best Practice Paradigms
RHTAC Webinar
September 13, 2012
1:00 pm CT

Operator: Ladies and gentlemen thank you for standing by. Welcome to the Refugee Women's Health: Reproductive Health Disparities and Best Practice Paradigms webinar. During the presentation all participants will be in a listen only mode.

If you would like to ask a question during the presentation please use the Chat feature located in the lower left corner of your screen. If you need to reach an operator at any time you may press the star followed by the zero. As a reminder this conference is being recorded today, Thursday September 13, 2012.

I would now like to turn the conference over to Dr. Paul Geltman, please go ahead sir.

Dr. Paul Geltman: Hi. I can now officially say, good afternoon to those on the East Coast and good morning to those out west. I want to again welcome you to our webinar today on Refugee Women's Health.

Before we get started we've got some, just some basic housekeeping to do. First and foremost, I just want to mention that this is a presentation of the Refugee Health Technical Assistance Center at the Massachusetts Department of Public Health, and funding for the Center comes from the U.S. Office for Refugee Resettlement. And I just wanted to acknowledge their support and funding, which makes all of this educational work we've been doing possible.

So you should be seeing the slide that says, "Webinar Overview." We're going to hear a presentation today on refugee women's health after which we should have plenty of time for question and answers and discussion.

Now as you heard from our operator the webinar is delivered in listen only mode, and the reason we do that is because we simply have listening audiences that are too large to have live microphones and live questions.

So if you do have a question at any time during the presentation you can submit it in writing via your Chat box, which on my screen is in the lower left corner. We will be keeping track of the questions that come in.

If it's appropriate or necessary I may interrupt Dr. Johnson and ask her to respond right away, but usually we'll plan to hold the questions until the end and then I will read ones that are either hot topics or most relevant. And Dr. Johnson will discuss them at the end. If we don't get to a question that you submit in writing we will respond to it in writing after the fact, usually within about two weeks at the most, hopefully sooner after the conclusion of the webinar.

The slide, the recording of the webinar, our question and answers as I just mentioned and some additional resources will be posted on the Technical Assistance Center Web site, which is refugeehealthta.org. If you have any question after the webinar. You can also email them to refugeehealthta@jsi.com.

Now before we switch into the introduction to the presentation I just want to say a couple more things. First, when we were doing our

rehearsal for this webinar, we noticed that one of us had some issue with the view on the screen, that it looked it a little truncated I think when we did our polling questions.

If at any point if looks like something is cut off or not showing properly try clicking on the button to go to full screen mode, and I think that should resolve it. If you still have any technical problem you can send a message to the chairperson via the Chat box. And we can try to troubleshoot it with you.

Now also at the end when the webinar is officially concluded, don't close your browser because you will get a pop-up box for doing the evaluation, which is very important for us. We like to hear from you as much as possible in terms of improving how we do these in the future.

Similarly, if you've applied for continuing education credit you will get a second evaluation via email from our Continuing Education sponsor. And it's mandatory that if you've applied for credit you will need to complete that second evaluation.

Okay, so our learning objectives for today are to describe the - actually I should back up because I didn't introduce myself, I'm Dr. Paul Geltman I'm the Medical Director of the Refugee and Immigrant Health Program at the Massachusetts Department of Public Health and a member of the Leadership Team for the Refugee Health Technical Assistance Center.

So our learning objectives for today are to describe the challenges faced by healthcare professionals in providing culturally competent reproductive healthcare and family planning, and Two, to discuss best practices in refugee women's health.

Now before I introduce our speaker we're going to do a couple of poll questions and I have, I think, some more of these sprinkled in the presentation. So this will give you a practice run on how to do it. So even though we asked these questions when you registered, we like to get a sense of who is actually on the call with us.

So the first question is, "What is your organization?" And you can just check off one there and after you've checked one of the boxes or one of the radio buttons I believe they're called, you'll click on the Submit button which should light up. And we just give a few seconds for these, I'm going to count down from five and then we'll move on.

Five, four, three, two, one, okay I'm going to close the poll so hit that button if you haven't done so.

All right so it looks like about 31% of you work as healthcare providers or at a healthcare institution, 28% or so are with public health agencies, 16% are with resettlement agencies, 7% with community based organizations, 1-1/2% at faith based community organizations, and the remainder about 16% are in the Other category.

So for those of you are not healthcare this is now our chance to find out who you are a little bit. So if you could check off a box for roughly what you do, if it's - if it fits in one of these, and then hit that Submit - hit Submit button again.

Just count down from five, four, three, two, one, and there still coming in. All right, it's slowing down so hit that Submit button if you haven't. I'm going to close the poll now.

Okay, so about a third of those who responded to this question are medical providers, and then 20% case managers and social workers, about 30% are refugee health program staff, and about 20% work in refugee resettlement.

So we have a pretty sizable number of non-clinical people it sounds like, so if at any time during the presentation there's a medical or technical term that you don't understand, you know, send a note in the Chat box, I'll try to just respond quickly to you via the Chat box. Or if it's something I think everybody should hear I'll either do it verbally or send a general message out to everybody. And Dr. Johnson will also try and avoid some jargon as much as possible in her presentation.

So just a reminder about the evaluation, it appears as a pop-up box at the end, so don't close your browser. And it will also be available via email with the second email regarding CE recipients. So that one should come from the Base Date Continuing Education Program.

So with that I'm going to introduce Dr. Crista Johnson-Agbakwu, she is an obstetrician gynecologist at the Maricopa Integrated Health System in Phoenix. I'm told we have pretty good turn out from the Southwest, so I guess she's a local celebrity, and she's the founder and Director of the Refugee Women's Health Clinic there. She's also a research assistant professor of the Southwest Interdisciplinary Research Center of Arizona State University.

Her current research interests include health disparities among refugee women across many facets of health, including women's reproductive, preventive, sexual and mental health.

And so with that I am going to turn it over to Dr. Johnson.

Dr. Crista Johnson-Agbakwu: Thank you so much Dr. Geltman, I would like to thank the Refugee Health Technical Assistance Center for inviting me to present this webinar, and just to clarify, yes I do have a dual faculty appoint both at Arizona State University as well as the University of Arizona College of Medicine.

So today I will examine the following objectives, I'll provide an overview of refugee women's health within the context of resettlement and then I'll explore pertinent health disparities specific to refugee women. And then give an example of best practice standards in place that are empowering women and improving health services utilization and promoting cultural competency through our Refugee Women's Health Clinic. And then finally, I'll propose future directives for research and health policy.

So to begin I would like to highlight the notion of the healthy migrant paradox which denotes that immigrants to the United States arrive often healthier than native born residents in their new countries of residence. It has been shown that this migrant health advantage diminishes drastically over time giving rise to obesity, hyperlipidemia, which is elevated lipids, hypertension as well as cardiovascular disease.

However, I would argue that among refugees evidence suggests that this health migrant effect may not actually be evident, as 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.

Refugee women are an especially vulnerable population facing additional obstacles to maintaining their health and well-being. So there are several factors that are multi-dimensional and interrelated and represent the key influences on the health of refugee women during the process of resettlement.

So I'm going to start with migration factors, that you can see here. When we refer to migration factors this includes war in the source country, the refugee camp experience, a history of torture, abuse or rape, loss of pre-existing social support.

When we look at some of the bio-psychosocial factors this may encompass changes in nutritional status, that says, "Having to skip meals due to a lack of money." Or emergent infectious diseases such as HIV and its associated stigma.

It can also refer to employment history, occupational exposures as well as mental health concerns such as stress and anxiety, substance abuse and what is the neighborhood and environment?

Next, when we examine women's health, this includes gender-based violence, pregnancy and childbirth, how many hours a woman works during pregnancy, their knowledge about how to access emergency services, their post-partum health, how soon they even return to work or school, as well as preventive health across the lifespan.

And finally, when we talk about infant health, this refers to infant mortality, birth weight, growth and development, breast feeding, are moms competency in childcare as well as infant car seat safety and immunizations history, as well as maternal and infant interaction and those processes occur.

And then in any of these categories, a change in social status, language barriers, access to interpreters, these can also influence these various factors. So one can see how these categories can overlap and influence each other.

So let's take a closer look at specific health disparities affecting refugee women. In the following slides I'll examine gender based violence, sexually transmitted infections, emerging chronic diseases, as well as recent evidence on breast and cervical cancer as well as reproductive health disparities surrounding pregnancy and childbirth. As well as specific cultural practices such as female genital cutting.

So when we look at interpersonal violence it is highly prevalent among refugee populations and it often occurs within the context of immigration, acculturation and rapid changes in family and social structures.

A number of studies have examined interpersonal violence against women to highlight a few, a study among 55 Iraqi women demonstrated the overall prevalence of controlling behavior, threatening behavior and physical violence ranged 76% to 93%. In addition, there was a significant association between interpersonal violence and poor physical health among 40% of the women, and the presence of psychosomatic symptoms in 90% of the women.

Another study among 62 Somali women demonstrated that women with greater English proficiency experienced more psychological abuse and physical aggression from partners. For these women the partners may indicate a painful reminder for the women to their loss of control

and their wives - their husbands or wives move towards greater acculturation to American society, independence and self-sufficiency.

And finally a study among 45 Nepali women, excuse me, showed that nearly 76% reported having been verbally insulted by their current partners, and 62% had to seek permission from their partners to visit friends and relatives. So as you can see culturally tailored domestic violence intervention and education are certainly needed these populations.

In regards to sexually transmitted infections I want to bring your attention to this recent study by Dr. Bill Stauffer, which is the first report of the prevalent rates of Euro Genital Chlamydia and gonorrhea in refugee population arriving in the United States. This was an evaluation of nearly 26,000 refugees who were resettled in Minnesota between 2003 and 2010, of whom about 72% were tested for at least one sexually transmitted infection.

I want to bring your attention to the highlighted region showing that the prevalence of Chlamydia was only 0.6%, which is well below that of the U.S. population, which is 2.2%. However, when they stratified this be region, refugees from the Middle East has a rate of 3.3%, and the predominant age range of infection was among 15 to 24 year olds.

Current CDC guidelines recommend annual screening for Chlamydia in sexually active females less than age 25, and then women over the age of 25 with risk factors or overt signs or symptoms of infection.

The CDC also strongly encourages screening for HIV in newly arriving populations and for any refugee with a confirmed non-HIV sexually transmitted infection.

And so while testing for gonorrhea is not mandated by the CDC, and this is pertinent to initial health assessments of new arrivals, right now they currently recommend only Chlamydia screening, but I want to point out in clinical practice particularly my clinical practice, often it's a single combined kit for both gonorrhea and Chlamydia. And so depending on your practice it might be hard to separate the two.

And then there's some evidence that there's some higher rates of co-infection, so just bear that in mind. And so future studies will need to examine sub-populations in which the prevalence of sexually transmitted infections is greater.

When we look at emerging chronic diseases it's important to consider how this may develop among refugee women. Obesity and hypertension as we know is a growing concern, however, very few studies have examined cardiovascular disease among refugee women.

So this slide presents a review of publications on Somali women in the Diaspora, and reveals no specific study examining cardiovascular disease directly. However, as you can see risk factors for cardiovascular disease, such as stress and mental health, physical activity, tobacco exposure and diabetes have had some attention.

What is particularly striking though, is the emphasis on reproductive and maternal health. You may be wondering, "Why the focus on reproductive health?" Many of these articles as you can see, it's about 32% of these articles have been centered around challenges caring for populations affected by female genital cutting.

So if we focus more on chronic disease we must also consider the role of context, such as how dietary changes, culture, acculturation processes as well as one's environment may influence these emergent conditions.

So let's focus in on diet and exercise. This study was conducted by Dr. Mark Wieland and colleagues to examine a socio-culturally responsive physical activity and nutrition program among Hispanic, Somali, Cambodian and non-immigrant African American women using community based participatory research.

So 45 women informed the design and implementation of a fitness program that was highly acceptable and specifically tailored towards them. So as you can see in the box for Exercise women recommended the inclusion of music and dance from different cultures, but they start slow and gradually build up intensity over time. And ensure that the exercise space is dedicated to women only without men nearby.

In terms of their recommendations for the nutritional component, when you see the next box, they advise that food groups and visual models be used, specifically in the context of English language barriers. And that these visual model focus on portion sizes, that they emphasize health food choices for the family, not just the individual.

And also not attempt to change culturally entrenched foods, instead modifications of traditional foods were suggested, that may add to their nutritional value. So as a result of this intervention there was a statistically significant increase in regular exercise and an improvement in women's quality of life.

So let's look at the cervical cancer disease burden. We know that the foreign-born account for more than 50% of cervical cancer deaths in the United States, it also accounts for 10% of all cancers worldwide. There's about 370,000 new cases annually.

Eighty percent of all new diagnosis and related mortality occur in under-served and resource poor population, and there are barriers to screening, such as lack of health insurance, less timely contact with the healthcare system, socio-cultural and demographic variables, as well as a lack knowledge.

So one study examined predictors of low cervical cancer screen among immigrant women in Ontario Canada, and this was a population-based cohort. And we found that there was a cervical cancer-screening rate of about 53.1%. And that was lower compared to nearly 65% among long-term Ontario residents.

The variables that were associated with a lack screening, and this was regardless of culture and ethnicity, were being outside the age range of 35 to 49 years, residence in lowest income neighborhoods, not having a regular source of primary care, having a provider from the same region of origin and not having access to a female provider. And that was significant across all regions.

When we looking at health disparities in breast cancer women in the United States for less than ten years are less likely to have had a mammogram within the last two years. Known barriers to screening are limited knowledge, racial discrimination, embarrassment, fear of diagnosis, cultural beliefs as well as a lack of insurance, culturally appropriate health resource, an under estimation of one's risk, as well as socio-demographic factors and access to care.

It's been shown that reduced screening rates among refugee communities can predispose women to increased breast cancer risk, presentation at later stage of breast cancer, as well as increased mortality and morbidity following diagnosis.

In a qualitative study of 20 Iraqi refugee women, this was examining perspectives of preventive healthcare and barriers to breast cancer screening, some salient emergent themes arose. And this was that there were culturally mediated beliefs about preventive care, and such examples were that, "If I am not sick, why would I go to the doctor?" And, "You must leave it up to God."

There are also themes relevant to one's knowledge about breast cancer screening, and the majority of the women who knew about mammograms would follow the advice of a doctor and were grateful for access to mammography services.

And then they were perceived barriers to obtaining mammography screening, such as psychosocial barriers such as a fear of pain, a fear associated with a cancer diagnosis. Women also mentioned the health consequences of war such as the day-to-day survival was paramount to seeking preventive health services.

And they also were concerned about exposure to radiation from biological or chemical warfare would increase their risk of cancer. And finally, there were religiously influenced concerns, such as concerns for modesty and preference for female providers.

So now let's look at some of the known adverse pregnancy outcomes, and this literature is most replete among the Somali refugee

community. In fact this one study highlighted here, is a study from the University of Washington at Harborview Hospital where they examined nearly 5,000 women, Caucasian and African American women, looking at birth certificate data and hospital discharge records. And they compared them to nearly 600 Somali women from 1993 to 2001.

And what they found is that the Somali women were a high risk sub-population and that they were found to have increase of varying delivery to fetal distress, they delivered beyond 40 weeks, more than 42 weeks gestation.

They had significant tears or lacerations during childbirth and developed diabetes during pregnancy, as well as low amniotic fluid. And they also found that among the new - the babies, they also had poor outcomes, such as prolonged stay in the hospital, lower five minute Apgar scores, the required assisted ventilation as well as meconium aspiration, which essentially is ingesting and aspiring fetal stool into the lungs.

So a recent study also examined fertility after cesarean delivery among Somali women in the United States. And so reproductive impact of cesarean versus vaginal delivery is very important to consider given the profound fear of cesarean delivery that exist among the Somali community. As well as the importance of having large families.

And so this study examined fertility after cesarean delivery in 102 Somali women, of whom 64% underwent a vaginal delivery and 36% the cesarean delivery. As you can see in this table the probably of subsequent delivery following the first index pregnancy was compared at Year 1, 2 and 3, as you can see here.

And then they compared the cesarean Section group in the next column, as well as the vaginal group. And what you can see is that the findings indicate that the likelihood of the Somali women having a second child after cesarean delivery is lower than after a vaginal delivery. And you can see the comparison here and here between the cesarean and vaginal group at Year 2, as well as Year 3 below and you can see that the vaginal delivery group was much higher in terms of subsequent deliveries.

So I must also point out that the authors did not control for use of a family planning method during the interval between these pregnancies, which would also impact fertility rates. But nonetheless the high cesarean rate coupled with decreased fertility at two years and three years is an important finding, worth focused counseling for women as well as further exploration in future studies.

Let's now examine some risk factors for post-partum depression. There are both migratory and post-migratory stresses that have been found. Migratory stresses may include stress due to war and persecution that may result in a high perinatal anxiety of somatic complaints. It could also cause social isolation and a lack of social support, as well as a loss of family support. Post-migratory stressors may involve housing difficulty, discrimination and prejudice as well as limited financial resources.

There are cultural influences that may be positive or negative, and may influence a refugee help seeking behavior and decision-making about post-partum care. Some positive influences include having informal social support from a partner or extended family, and also it's been shown that greater religiosity is associated with decreased post-partum

depression. And then support during the perinatal period needs to be perceived as support by the mother.

Some negative influences include mental illness being highly stigmatized, post-partum depression symptoms more likely to be unrecognized and refugee women are less likely to seek help.

Also it's important to point out that unwanted emotional support, say from parent-in-laws, or rituals not viewed as helpful by the mother, can have a negative influence.

So let's take a little break here and turn to our first poll question. I'm going to read the question and then allow some time for you to respond. So the questions is, "Risk factors for post-partum depression include all of the following direct migratory stressors except, housing difficulty, limited financial resources, use of family planning, experiences of discrimination or prejudice, and finally loss of family or social support?"

So I'm going to count down from ten to allow time to pick and answer, and then we will close the poll. Ten, nine, eight, seven, six, five, four, three, two, one, so I'm going to close the poll at this point and let's see how we responded.

So yes, the overwhelming majority, 78% of you, did choose, use of family planning. And yes, it does have an indirect influence on potential stress over time in terms of a woman's planning for her future children, but yes, you are correct in that the other choices where more appropriate in terms of direct migratory stressors.

So now let's turn our attention traditional practices such as female genital cutting. So this is a cultural practice steeped in ideals of femininity and modesty. And often is practiced to ensure a woman's future as a wife and mother. And often it can be a prerequisite for marriage and ensure a woman's future livelihood.

So if you can imagine a young girl growing up in a society where this practice is indigenous, one's frame of reference maybe other women within her community, as she may be teased by other peers and other girls, or maybe ostracized. So there are very strong socio-cultural pressure that may ensure the persistence and continuation of this practice.

When we look at it from an epidemiologic standpoint, it affects 140 million women worldwide, it is most prevalent in Sub-Saharan African across 28 countries, but it also exists in certain regions of the Middle East and Southeast Asia.

It is estimated that each year 3 million girls are at risk for this procedure, and in the United States we only have evidence from the 2000 census. So we already know that this data is outdated. But from what we know more than 228,000 females have undergone or at risk for this procedure.

It is also estimated, when you look at Europe, more than 500,000 women and girls are living in Europe with a form a genital cutting. And about 180,000 are estimated to be at risk for undergoing this practice.

Focusing on the continent of Africa there is tremendous heterogeneity across different regions of the continent where there may be difference in the prevalence of cutting based on ethnicity, based on urban versus

rural settings. The East Horn of Africa tends to have the higher prevalence of the more severe forms of cutting, whereas in regions of Western Africa there are milder forms of cutting practice.

But also if you can look at countries such as Ghana here, where it is as low as 5%, but then look at countries such as Guinea, it's as high as 99%. So you can see there's great heterogeneity in terms of the type and extent of cutting as well as the regional differences.

When you look at it from a global perspective, as you can see the highest prevalence rates are really concentrated in Sub-Saharan Africa and as I mentioned in regions of South Asia. However, in the lighter purple regions that are highlighted designate immigrants who have now migrated to North America, Europe, Australia, that may have undergone this practice in their countries of origin.

The World Health Organization classifies genital mutilation, as the term is referred to, as, "Any procedure that involves partial or total removal of external female genitalia or other injury to female genital organs whether for cultural or non-therapeutic reasons."

So as you can see here Type 1 is the mildest form of cutting, which can easily be missed on a hasty public exam. And it's cutting portions of the prepuce, or hood of the clitoris, as well as portions of the tip of the clitoral gland.

When you look at Type 2, which is more intermediate, you have this outlined in red more significant cutting involving not just the hood and portions of the clitoral glands, but also the labia minora or majora may be involved. But the distinguishing features that generally discard does not come down below the level of the, urethral meatus here. And often

the scar heals with a linear scar just with the girl's leg opposed together, and does not involve any stitching of any kind.

In contrast, Type 3, which is otherwise known as infibulation or by communities as pharaonic infibulation, as a more extensive form of genital cutting. And this is the form that generally has the most complications related to urinary infections, infections in the vagina, sexual pain, challenges during childbirth.

And as you can see in the top picture on the left, that the tissue that is excised involves the labia majora and minora, which are the outer and inner lips of the labia and the clitoral glands. And then in the bottom picture on the left, the tissue is then re-approximated with various types of suture material or other products to basically form a seal.

Now as you can see, the photo on the right is actually a picture of one my patients, and it's a complete seal or scar over the vulva leaving a small opening here, which is the vaginal introitus, and you can compare it to the anal opening. And about 15% of all genital surgeries, cutting surgeries, are this severe form Type 3, 85% of the cutting practices are the milder forms that I listed previously.

So the defibulation procedure is a procedure to release that scar tissue specifically in women with Type 3 infibulation. Ideally, if the women can have this procedure done prior to marriage or initial intercourse is great, often times that may not be the case and the patient might present during pregnancy actually.

It's advised by experts that the second trimester it is better to perform the defibulation mainly to avoid acute problems at the time of delivery. At the time of labor the vaginal introitus, may be able to be accessed

without causing significant pain. And often if you have place a Foley catheter or other instrumentation of the baby or the uterus during labor, it can be easily accessed without much difficulty. And it avoid excessive blood loss at delivery.

Other studies, especially a recent study in Saudi Arabia, has found that there was no difference actually in the timing of the defibulation performed at delivery or antenatally. So it's interesting that more research is needed to examine the most appropriate timing.

However, it's important when performing this procedure to provide anticipatory guidance and counseling women on what to expect after this procedure. Often women may not realize that they will experience a change in their urinary stream or their menstrual flow, that their stream may be stronger or their menstrual flow not as long after the procedure. And so it's important to provide that guidance and counseling for women who may need this procedure.

When we look at some of the legal issues, in 1995 Congress passed the Federal Prohibition of Female Genital Mutilation Act which made it a federal crime to perform any medically unnecessary surgery on the genitalia of girls less than 18 years of age.

This did not address women over the age of 18 or re-infibulation; that means re-approximating the cut tissue after delivery. There was a bill introduced before Congress in 2010 addressing female minors who may be taken out of the country to undergo genital cutting.

And when we look at state-based legislation that has been passed, as you can see highlighted in red, states have passed their own specific laws criminalizing the practice. And some have included caveats for

women over the age of 18 or parents and legal guardians being held liable for consenting to the procedure if - even if they're not the ones doing this procedure.

So the American Congress of Obstetrics and Gynecology has raised a committee opinion, and this was back in 1995, opposing all forms of genital cutting and advises members not to perform these procedures and advocates for counseling, education, not only at the community level but also at the provider level.

So let's take a brief pause and I'm going to pose a second poll question. And it's, "When is the appropriate timing for defibulation procedure in women with Type 3, which is infibulation, female genital cutting? Is it; A, during the second trimester of pregnancy; B, prior to pregnancy; C, at the time of delivery; D, prior to initial intercourse; or E, all of the above?"

And I'll allow some time for you to submit your responses; ten, nine, eight, seven, six, five, four, three, two, one. So I'm going to close the poll at this time.

Dr. Paul Geltman: Crista, before you get into the answers on the poll, perhaps you could just comment on whether doing this defibulation requires any special training, you know, who can do it, are there particular...

Dr. Crista Johnson-Agbakwu: Yes.

Dr. Paul Geltman: ...centers or will any gynecologist do it.

Dr. Crista Johnson-Agbakwu: Yes.

Dr. Paul Geltman: And then, what happens to women who don't want it done?

Dr. Crista Johnson-Agbakwu: Yes, so that's a heavy loaded question, and it's one where we do need further policies in place here in the United States.

So yes, we really do advocate for training in residency programs. In fact, Dr. (Noel Nore) and ACOG did produce a training guide, a slide kit a number of years ago, on the technique of defibulation. And there are OB/GYNs of course at my hospital, which is a teaching hospital, I am involved in training residents and students on this technique.

And I would encourage those providers that are working in areas with high populations of women affected by this practice, that they seek opportunities to familiarize themselves with this technique. It's very straight forward for anyone trained in gynecology or obstetrics, in terms of the technique of releasing the scar tissue.

And there are videos, ACOG videos that have been developed, that are on the ACOG Web site, that describe the actual process of defibulation, in terms of the surgical technique.

And then for women who may not want defibulation, that is a separate discussion. Perhaps we can save some time at the end. Dr. Geltman, if you could remind me we can go into some of those caveats, which are a little bit more involved. But we can certainly - I can spend a little bit more time describing it at the end of my talk.

Dr. Paul Geltman: Great.

Dr. Crista Johnson-Agbakwu: So in the response to this question, you are correct; 61% did say all of the above. But I also want to - do say, for our

practices here in the states, if there's an opportunity to - for the patient to arrive early enough in pregnancy or prior to pregnancy, there should be counseling done in advance regarding opening the scar in advance during the second trimester or earlier, if possible.

This may not always be feasible, but it does reduce the issues of pain, access to cervical exams, bleeding, et cetera, that may happen during labor and make placing foley catheters, et cetera, especially if it's an emergency, more difficult.

So let's move to the next section. I'm just going to spend just a few minutes describing my current practice. I started a Refugee Women's Health Clinic nearly 4 years ago in Phoenix, Arizona. And our mission is 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 and eliminate health disparities and cultural barriers to care.

So we have some core missions and goals that ground our clinic. And one of them is that we are locally accessible and globally minded, helping refugee women navigate the health care system and increase their health seeking behavior.

How do we do that? Well our priorities are community driven. We have hired staff who are themselves from the refugee community, and they are also culturally and linguistically appropriate trained medical interpreters. And we do a host of in service cultural sensitivity training across our health system in various departments, in our hospital, as well as among our various staff, both at the hospital as well as in the community.

Since we started the clinic we have grown tremendously. We now serve over 1500 women from 35 countries across sub-Saharan Africa, Southeast Asia and the Middle East. Our largest populations are from Burma or Myanmar, as well as Somalia, Iraq, and a growing number now from the Democratic Republic of Congo, Liberia, Sudan.

We provide live, in person direct interpretation in more than 13 languages. And we have also expanded our locations on the main medical campus of our hospital, as well as a satellite site, which is more accessible to our local refugee communities.

Another major overarching theme of our clinic is that we strive to overcome barriers by providing culturally sensitive health care. How do we do that? One major strategy is our patient education classes which help to demystify the fear of labor and delivery. Oftentimes women would report, you know, we as obstetricians, we tie our patients down to the bed. And of course we don't tie our patients down to the bed.

But guess what? It was very enlightening to learn that women may perceive the IV line, the blood pressure cuff, the monitoring straps that we as providers view this as helping to monitor the mom and baby's wellbeing, women may perceive this as being strapped and immobilized to the bed.

And so we do a lot of orientation, not only to the labor room, but why an IV may be necessary, the process of induction. We provide tours in our hospital where they can learn about the various processes of what they will experience during their labor, and explore some of the pain management options.

And then we also enlighten them on what to expect after delivery, with the nursery and postpartum care. And a lot of our classes involve postpartum care of the mother and newborn care, breastfeeding strategies, car seat safety measures as well as family planning.

And our staff are available not just in the outpatient setting but also in the inpatient setting in helping women with discharge planning and setting their next appointments after discharge with the OB/GYN or midwife, as well as with our pediatric partners.

Another major essential part of how we hope to overcome barriers is through our intensive care coordination, where we through our team, provide home visits, patient reminders of appointments, we coordinate transportation services.

We have volunteers assisting patients in going to other ancillary services such as radiology, the pharmacy, to get blood drawn in the lab, to the emergency room or labor and delivery. And this is to help refugees who may not be able to read signs. The hospital can be a very big and scary place. And this is helping to quell some of those gaps in follow-up for necessary tests and services.

We also assist with ensuring insurance coverage and minimizing any gaps in service, as well as advocating for other social services as needed, child care, and as I mentioned, "The live interpretation throughout all of these activities," as well as cross-referrals within our health system and our outpatient family health centers.

We also work closely with case managers at the various refugee resettlement agencies and with the health plans that the patients may have.

Another main aspect of our mission is to empower women by eliminating the myths surrounding labor and delivery and preventative health services. How do we do that?

Well one very successful measure has been our communication card. And this is a pocket sized laminated double-sided card, as you can see featured, and it says, "I am receiving care at Maricopa Medical Center, please take me there." It includes our numbers.

And we have an intervention that's currently underway that has been extremely successful where we're providing targeted education to women in their last trimester of pregnancy on recognizing the signs and symptoms of labor, as well as working with our area fire departments and emergency services to help them.

When they show this card to the ambulance, they are preferentially bringing our patients to our hospital if it's safe, as well as helping to facilitate their access to care in an emergency. And this has been extraordinarily successful, and has been successful in empowering our women to be able to access care when needed.

Another major aspect of our empowerment has been through our Refugee Women's Health Community Advisory Coalition, which is a coalition comprised of community stakeholders who are co-equal partners with our Refugee Women's Health Clinic, working to empower, mentor, connect, and reshape the lives of refugee women towards improved health and wellbeing.

This is just a schematic of our very various community partnerships that comprise this coalition. We have nearly 70 members involving

primary care providers, grass roots ethnic organizations, academic partners, the state's refugee resettlement program, the refugee resettlement agencies, the public health department, faith based organizations, and other community social services, and our cultural health navigators that are integrally involved in our care.

And so we function as a patient-centered medical home. And we have been able to successfully achieve enhanced access to care, intensive care coordination and case management, as well as continuity of care. And we've been successful in integrating a team-based approach to health care delivery that is culturally sensitive, engages our community partners, and improves patient trust and empowerment.

And we have a very hands-on, patient-centered approach that provides culturally sensitive care in a safe, accessible environment that meets the language needs, and builds trust by engaging patients and their communities and empowers women towards improved health literacy. And we're beginning to track some of these outcomes, in terms of how we are improving reproductive health outcomes.

And so this integration involves not just clinical care, but community engagement and community-based participatory research. And with our community engagement we have many programs out in the community that are working to empower and improve health literacy in the apartment complexes, through various health fairs and other social support that we're able to provide for our community and our patients.

And in terms of some of the community-based participatory research involvement that we've been engaged in, I'm just highlighting just a couple of projects that have been aimed to promote health literacy.

We had a community needs assessment a few years ago, examining some of the reproductive health priorities of Somali women and Bruneian women. And this informed one of the subsequent interventions.

And you can see the next one, this was focused on breast health. We developed a Train the Trainer intervention through assistance by the Susan C. Coleman Foundation to increase breast health literacy, as well as build community capacity in the Somali refugee community. And it's been extraordinarily successful in improving their knowledge and health-seeking behavior.

So now let's just close with some tips on promoting cultural competency. So I want to emphasize, one of the most important aspects of culturally sensitive care is engendering trust. And this, I can't overemphasize how critical this is in informing all other aspects of care.

And this can be achieved through continuity of care, and if possible female providers should be involved whenever feasible in the care of refugee women. We should also aim to address some of the structural barriers to health care access, such as transportation, lapses in health insurance coverage, long wait times or women feeling rushed through the visit. It's also important to involve the partner and spouse, especially as it may pertain to health care decision making.

And then also cultural health navigators. As I mentioned in our practice, they are such an integral portion and component of our services because these health navigators are women from the same refugee communities that we're serving, they're multilingual. They're

working, not only out in the community, but also in the health care setting of the clinic, as well as in the hospitals for inpatient care as well.

And that's been hugely successful in engendering trust and really building that empowerment of women but also trust towards improved compliance with care recommendations and treatment.

And it's also - of course everyone is aware of the need for effective use of interpreters. But I also want to emphasize the need to respect modesty and understand some of the cultural or traditional practices that may be unique to the population you're serving.

And be aware of any religious observances, such as Ramadan for Muslims during pregnancy and provide anticipatory guidance and answer any questions and provide counseling to help dispel some myths or fears women may have. And then of course, as you've seen care coordination and case management is extremely important.

I also need to emphasize that it's common to look at refugee women's health from a deficit model in terms of all the barriers to care. But it's important to encourage an asset based approach to promoting self-efficacy and health coping mechanisms.

And this can be through looking at the supportive family and social interactions that are inherent in refugee communities or some of the community-centered values, the sharing that occurs within the cultural unity and the strong sense of resiliency that is exhibited in and throughout the community and how it - they maintain strong cultural beliefs. These attributes have been shown to have a positive impact on coping mechanisms and problem solving during difficult circumstances.

So now let's take a look at our final polling question. It's, "What is an essential component of culturally sensitive care? Is it; A, engendering trust; B, ensuring access to transportation; C, involving the partner and spouse; D, the use of female providers only; or E, all of the above."

And I'll allow you time to answer this question; ten, nine, eight, seven, six, five, four, three, two, one. And I will close the poll at this time. And yes, the overall majority noted, "All of the above," which is correct.

But I also want to speak to the importance of engendering trust. I would say that is the most important aspect, which all of the other factors are critical as well, but engendering trust is probably the very first thing, and most essential component to consider in culturally sensitive care, including all the other factors that I mentioned.

So now let me just conclude with some points on research directives. As we move forward in considering future research, partnerships and approaches to understanding refugee women's health, we really need to distinguish refugees as a unique sub-population of immigrants. They are a vulnerable sub-population, as I've discussed in this presentation, and we need better ethno-cultural specificity.

For instance, often African refugees may be clumped under the umbrella of African-American. And that truly shouldn't be done, but often that's the only way to capture a racial distinction or ethnicity. But we really need better specificity to distinguish African-Americans from African immigrants for instance, and then African refugees who are a separate population. So that's just an example of the need for better ethno-cultural specificity.

We also need more linguistically appropriate and validated instruments that are culturally relevant. And we need measures that are validated for working with low literate populations, especially populations that rely on oral tradition, who may not be literate in their native language, much less English.

I have many patients who have never had any formal education. And they heavily rely on oral communication to transmit information and gain knowledge. And so we really need to look at how, from a research standpoint we can incorporate measures that can assess and include this consideration.

And then as I mentioned, the cultural health navigators, which are also termed promotoras or patient navigators. This is such an important component of refugee health services and that link between the community and the hospital and the clinic, and the cultural liaison through multilingual navigators, who can really be - and are such an integral component of care.

And then finally, the patient-centered medical home is the big sexy term these days. Can it transform health care delivery? The notion of the patient-centered medical home has been around for quite a long time actually, since 1967, and it has gained considerable traction in recent years with the focus on health care reform.

And it focuses on enhancing outreach and engagement of patients, better documentation and coordination of care, such as the use of electronic medical records, increasing the use of population based disease management. And this is particularly pertinent regarding emerging chronic diseases and it's aimed to improve the quality of care, increase satisfaction with care, and lower the cost of care.

So more evidence is needed on what processes would achieve these outcomes and what reimbursement models for care coordination and patient navigation would be necessary. And so there are some health policy implications for refugee communities. One is - that is key is community engagement.

And this creates bidirectional dialogue and partnership at every juncture, it engenders trust, dispels myths and misunderstandings, ensures sustainable capacity building such as the use of community health workers, and it creates social capital which empowers communities in navigating the health care systems.

We also need evidence based clinical guidelines and protocols which addresses the needs and values of refugee women, involves men as partners in medical decision making, and engages a multidisciplinary team which may be comprised of providers, social workers, community advocates, resettlement agencies, interpreters, et cetera.

We also need to involve and engage our local as well as national stakeholders, and design replicable intervention programs that improve the quality of health care delivery.

So I want to just list here some Web resources. An expanded version of my presentation is available and posted on the North American Refugee Health Care Conference Web site.

And also the Refugee Health Technical Assistance Center can be a repository as I have been building the content on Refugee Women's Health that you can see.

And also I have included some tips and strategies for culturally sensitive care that is also included under women's Health on the Technical Assistance Web site. And then there are also archived webinars on culturally and linguistically appropriate services that you can find on the Refugee Health Technical Assistance Center Web site.

And in follow-up to the question on training on defibulation, I'll make sure that the Web site to ACOG is also included, which is a link to the technical video describing the technique of defibulation for those providers who are interested in learning the technique of performing this practice.

So I want to thank you for your time and your interest and your participating in this webinar today. And I will take any questions in the remaining time that we have. Thank you so much.

Dr. Paul Geltman: All right, well thank you Crista. So we've had a bunch of questions come in, a couple I've been able to answer directly via the chat box. And we've been taking notes of others that have come in. And people should continue to send questions in if any come to mind.

And so Crista I'm going to just pose a quick one to you which is someone asked, "Whether a midwife can do defibulation?"

Dr. Crista Johnson-Agbakwu: Yes they can, absolutely. And in - if you're able to perform an episiotomy, I mean midwives can absolutely perform a defibulation. It's a very, very simple technique.

And the video through ACOG describes and shows the actual technique strategy. And also the expanded version of my slides, the ones that are posted - that will be posted on the North American

Refugee Health Care Conference, includes still pictures, images, of the steps of defibulation.

But yes absolutely, nurse midwives can perform defibulation. And nurse midwives are an integral part of our current practice. We work hand-in-hand with them in the care of our refugee women.

Dr. Paul Geltman: Okay, well that's good to know because my initial response was that I wasn't sure that midwives were licensed for any kind of surgical procedures. So I'm glad I decided to ask you that.

Dr. Crista Johnson-Agbakwu: In the setting - really quick, in the setting of delivery, at the time of delivery, I - you're right regarding surgery. For instance, if it's performed before pregnancy or antenatally. But at the time of delivery I don't see why midwives should - would not be able to perform this procedure. And I have to look into the licensing, I'm not familiar with the regulation specific to defibulation.

Dr. Paul Geltman: Right. And it may be something that varies from state to state so if you are a midwife and interested in this, it is probably something best to check with your board of registration in your particular state, if it's not something that's not generally in your practice. And also it may be something that you need to check on your hospital privileges as well, in terms of what you're credentialed to be doing.

So let me move on. The question also about the resources and videos for training on defibulation. As Crista mentioned, she has some still-shots in her other slide set. And we will see if we can get some kind of a link to a good example that we can put on the Technical Assistance Center Web site as well.

And the - so let me move on to another question then. This came from a practitioner who wrote in response to your discussion of the orientation that you do for pregnant women to sort of acclimate them to labor and delivery and postpartum care.

This person wrote that, "It's crucial to minimize medical interventions and care and allow women to achieve the type of birth they are used to in their countries to the greatest possible extent."

So Crista can you describe what, if any, kinds of accommodations or orientation that you may do for refugee women, other than kind of explaining the Western approach and sort of a medical approach to labor and delivery that they...

Dr. Crista Johnson-Agbakwu: Sure.

Dr. Paul Geltman: ...you know, might encounter?

Dr. Crista Johnson-Agbakwu: Sure. That's an excellent question and I'm glad it was raised. Yes, and this is what I stress, especially when I teach locally, every effort should be made to help in accommodating any cultural specific requests or norms that are comfortable for the patient, as long as it's safe and does not incur any, you know, undue harm to the mom or the baby.

For instance, something that I strongly advocate is walking in labor. Because again, I know at least for the patients that I serve, the big fear is having a C-section. And they feel as though that being, you know, encumbered on the bed, it sets them up for a C-section.

So I encourage, especially when it's safe and the fetal tracing is good in the earlier stages of labor, for women to walk. And I have so many refugees that do laps around labor and delivery. I really encourage when feasible, to walk. And even if they're pushing the IV, so that they can help create some semblance of normalcy to their - what's normative for their labor and birthing experience that they're used to.

So we really try to make efforts whenever possible to encourage, whenever it's safe, for women to, you know, squat, walk around the room, walk around labor and delivery. If they - if the baby is good, if they don't want the straps on, at least for a portion of their labor, that is fine if it's intimate. And so we really try to accommodate these requests, especially if it really helps assuage their fears and helps with their experience during labor.

And we've done a lot of training and education with our nurses on labor and delivery. And you know, they've been very accommodating and hopeful. And this is something that we really need to look at more rigorously with research and trials to look at how this - whether this can improve outcomes or not make a difference in terms of address outcomes. So that's something that we try to accommodate as much as feasible and safe.

Dr. Paul Geltman: Okay. So before I leave this topic - or actually, backing up a little bit in the topic, before I leave defibulation, one person had asked earlier, and we agreed to come back to it, "What about the women who don't want defibulation?"

Dr. Crista Johnson-Agbakwu: Good. So yes, so this comes up quite a bit in my practice. I would say the overwhelming majority of patients with - that I see with female genital cutting do want the defibulation. But I do have

a subset of patients who for their own notions of beauty, genital self-image, pride, honor, actually prefer their infibulation scar and actually request that after delivery, portions of their scar be re-approximated.

So I do have a subset of patients who actually, even outside of pregnancy, come to me requesting re-infibulation. So that of course, as you can imagine is an ethical controversy. We don't have policy guidelines in place in the United States.

I do know in countries, say in Europe, they have federal laws prohibiting any form of re-infibulation. And so how do I deal with this locally? And you may also have to check with your state because there may be state-specific laws regarding this as well.

What is key for me in my practice is counseling; counseling and educating the patient extensively. I have found that in women for whom their sense of honor, pride, self-image, is so key relating to their circumcision scar, I've been able to achieve a compromise where as long as they're not having any sexual concerns or other morbidity relating to their circumcision, I've been able to achieve a compromise where the most superficial aspect of their scar, which is around above the mons pubis or clitoral - peri-clitoral region, I may re-approximate. But I do not re-approximate anything below the urethra.

And so that has been a compromise that has been amenable to that subset of patients for whom they have requested some sort of re-infibulation. But I have never, and will not, re-infibulate a patient to their original circumcision obviously, because I am not going to recreate any new harm or create new morbidity.

But for those women who this is staunchly defines their sense of normalcy, I have been able to achieve that compromise just with the most superficial, superior aspect of the scar, re-approximating that tissue down to the level right above the urethral meatus.

I must also add this other caveat, and this has to do with patient autonomy, and I've had this conundrum as well clinically, where women in the office, in my office in the clinic, will request defibulation and be thankful and grateful for defibulation, which may only be able to be performed say at the time of delivery, based on when they present for prenatal care.

But I've had the situation where I'm literally in the labor room and it - we are now reviewing with the patient, "Okay you know, as you requested we're going to perform the defibulation," right, just to make sure that we're all on the same page and everyone is in agreement.

And the next thing you know, in the room the patient is surrounded by her social support, matriarchs in the community and in her extended family; the grandmother, her mother-in-law, her own mother, other matriarchs that are shaking their head and scowling and saying, "No, no, no," and you know, speaking in their native language.

And it's been a challenge because the patient herself wants a defibulation. However, she is going home to her social support, which is these matriarchs -- aunts, mother-in-laws, grandmothers -- that are going to help her during the postpartum period.

What are the ramifications if she does not acquiesce to requesting that her scar being re-approximated in - to a certain degree? Because it's

no longer her own choice because she may not have the autonomy to make that decision for herself.

So I don't think there's a right or wrong answer. It is an ethical conundrum. It's something that I have faced on many occasions. And in those situations, those patients - these patients have changed their mind at the time of labor and said, "No, I don't want it anymore. Please re-approximate my scar."

So despite counseling and despite the patient's request in the outpatient setting, sometimes due to the pressure from her social support - which is a positive, you know, we need social support to help women in the early phases after delivery, but also it can be a negative influence in that she might lose her autonomy.

So in those circumstances, I have you know, achieved again a compromise where we will open the scar, but only re-approximate, again the most superficial, superior aspect of the scar, but nothing below the urethra. And that has been amenable to both the patient and her family.

So I'm open to other comments or discussion. It's extremely controversial. And this is - I'm on the soapbox about this, in terms of how we as providers, OB/GYNs and nurse midwives, really need policy to help guide our counseling and our practice in these very sensitive cases and circumstances when they arise.

Dr. Paul Geltman: Great, thanks Crista. Now I have about four or five questions that all kind of touch on cultural issues and health promotion. So I am going to try to bundle them and summarize them to you, all right?

So there was an interest in knowing whether you have tips or strategies in a variety of areas. For example, just encouraging initiation of prenatal care, or even just primary care in the community, or tips or strategies around navigating through topics like birth control or family planning.

And then also someone asked specifically about training for cultural health navigators, like community health workers. And the latter is something we have some experience with at the Mass Department of Public Health and we can post some information on what we do. But I would put those to you Crista.

And then another question in that vein is when - is whether when you do a structured program, with say a group of refugees, whether you find - you know, around empowerment and self-direction skills, whether you find that those skills are sustained after the program ends.

Dr. Crista Johnson-Agbakwu: Oh yes. Yes. So yes, thank you. These are really excellent questions.

Let me start with the first one in terms of tips and strategies on how to help promote early prenatal care use. So that is something that we are very much engaged with throughout, you know, these years since we've started the Refugee Women's Health Clinic. We are out in the community.

So you know, yes we are - we have you know, the brick walls of the hospital and - where the clinic is housed, but you will find that our staff, every single week we are out in the community. Our staff of cultural health navigators and our program manager, they are the face of our community.

They speak the languages of the patients, they are refugees themselves. They're in the apartment complexes, they're at community meetings based on the different ethnic groups. And they're promoting awareness about prenatal care.

And in that awareness, we've been able to emphasize the importance of reproductive health, the importance of seeking early care. And not just for pregnancy, but also for reproductive health in general, as well as cervical, breast cancer screening and awareness, general wellbeing and health.

And so I think as a guide, for those who may be looking at ways to implement similar strategies I would say, "Partner with or find leaders in the community in the various ethnic groups and communities that you're serving and seek to bring them to the table to engage them on strategies that would be appropriate to the local community that you are serving."

Another key aspect is the fact that we have a Community Advisory Coalition. We meet quarterly, every three months, where they inform everything that we do. We talk about our programs and our initiatives and they help drive the emphasis and focus of where we should devote our energy and attention.

And that is another way to provide empowerment, because these stakeholders who come and are part of our coalition, then go back to their respective communities and spread the word. So we heavily rely on face-to-face word-of-mouth dissemination and education.

And the same holds true for birth control and family planning. And as you probably are well aware that there is a reservation towards using what we would perceive as traditional forms of contraception whereas - whether it's birth control pills or Depo Provera or the IUD. And in certain communities I find that there is a strong reluctance to use any form of family planning.

And so what we have done to address that is we have started a natural family planning class, where for those women who may not be receptive to contraception for instance, we are educating them on the menstrual cycle using pictures, videos.

We have a small curriculum that we have been able to use in partnership with the local dieses here in Phoenix. And we've been able to successfully implement natural family planning classes so that women, even if they may not want to use hormonal contraceptive methods, may still be armed with knowledge about their menstrual cycle, how their menstrual cycle works, how to you know, to monitor their cycle, et cetera, that will at least empower them to be able to have some kind of knowledge and control in terms of their fertility.

But also, education is key. Because I find that the more we're able to help dispel some of the myths and fears about contraception, we're slowly getting, you know, more and more women up, considering say the IUD, especially for those who have had five, six children and are through and face the challenges of raising a large family in the United States.

And so I find that's something that we're going to be tracking over time, to see you know, ensuing - the impact of our educational outreach and how that may be influencing increased use of contraception.

And the same goes for empowerment, sustained empowerment. We have found that our women's empowerment type programs is continual. And we have seen - because now we have patients that are now on their second and third pregnancy with us, and they are so self-sufficient. It's amazing how we can see the improvement in their self-efficacy, where they do not rely on us to make their own appointments.

They know where to go if they have to go to the lab or to the pharmacy. They're setting up and scheduling, you know, things on their own and seeking our advice, and really being very proactive.

So we have seen the growth in improvement, not just within the individual patient, but in her family, in her being able to navigate care for her children, in bringing her partner in for services, in spreading the word in the community across their neighbors and families and other community members.

So we have really seen the improvement in just narrowly four years, since we've started the clinic and self-efficacy in the community. And we do a lot of work with community development; capacity building out in the community, so they themselves can help conduct some of these seminars themselves.

So it's not just the provider doing it, but it's actually the community members themselves leading some of these educational forums and sessions. So it's an ongoing process that we have continued and we will continue to sustain and build upon. But we are - in just 3-1/2 years we've shown that there is self-efficacy that has been built. And we are continuing to look at that formally through some research projects that we have in place.

Dr. Paul Geltman: Great. I think there's one more question that we haven't gotten to yet. And we have a few minutes so maybe just a quick answer to this Crista. But it's a question about adolescents. So if you do any adolescent gynecology, the participant is wondering how you approach sexual and reproductive health with adolescents given the cultural taboos, and you know, sort of the inter-generational issues, the acculturation issues that will be faced?

Dr. Crista Johnson-Agbakwu: That's a really great question. That one is a sensitive one because we do have a very high teen pregnancy rate, especially in our Liberian refugee community. We're seeing a lot of teen pregnancies.

One thing that we really, I guess would advocate for, is being able to talk to these young women by themselves if possible, in terms of if they may be accompanied by partner or their mother or some other person in the community, providing an opportunity to speak to the young woman by herself allows you to be able to tap into more sensitive issues relating to sexually transmitted infections and sexual health, reproductive health, birth control, et cetera.

There are though - there is a conundrum where - and I've faced this myself clinically, where when I try to engage in this conversation young women may say, "Oh no, that's not me because my culture doesn't allow or my religion doesn't allow because" - meaning that we should not have this conversation because, "I'm not supposed to do this until I'm married," kind of thing.

So - and that's okay. You may not be able to cover at that visit. But I would potentially say, you know if there is trust that's built over time,

you know, perhaps broaching that topic at a later date or being able - especially if there's greater trust, we may be able to get through that shield by being able to get to the heart of what might be bothering her.

Or asking her, "Well, do you have any concerns that, you know, you would like," she would like the provider to address.

So I think it's something that is on an individual basis. You would probably have to garner trust with the patient, and it might need time, to be able to begin to provide education and counseling on sexual and reproductive health.

Dr. Paul Geltman: We're going to have to end there. I'll just add to that, as a pediatrician, that one of the important things that should be emphasized with adolescents is their right to confidentiality. And that's a big step in engendering the trust that's necessary.

So I want to thank all the participants for sticking with us and the lively questions that we received. You can still send in questions while the chat box is open, or you can email them to refugeehealthta@jsi.com. And we'll respond to all questions in writing. And materials, the slides et cetera, will be posted on the refugeehealthta.org Web site.

And as the chair is posting in the chat room, don't close your browsers until the - you get the pop-up box for the evaluation okay? When the webinar concludes in a moment, you'll get a pop-up box for the evaluation.

So I want to thank Dr. Johnson-Agbakwu again. And to all of you, have a great afternoon and stay tuned for our next webinar in the future.

Operator: And ladies and gentlemen that does conclude our webinar for today. We thank you for your participation and ask that you please disconnect your line.

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