REFUGEE HEALTH TECHNICAL ASSISTANCE CENTER

WELCOME

You are attending the webinar on

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

presentation will begin shortly

***Please listen via computer speakers or headphones**
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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 after the webinar
- Email 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,
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Arizona State University

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College of Medicine - Phoenix

REFUGEE WOMEN'S HEALTH CLINIC

Locally Accessible.
Globally Minded.
Overcoming Barriers.
Empowering Women.

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

Crista E. Johnson-Agbakwu, MD, MSc, FACOG
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University of Arizona
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MARICOPA INTEGRATED HEALTH SYSTEM

ASU Southwest Interdisciplinary Research Center
ARIZONA STATE UNIVERSITY

DMG District Medical Group

THE UNIVERSITY OF ARIZONA COLLEGE OF MEDICINE PHOENIX

Objectives

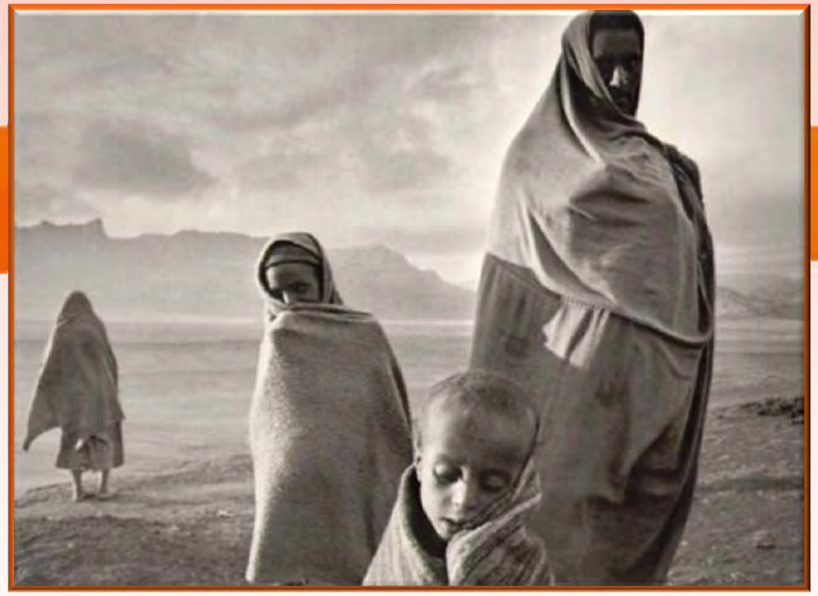
- Refugee Women's Health within the Context of Resettlement
- Refugee Health Disparities
- Best Practice Strategies
- Future Research Directives
- Health Policy Implications

‘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

Among Refugees….

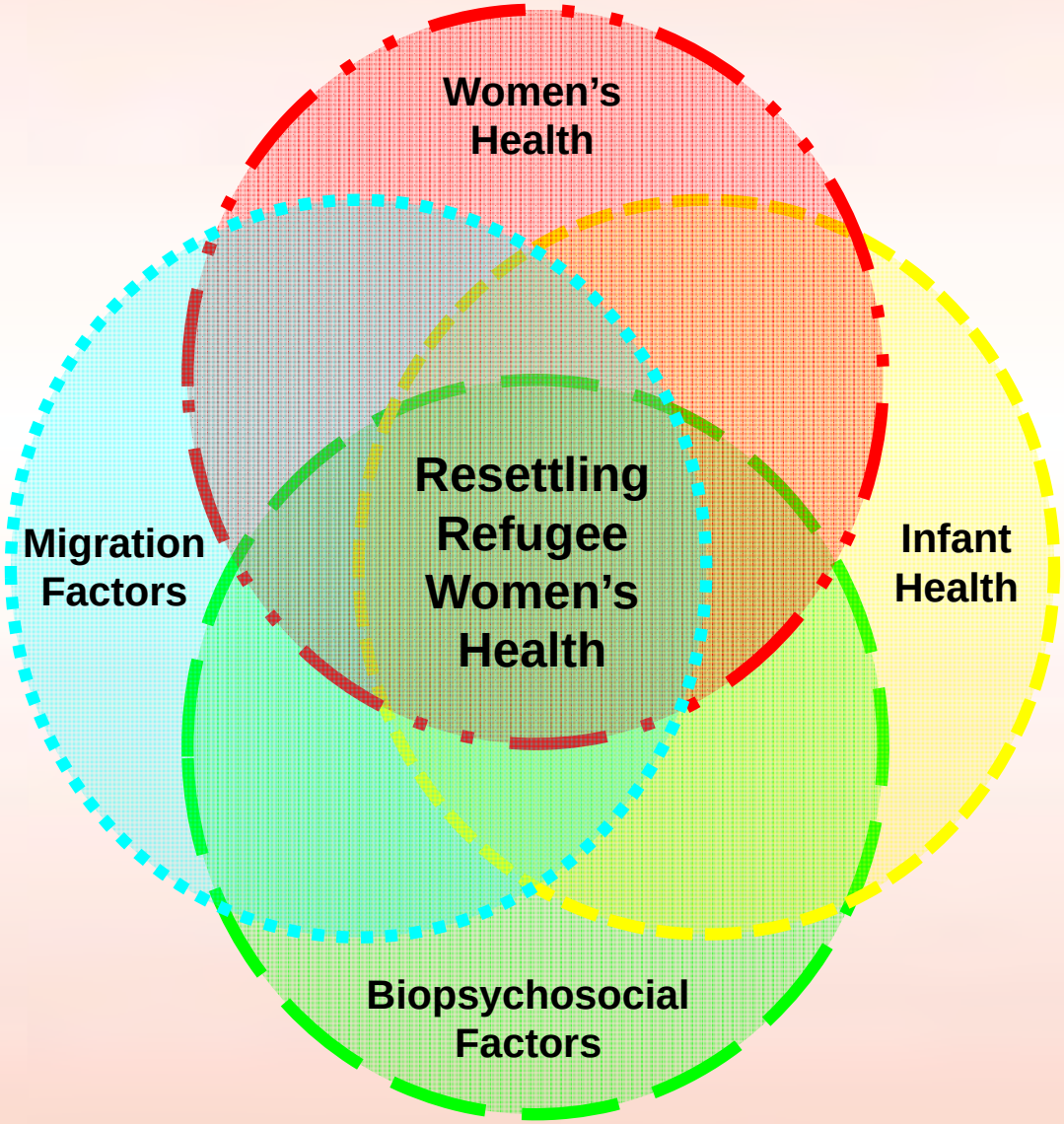


- Evidence suggests the ‘Healthy Migrant’ effect may not be evident….

  - 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.

Caulford P, Vali Y. (2006) CMAJ; Hyman I (2001) Immigration and Health; Dilman E, et al (1993)

Factors Related to the Health of Resettling Refugee Women



Adapted from: Gagnon AJ, et al Health Care for Women Intl 2004, 25: 111-149

Refugee Health Disparities

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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%)

Barkho E, et al (2011) J Immigrant Minority Health

Nilsson JE (2008) J Interpersonal Violence

Thapa-Oli S, et al (2009) Violence Against Women

Short Report: Sexually Transmitted Infections in Newly Arrived Refugees: Is Routine Screening for *Neisseria gonorrheae* and *Chlamydia trachomatis* Infection Indicated?

- Evaluation 25,779 refugees resettled in MN between 2003-2010
- N=18,516 (72%) refugees tested for at least on 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

Stauffer WM, et al. Am J Trop Med (2012)

Cardiovascular Disease Among Somali Women in the Diaspora

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

[a] Four articles on diabetes in pregnancy were included in this category

Kumar R, Einstein G. Curr Cardiovasc Risk Rep (2012)

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.

Wieland ML et al. Women's Health Issues 2012 22(2): e225-e232

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)

Predictors of low cervical cancer screening among immigrant women in Ontario, Canada

- 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)

Lofters AK, et al. BMC Women's Health (2011) 11:20

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

*Swan J, et al Cancer (2003); ˜Saadi A et al, J Immigrant Minority Health (2011)

Perspectives on Preventive Health Care and Barriers to Breast Cancer Screening Among Iraqi Women Refugees

Qualitative interviews of 20 Iraqi refugee women

Emergent Themes

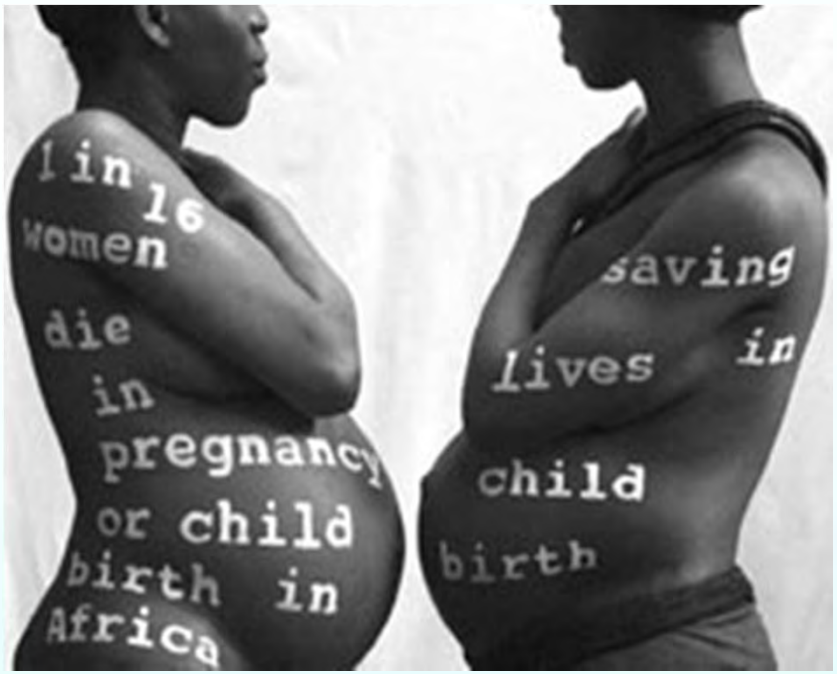
- Culturally mediated beliefs about illness and preventive care
- Knowledge about breast cancer screening
- Barriers to obtaining mammography screening:
  - Psychosocial barriers
  - Health consequences of war
  - Religiously influenced concerns

Saadi A, et al. J Immigrant Minority Health (2011)

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



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EB Johnson, et al. Amer J Obstet Gynecol 2005. 193, 475-82

Fertility After Cesarean Delivery Among Somali-Born Women Resident in the USA

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

Probability of Subsequent Delivery Following Index Pregnancy

Time point following index delivery	Cesarean section group estimate (95% CI)	Vaginal group estimate (95% CI)
	Group 1	Group 2
1 year	2.9% (0–8.2)	3.3% (0–7.8)
2 years	25.9% (9.8–39.2)	55.4% (40.1–66.8)
3 years	58.1% (27.0–72.2)	74.4% (59.0–84.0)

Likelihood of Somali women having a second child after cesarean delivery is lower than after vaginal delivery at 2 and 3 years follow-up.

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Salem W, Flynn P, et al. J Immigrant Minority Health (2011)

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

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O'Mahony J, Donnely T. J Psych Mental Health Nursing 2010

Refugee Women's Health Clinic

Cultural Influences on Postpartum Depression

Positive

- Informal social support
  - Partner
  - Extended family
- Greater religiosity associated with decreased postpartum depression
- Support during perinatal period needs to be perceived as support by mother

Negative

- Mental illness highly stigmatized
- Postpartum depression symptoms more likely to be unrecognized
- Refugee women less likely to seek help
- Unwanted emotional support
  - Parents-in-law
  - Rituals not viewed as helpful by mother

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O'Mahony J, Donnely T. J Psych Mental Health Nursing 2010

Phoenix Women's Health Clinic

Female Genital Cutting

Tradition

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

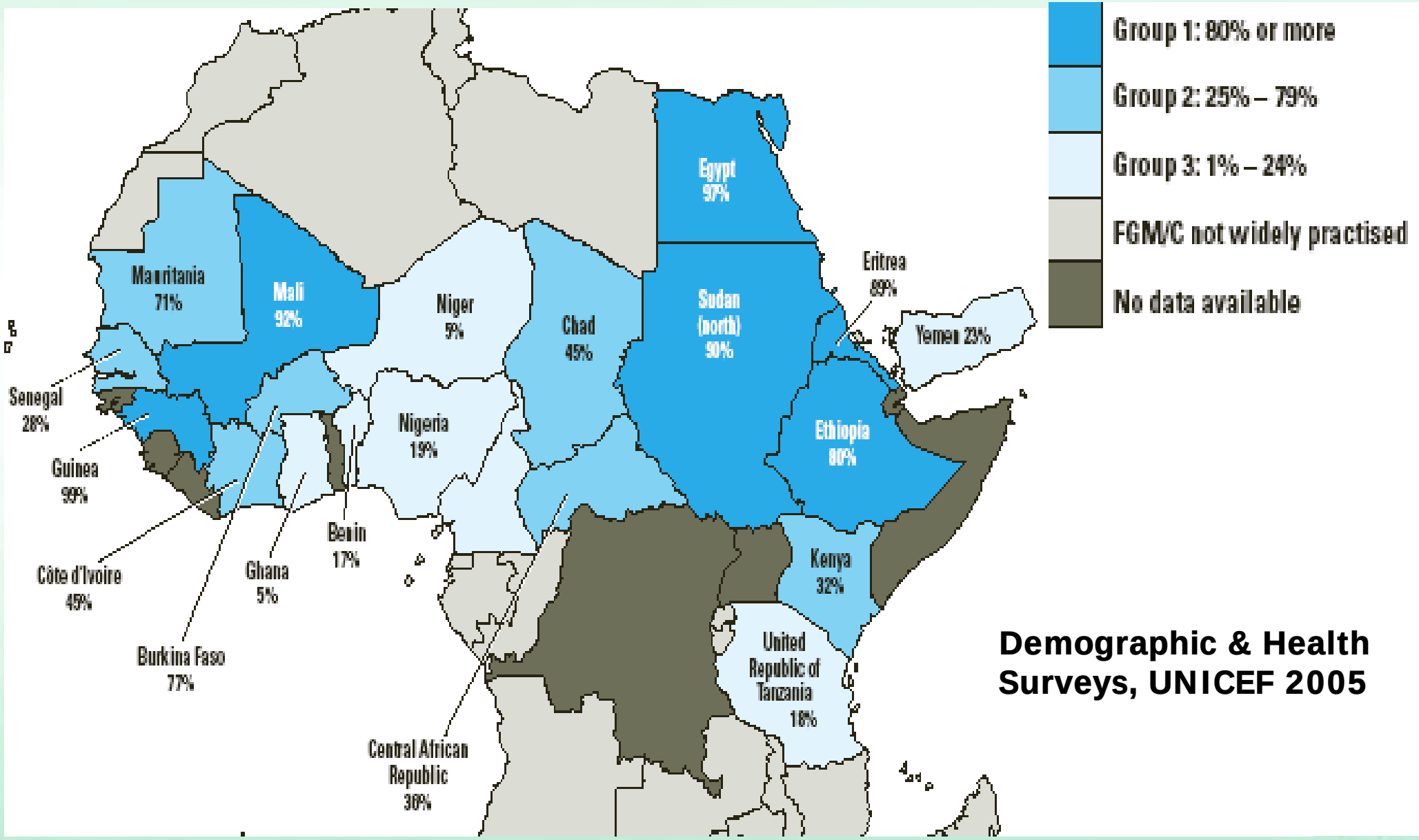
Epidemiology

- 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

Jones, et al. Public Health Reports (12), 1997, 369-377, Wilson. Abstract. Assoc. Amer.

Geographers Annual meeting, 2003 Nour, N. African Women's Health Center, - (Data from U.S. Census 2000).

FGC Prevalence in Women Age 15-49



Demographic & Health Surveys, UNICEF 2005

A Global Perspective

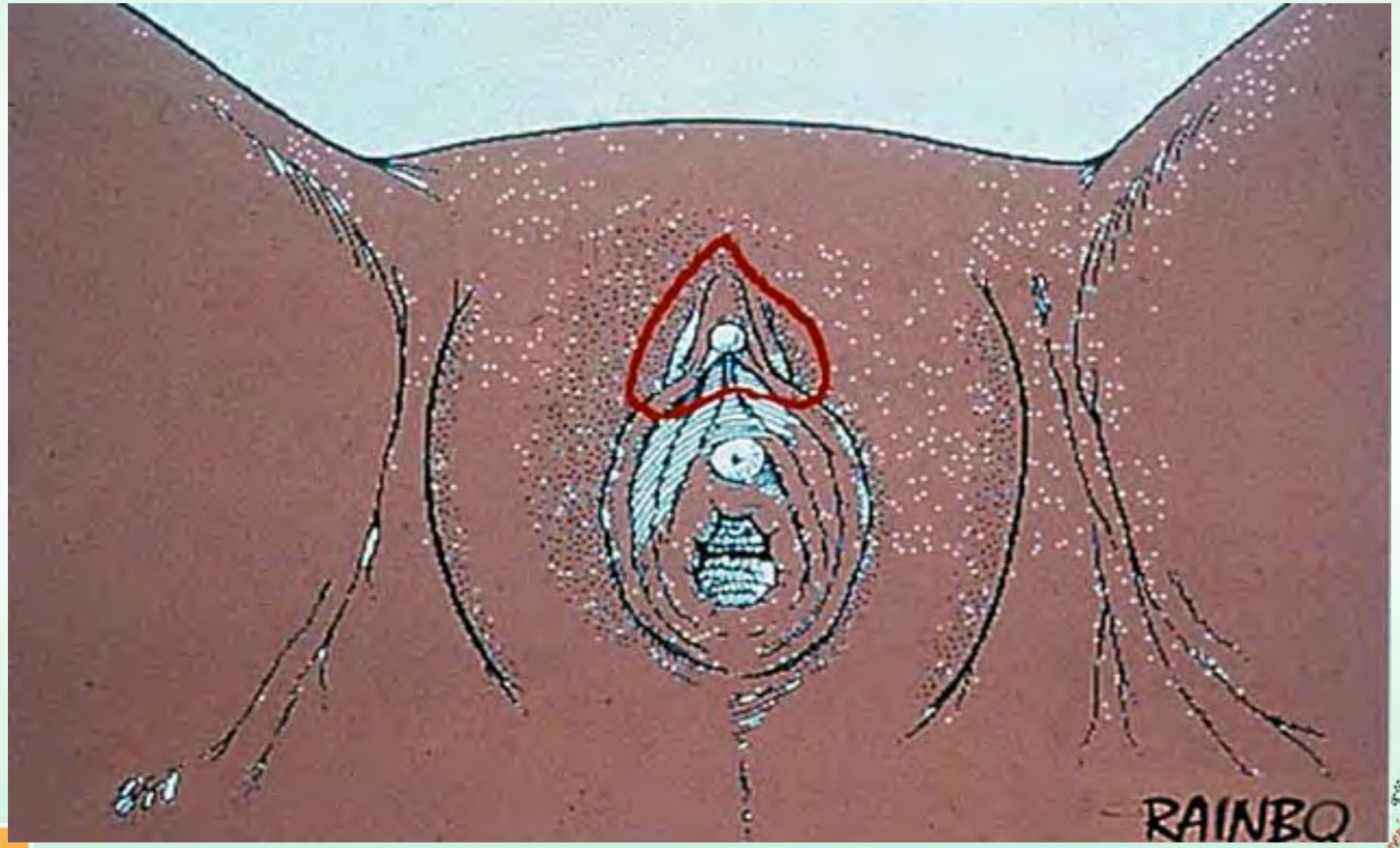
WHO CLASSIFICATION of FGC

- 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”

WHO. FGM. Geneva, Switzerland 1997

Female Genital Cutting (FGC)

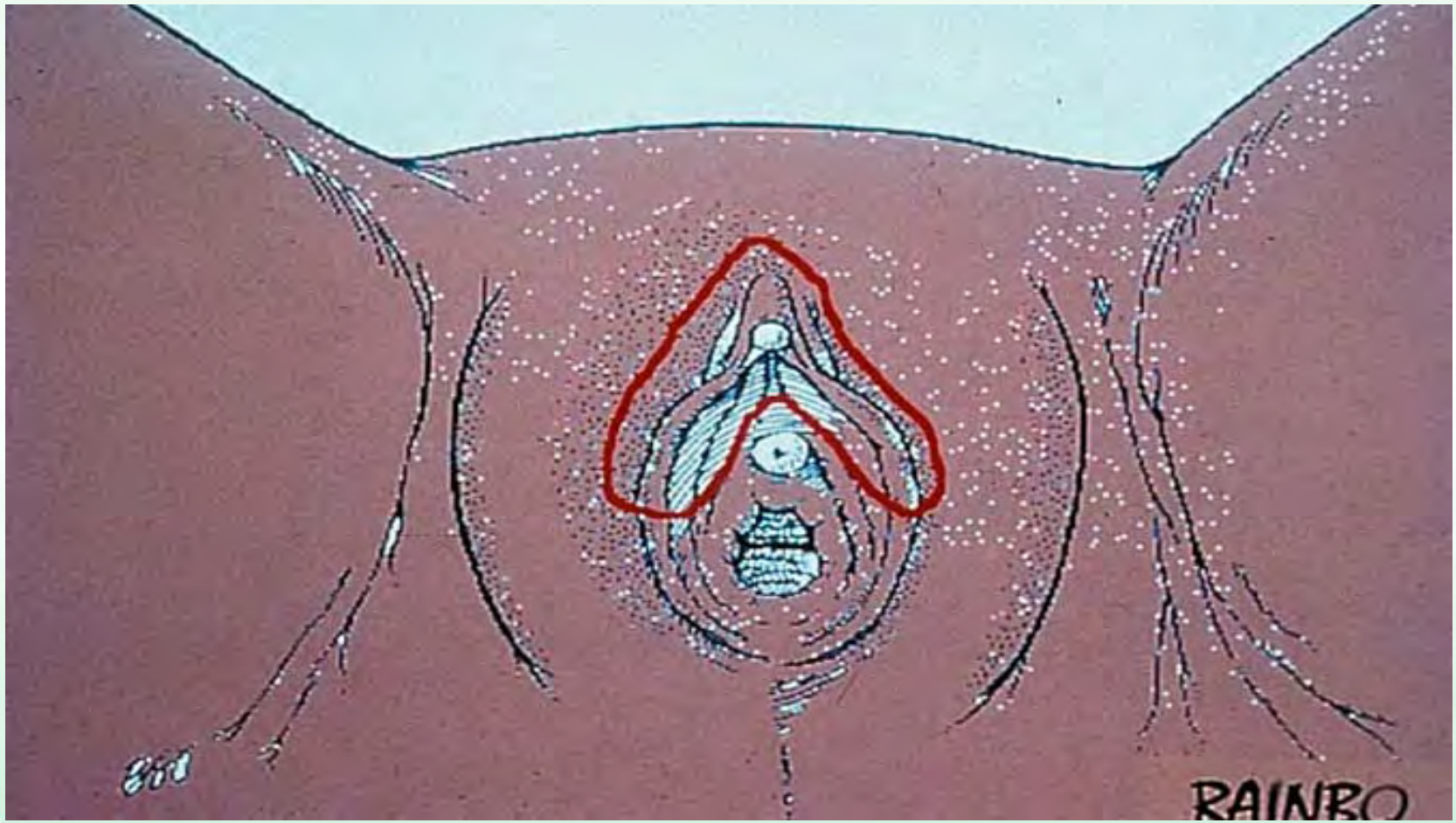
Type I – Excision of prepuce with/without excision of part or all of clitoris



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

Female Genital Cutting (FGC)

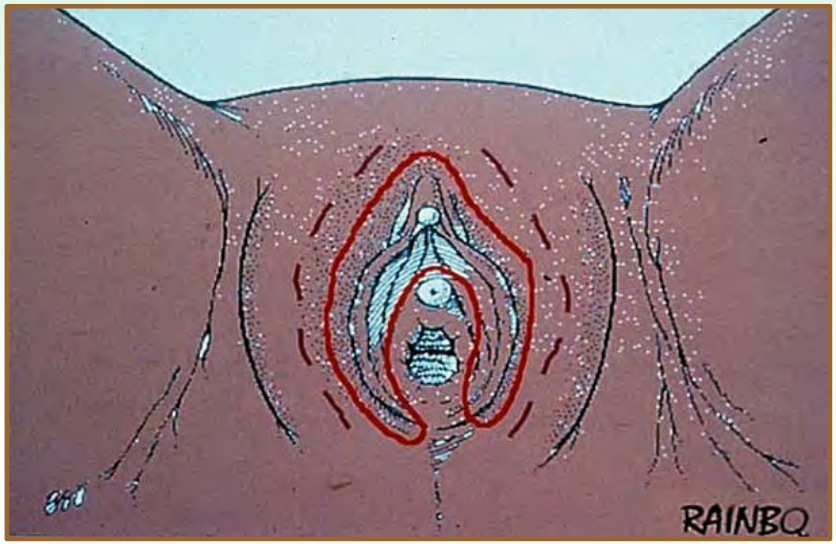
Type II – Excision of prepuce and clitoris together with partial or total excision of labia minora.

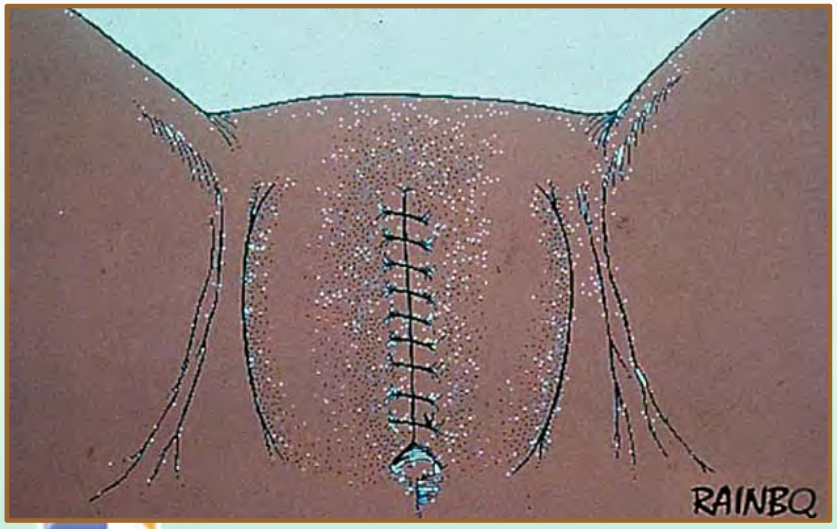


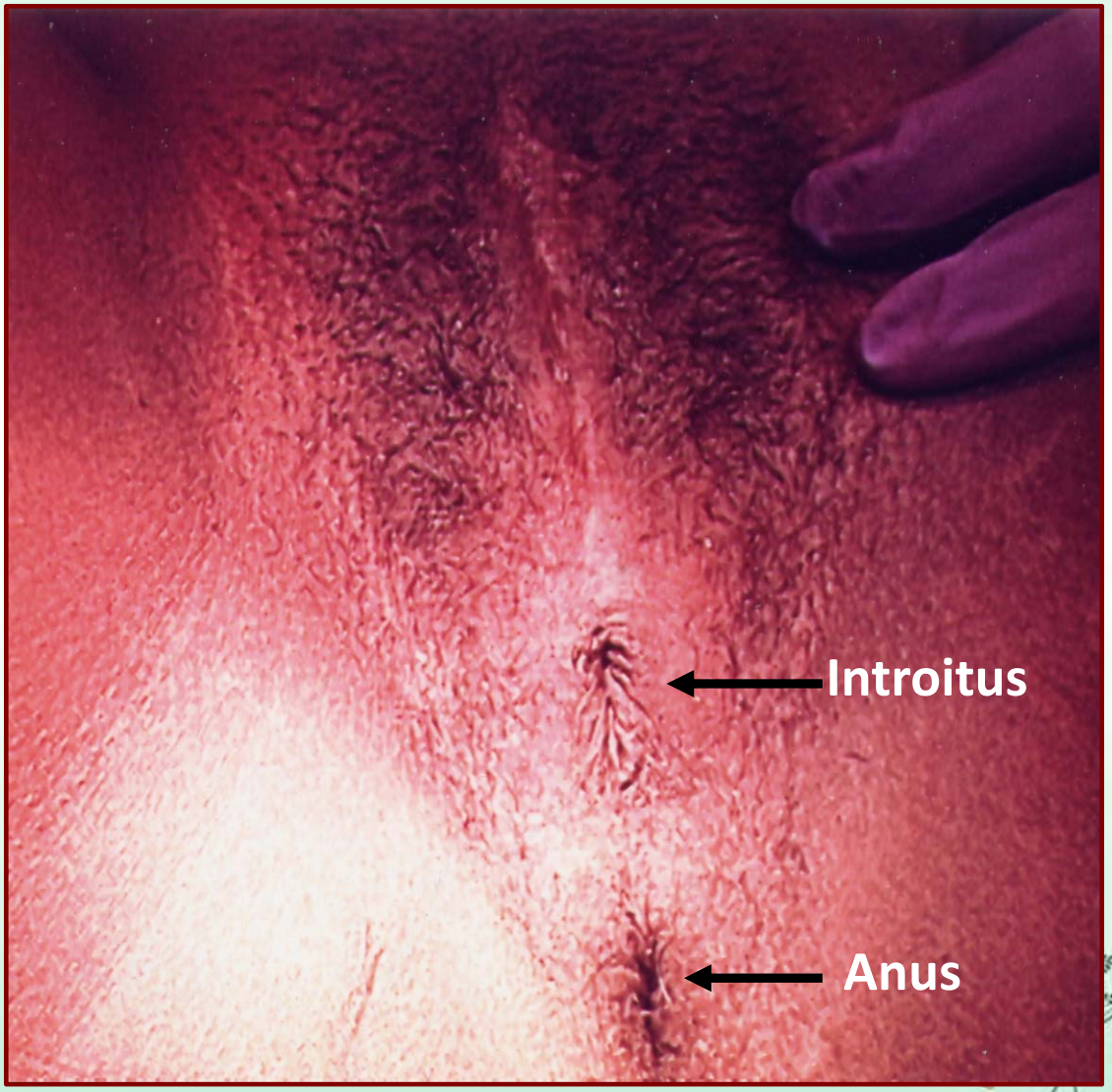
ACOG. Female Circumcision/Female Genital Mutilation, Clinical Management of Circumcised Women. RAINBO 1999

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)

McCaffrey, Sexual and Marital Therapy 1995 787-790.

Legal Issues

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)

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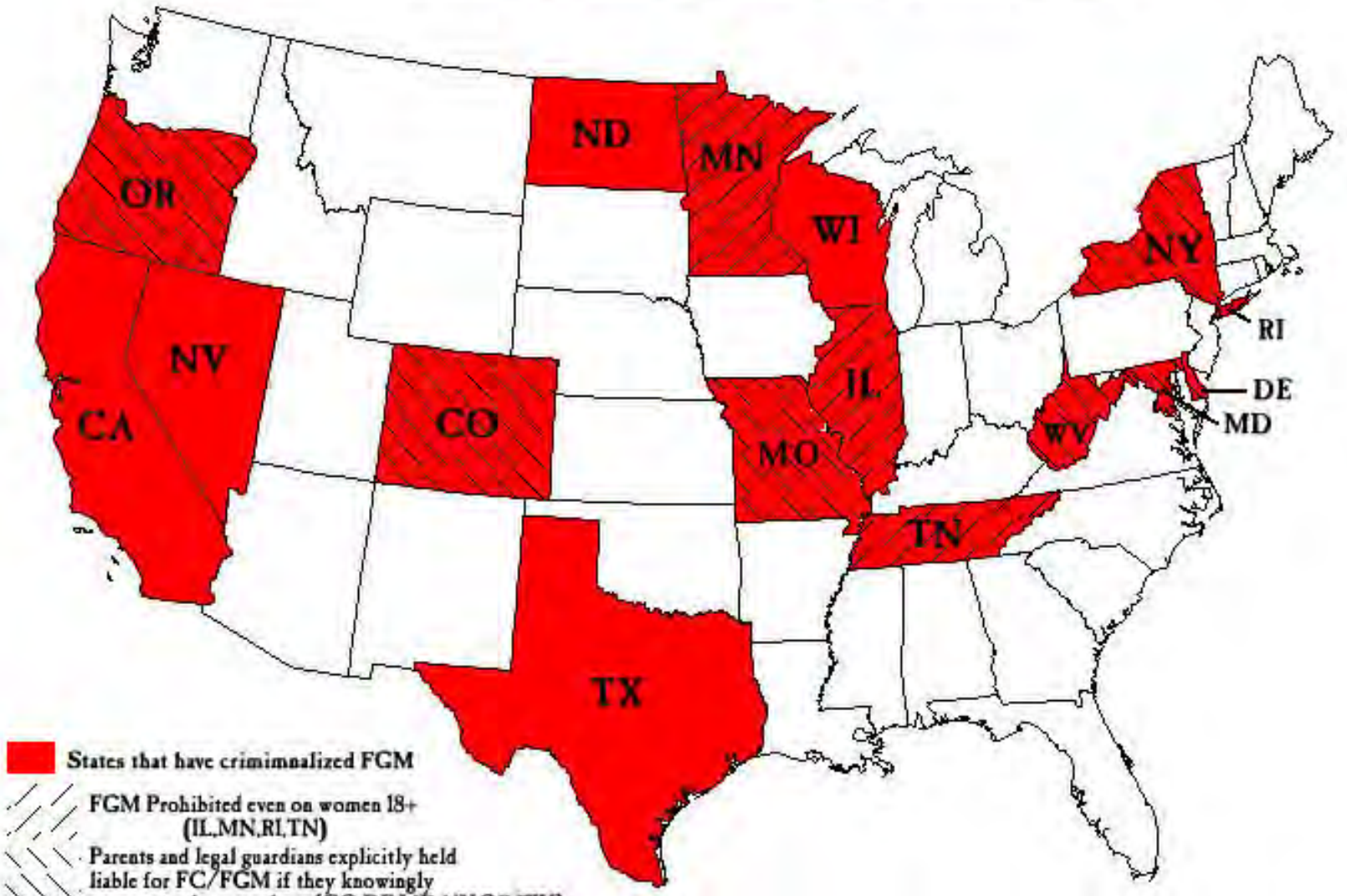
Federal Prohibition of Female Genital Mutilation Act of 1996. Public Law 104-110, Stat 1327, 1996.

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: Punish doctors and Parents. Parents sentence: One year + regular penalty for child endangerment.
CA, CO, MN, NY, OR: Additional provisions for education and outreach to relevant communities.

(Last updated 2/7/2007)

Toubia, N – FGM Guide to Laws and Policies Worldwide, 2003, www.fgmnetwork.org

ACOG committee opinion

Female genital mutilation

Number 151 – January 1995

Committee on Gynecologic Practice

Committee on International Affairs

REFUGEE **WOMEN'S** HEALTH CLINIC

Locally Accessible.
Globally Minded.
Overcoming Barriers.
Empowering Women.

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.

MARICOPA INTEGRATED HEALTH SYSTEM

Refugee Women's Health Clinic

LOCALLY ACCESSIBLE.
GLOBALLY MINDED.

Helping refugee women navigate the healthcare system and increase health seeking behavior

MARICOPA INTEGRATED HEALTH SYSTEM

Refugee Women's Health Clinic

Locally Accessible. Globally Minded.

Refugee Women's Health Clinic

- Priorities are community-driven
- Hired staff are from the refugee community
- Culturally/linguistically appropriate interpreters
- In-service cultural sensitivity training for medical staff

MARICOPA INTEGRATED HEALTH SYSTEM

Refugee Women's Health Clinic

LOCALLY ACCESSIBLE. GLOBALLY MINDED.

Helping refugee women navigate the healthcare system and increase health seeking behavior

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

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Refugee Women's Health Clinic

OVERCOMING BARRIERS.

Providing culturally sensitive healthcare to a growing refugee & immigrant community

MARICOPA INTEGRATED HEALTH SYSTEM

Refugee Women's Health Clinic

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

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Family Women's Health Clinic

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

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Maryvale Women's Health Clinic

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

MARICOPA INTEGRATED HEALTH SYSTEM

Maryvale Women's Health Clinic

EMPOWERING WOMEN.

Eliminating myths surrounding labor & delivery and preventative health services

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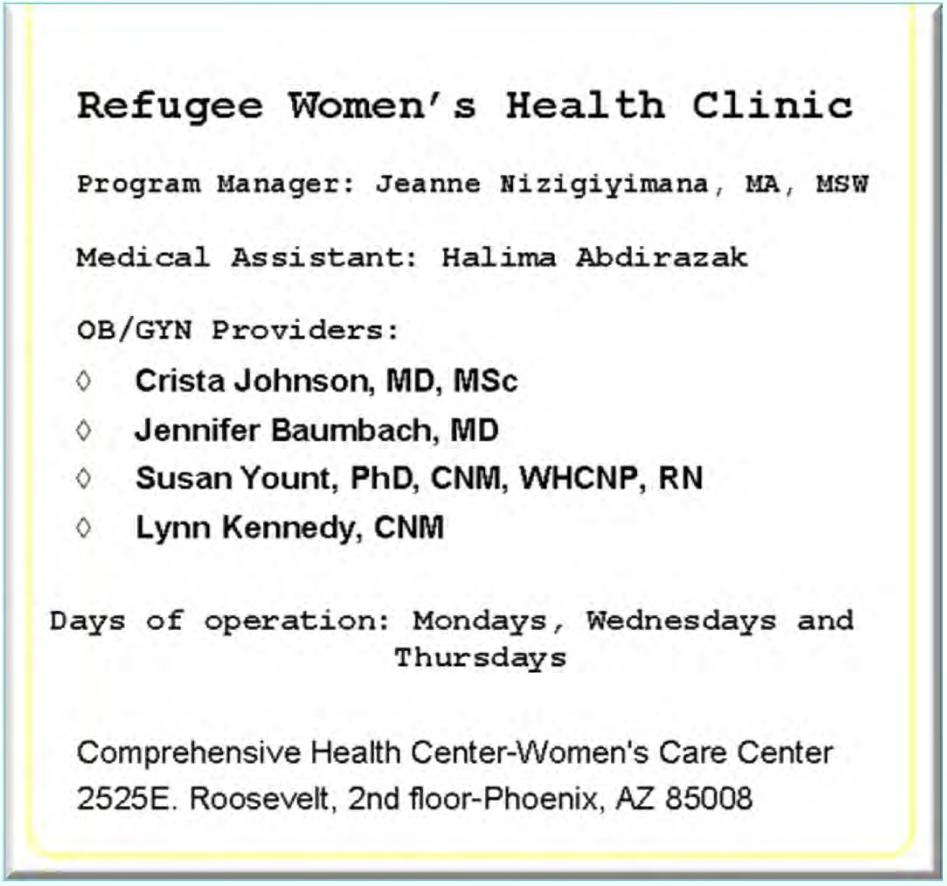
Refugee Women's Health Clinic

Empowerment Tools

RWHC Communication Card



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Refugee Women's Health Clinic

Refugee Women's Health Community Advisory Coalition

"To Empower, Mentor, Connect and Reshape"

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.

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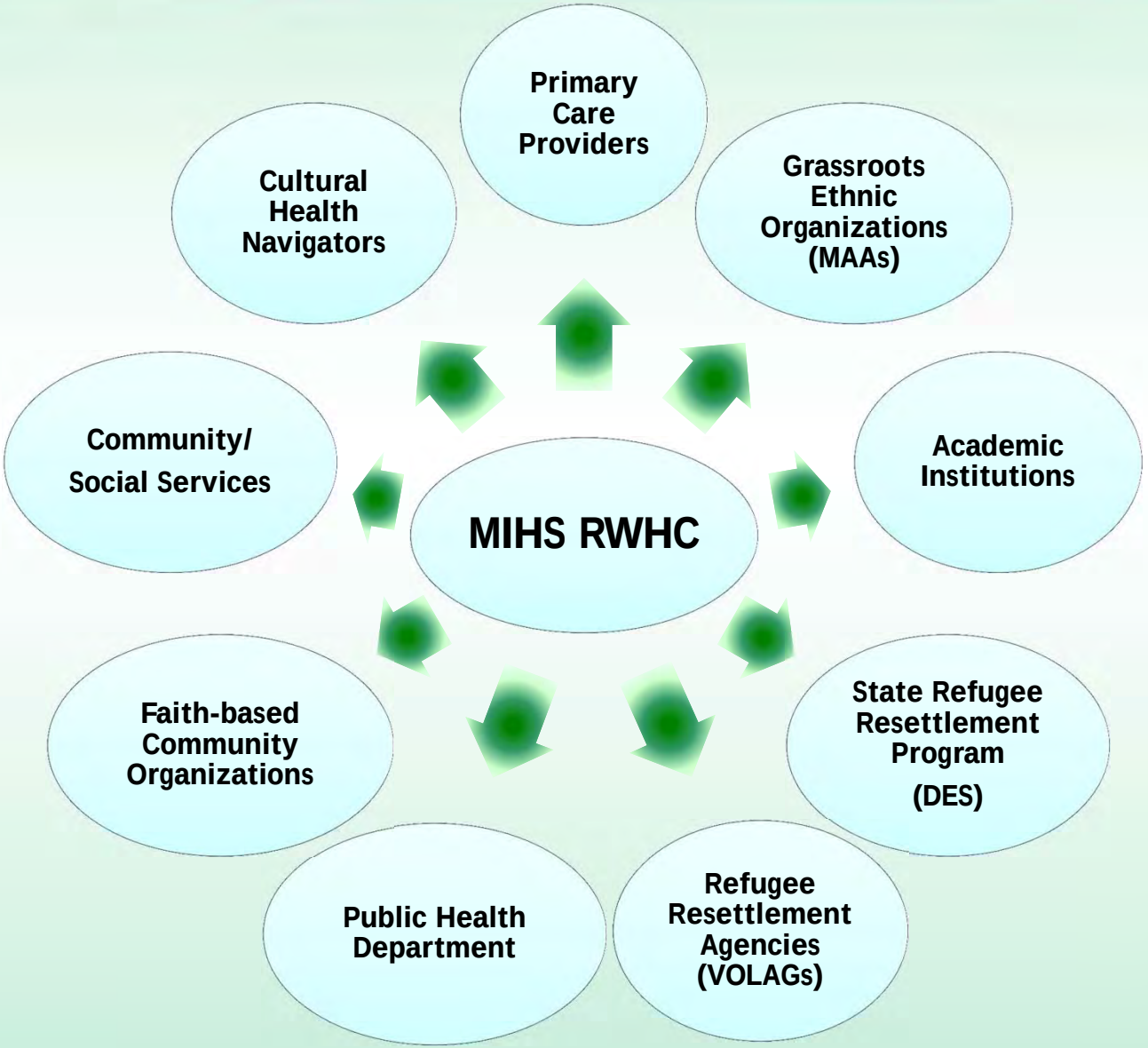
Refugee Women's Health Clinic

Empowering Women

Community Partnerships



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

MARICOPA INTEGRATED HEALTH SYSTEM

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

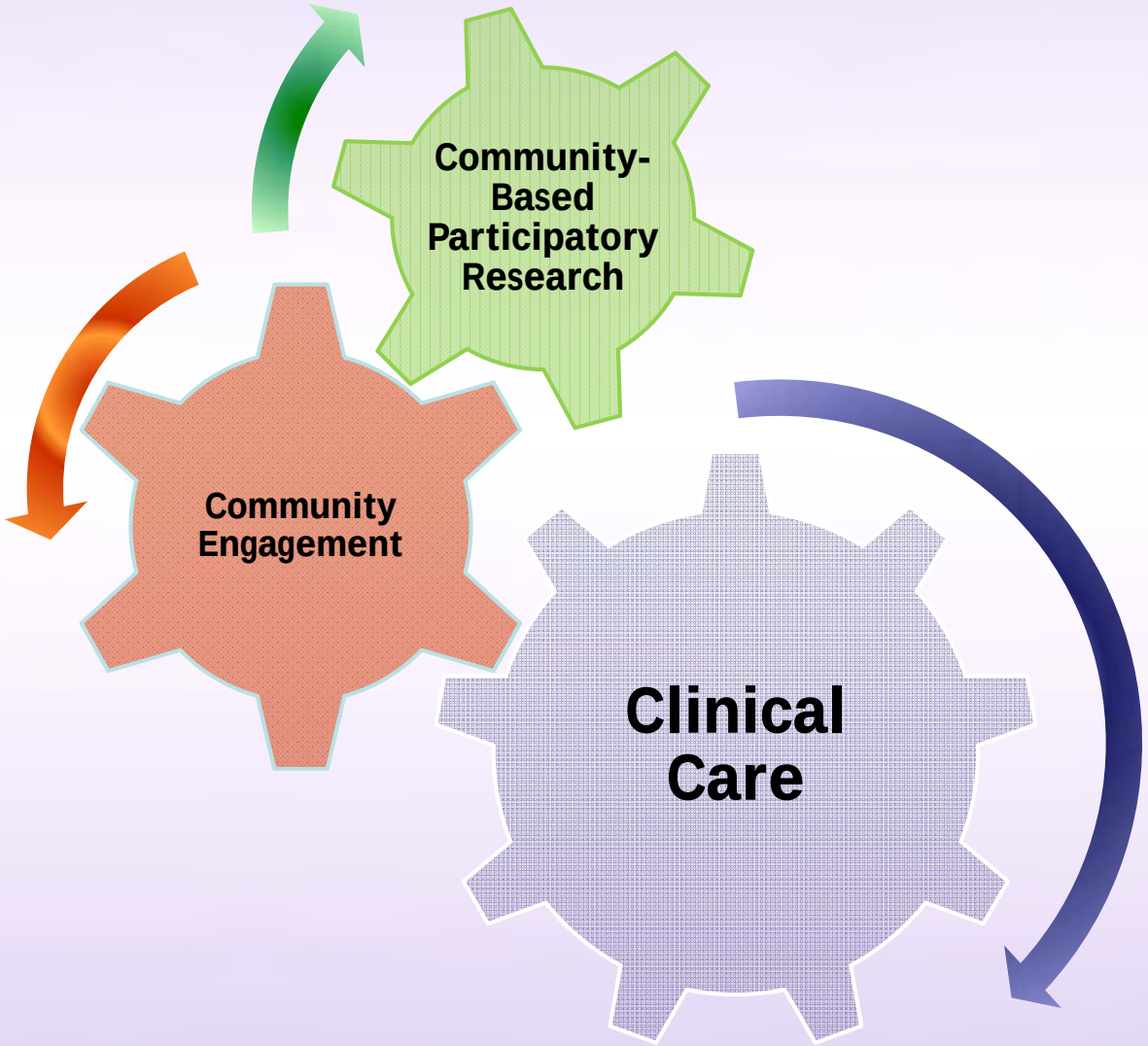
Improved Reproductive Health Outcomes

Build trust by engaging patients & their community

Empower Women & Improve Health Literacy

Integration

Clinical Care, Community, and Research



Engaging Refugee Communities

Community-Based Participatory Research (CBPR)

In Refugee Communities

Community-Partnered Research

To Promote Health Literacy in Refugee Communities

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

St. Luke's Health Initiatives
A Catalyst for Community Health

Arizona Department of Health Services

ARIZONA HEALTH FACILITIES AUTHORITY
"Financing the Future of Healthcare in Arizona"

- Train-the-Trainer intervention to increase Breast Health Literacy and build community capacity in the Somali Refugee Community

Susan G. Komen for the Cure

MARICOPA HEALTH FOUNDATION

ASU Southwest Interdisciplinary Research Center
ARIZONA STATE UNIVERSITY

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Refugee Women's Health Clinic

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, Donnely 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

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Web Resources

- North American Refugee Healthcare Conference
  - Expanded version of presentation
  - http://www.refugeehealthcareconference.com/
- Refugee Health Technical Assistance Center

www.refugeehealthta.org

-Tips and Strategies for Culturally Sensitive Care

http://www.refugeehealthta.org/physical-mental-health/health-conditions/womens-health/tips-and-strategies-for-culturally-sensitive-care/

-Archived webinars

Culturally and Linguistically Appropriate Services

http://www.refugeehealthta.org/webinars/clas/

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Thank You!

MARICOPA INTEGRATED HEALTH SYSTEM

Refugee Women's Health Clinic