ASSESSING THE FAMILY PLANNING NEEDS OF NEWLY ARRIVED REFUGEE WOMEN AND ADOLESCENTS

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Ying Zhang, Heike Thiel de Bocanegra, and Nossin Khan have no financial disclosures or conflicts of interest.
POLL: WHAT ORGANIZATION ARE YOU REPRESENTING? (CHOOSE THE OPTION THAT FITS BEST)

1. University
2. Clinic /Hospital
3. Community based/social service organization
4. State/Local Department of Health
5. Resettlement Agency
6. Student/Trainee
7. Other
POLL: WHICH COUNTRY OR REGION ARE YOU FROM?

1) US EAST
2) US CENTRAL
3) US WEST
4) CANADA
5) OTHER
POLL: For the refugee populations you work with, how long have they been in the U.S.? (CHOOSE THE OPTION THAT FITS BEST)

1. < or = 3 months
2. up to one year
3. 1-5 years
4. > 5 years
5. I don't work with refugees
Please type in chatbox:

• Which refugee group(s) are you working with?
OBJECTIVES

• Describe opportunities and challenges of assessing refugee reproductive health at federal, state and local level
• Describe the California Refugee Reproductive Health Network (ReproNet)
• Describe virtual outreach and engagement with refugee communities and providers during COVID-19
• Describe contraceptive attitudes and knowledge from Somali refugee women
U.S. refugee resettlement drops, falling below Canada in 2018

Number of resettled refugees, in thousands

Note: Nations shown are top four resettlement countries. Complete data for UK prior to 2004 is not available through the UNHCR. Figures rounded to the nearest thousand. Source: Pew Research Center analysis of United Nations High Commissioner for Refugees data, accessed June 12, 2019.
Evidence-based clinical guidelines for immigrants and refugees

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Competing interests: See end of document for competing interests.


Editor’s note: See Appendix 1, available at www.cma.ca/cgi-bin/campub/CAMJ/CMJ1513/583/583-DC1, for affiliations and contributions of coauthors.

This document has been peer reviewed.

Correspondence to: Dr. Kevin Pottie, kpotti@uottawa.ca

K E Y P O I N T S
- Clinical preventive care should be informed by the patient's region or country of origin and migration history (e.g., forced versus voluntary migration).
- Forced migration, low income and limited proficiency in English or French increase the risk of a decline in health and should be considered in the assessment and delivery of preventive care.
- Vaccination (against measles, mumps, rubella, diphtheria, tetanus, pertussis, polio, varicella, hepatitis B and human papillomavirus) and screening (for hepatitis B, tuberculosis, HIV, hepatitis C, intestinal parasites, iron deficiency, dental pain, loss of vision and cervical cancer) should be routinely provided to at-risk immigrants.
- Detecting and addressing malaria, depression, post-traumatic stress disorder, childhood maltreatment, intimate partner violence, diabetes mellitus and unintended contraceptive needs should be individualized to improve detection, adherence and treatment outcomes.
• Encourage use of checklists and algorithms for systematic assessment

• Implementation of recommendations may take 3-4 visits; If possible, same primary care provider screens and provides care for the next two years

• Guidelines include testing infectious diseases, mental health, but also screening for cervical cancer, intimate partner violence, contraceptive needs
• “To prevent unintended pregnancy, screening for unmet contraceptive needs should begin soon after a woman’s arrival in Canada.”

• For the evidence review populations, see Appendix 18

ASSISTANCE TO REFUGEES AFTER ARRIVAL TO THE UNITED STATES

• Standardized health exam at entry to US
• Support from resettlement agencies, including “cultural orientation” and Medicaid enrollment assistance (90 days)
• Eligible for Medicaid for at least eight months
### Top states for U.S. refugee resettlement in fiscal 2019

<table>
<thead>
<tr>
<th>State</th>
<th>Number of Refugees Resettled</th>
</tr>
</thead>
<tbody>
<tr>
<td>Texas</td>
<td>2,500</td>
</tr>
<tr>
<td>Washington</td>
<td>1,900</td>
</tr>
<tr>
<td>New York</td>
<td>1,800</td>
</tr>
<tr>
<td>California</td>
<td>1,800</td>
</tr>
<tr>
<td>Kentucky</td>
<td>1,400</td>
</tr>
<tr>
<td>Ohio</td>
<td>1,400</td>
</tr>
<tr>
<td>North Carolina</td>
<td>1,300</td>
</tr>
<tr>
<td>Arizona</td>
<td>1,200</td>
</tr>
<tr>
<td>Georgia</td>
<td>1,200</td>
</tr>
<tr>
<td>Michigan</td>
<td>1,100</td>
</tr>
</tbody>
</table>

Note: Fiscal year ended on Sept. 30, 2019. Numbers rounded to the nearest hundred.

PEW RESEARCH CENTER

<table>
<thead>
<tr>
<th>County</th>
<th>Refugee Arrival, 2012-2016¹</th>
<th>SIV arrival, 2012-2016²</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>San Diego</td>
<td>13,153</td>
<td>1,490</td>
<td>14,643</td>
</tr>
<tr>
<td>Los Angeles</td>
<td>7,818</td>
<td>511</td>
<td>8,239</td>
</tr>
<tr>
<td>Sacramento</td>
<td>4,348</td>
<td>3,775</td>
<td>8,123</td>
</tr>
<tr>
<td>Other</td>
<td>5,982</td>
<td>3,389</td>
<td>9,371</td>
</tr>
<tr>
<td>California</td>
<td>31,301</td>
<td>9,165</td>
<td>40,466</td>
</tr>
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</table>


REFUGEE HEALTH SCREENING AT ARRIVAL TO THE US

- Screening focuses on infectious diseases and mental health issues
- Not designed to provide clinical preventive screening
- No standardized follow up to “referral”
- No assessment of contraception or preconception care needs
Reproductive health questions:
1) Are you pregnant?
2) How regular is your menstrual cycle?
3) How many pregnancies have you had?
4) How many children do you have?
[5] Question on Female Cutting ]
Minnesota COE-RH:

• Improve the guidelines on refugee health screening and their use, conduct quality improvement projects such as Hepatitis B prevention.

• **A women’s health guideline is planned to serve as a nationwide standard.**

COE-RH in Colorado:

• Assess long-term health outcomes of refugees, multistate surveillance of chronic and infectious diseases among refugees.

• Standardize data collection of medical screening data and display it in a business intelligence platform.
REFUGEE REPRODUCTIVE REFUGEE HEALTH NETWORK (REPRO-NET)

- Engagement award, collaboration of University of California campuses with local refugee communities
- San Diego and Sacramento
- Engage in dialogue with refugee communities to investigate their preferences for reproductive health and well-woman care
- Organize symposium at UCD Medical Center, Sacramento Fall 2021 to develop a Research and Policy Agenda with and for refugee women
Figure 1: Refugee Reproductive Health Network (RRHN) Governance Structure

- Patient Task Force (PTF)
  - 6 Refugee GB members
  - Refugee women
    - Quarterly meetings, social media network
  - Refugee-lead small group meetings
    - English, Pashto, Arabic, Farsi, Dari, Suaheli

- Governance Board (GB)
  - 6 PTF members
  - 4 PRSP members
  - UC researchers (Thiel, Mody)

- Meeting and Symposium Planning

- Communication

- Governance and Decision-making

- Panel of Researchers and Service Providers (PRSP)
  - Researchers and clinical and refugeservices providers - quarterly meetings
Sacramento County Department of Health Reorganization 2019

• All primary care clients get a full assessment, regardless the reason of visit.
• Federal refugee assessment is complemented with obstetric and gynecological health, including contraceptive needs.
• Women can stay at same clinic for maternity and gynecologic care. DOH has interpreters in multiple languages.
COVID-19 OUTREACH PROJECT WITH SACRAMENTO REFUGEE CLINIC

47 new refugee families with health appointment on hold

37 Afghan families consisting of 169 individuals interviewed: 19 in English, 11 in Dari, 7 in Pashto

4 families had disconnected phone number
3 families did not return voicemail
3 families already had appointment
CONTRACEPTIVE USE

Methods on Contraception Among Afghan Newly Arrived Refugee Women (n=31)

- Condoms, 7 (23%)
- Birth Control Pills, 2 (7%)
- Patch, 1 (3%)
- IUD, 1 (3%)
- None, 13 (42%)
- Pregnant/Seeking Pregnancy, 6 (19%)

<table>
<thead>
<tr>
<th>Method of Contraception</th>
<th>Number</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>First/Second Tier</td>
<td>5</td>
<td>16%</td>
</tr>
<tr>
<td>Condoms</td>
<td>7</td>
<td>23%</td>
</tr>
<tr>
<td>None</td>
<td>13</td>
<td>42%</td>
</tr>
<tr>
<td>Pregnant/Seeking Pregnancy</td>
<td>6</td>
<td>19%</td>
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REPRONET IN TIMES OF COVID-19

- Change from in-person meetings to virtual meetings
- Assess digital readiness of refugee communities and pilot virtual groups regarding sexual and reproductive health topics
- Change in service delivery impacts provider priorities
- Sign up for ReproNet provider and volunteer contact list:
  - https://ci-redcap.hs.uci.edu/surveys/?s=L49TD9F9E8
885 million women of reproductive age (15-49) in developing regions want to avoid a pregnancy. 214 million of them have an unmet need for modern contraception. This means they want to avoid a pregnancy but are not using a modern method of contraception.
REPRODUCTIVE JUSTICE FRAMEWORK

RJ is “the human right to maintain personal bodily autonomy, have children, not have children, and parent the children we have in safe and sustainable communities”—Sister Song

- RJ is about
  - Human Rights
  - Access
  - Activism
A Qualitative Exploration of Somali Refugee Women’s Experiences with Family Planning in the U.S.

Ying Zhang1 • Erin E. McCoy2 • Roda Scego3 • William Phillips4 • Emily Godfrey5

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Table 1  Demographic characteristics of focus group participants by language groups

<table>
<thead>
<tr>
<th></th>
<th>Somali language focus group participants N = 35</th>
<th>English language focus group participants N = 18</th>
<th>All participants N = 53</th>
</tr>
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<tbody>
<tr>
<td></td>
<td>Mean ± SD</td>
<td>Mean ± SD</td>
<td>Mean ± SD</td>
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<tr>
<td>Age</td>
<td>35 ± 9.1</td>
<td>27 ± 6.7</td>
<td>32.2 ± 8.95</td>
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<tr>
<td>Years in U.S.</td>
<td>15.2 ± 5.3</td>
<td>14.6 ± 6.0</td>
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<td>Number of children</td>
<td>3.14 ± 2.45</td>
<td>1.06 ± 1.43</td>
<td>2.43 ± 2.37</td>
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</thead>
<tbody>
<tr>
<td><strong>Age</strong></td>
<td>Mean ± SD</td>
<td>Mean ± SD</td>
<td>Mean ± SD</td>
</tr>
<tr>
<td>&lt;20</td>
<td>35 ± 9.1</td>
<td>27 ± 6.7</td>
<td>32.2 ± 8.95</td>
</tr>
<tr>
<td>20-34</td>
<td>15 ± 5.3</td>
<td>14.6 ± 6.0</td>
<td>15.0 ± 5.48</td>
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<tr>
<td>≥35</td>
<td>3.14 ± 2.45</td>
<td>1.06 ± 1.43</td>
<td>2.43 ± 2.37</td>
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<tr>
<td><strong>Years in U.S.</strong></td>
<td>n</td>
<td>n</td>
<td>n</td>
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<tr>
<td>≤5</td>
<td>4</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>6-10</td>
<td>17</td>
<td>15</td>
<td>32</td>
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<tr>
<td>&gt;10</td>
<td>17</td>
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<td>19</td>
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<td><strong>Years of formal education</strong></td>
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<td>&gt; high school</td>
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<tr>
<td>No</td>
<td>9</td>
<td>26</td>
<td>8</td>
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<td><strong>Parity (# of live born children)</strong></td>
<td>n</td>
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<td>n</td>
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<tr>
<td>0</td>
<td>6</td>
<td>17</td>
<td>61</td>
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<tr>
<td>1-2</td>
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<td>3-5</td>
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<td>&gt;5</td>
<td>7</td>
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<tr>
<td><strong>Birth Country</strong></td>
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<td>n</td>
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<tr>
<td>Somalia</td>
<td>35</td>
<td>94</td>
<td>48</td>
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<tr>
<td>Other</td>
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<td>6</td>
<td>3</td>
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<tr>
<td><strong>Muslim religion</strong></td>
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<td>n</td>
</tr>
<tr>
<td>Yes</td>
<td>35</td>
<td>100</td>
<td>53</td>
</tr>
<tr>
<td>No</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

*1 participant declined to report age
*3 participants did not report educational level
Family Planning Practices are Rooted in Cultural, Religious, and Social Identities

- “It’s kind of something to be proud of. When someone says I have 12 kids or more than 12 kids, that’s a large family, that’s a powerful family. It’s something that shows social power.”
- “We also believe like if you have more kids then you have a better chance… when you die… to ask supplications like asking God to enter Heaven. It increases your worth to go to heaven.”
- “Preventing pregnancy, so some people think that’s haram [i.e. sin], like making sure you don’t get pregnant.”
• **Allah has Ultimate Control Over Individuals’ Fertility and Pregnancy Timing**
  
  “Like I know in American culture part of the reason why they have the 2.5 is because they’re worried about providing for the kids… If I can’t pay for his college, we’re not ready to have kids. In Islam it teaches us that Allah is our provider. If you trust in Allah, Allah is going to provide for you.”

  “I took the pills first because I wanted to space them apart, but it didn’t work…and I still got pregnant…I also think it’s all up to God.”

  “I think the family planning has a western approach. It’s not something in the Muslim society that is talked about or considered.”
• Facilitators and Barriers to Modern Contraceptive Uptake Among Somali Women are Influenced by Their Experiences After Immigration to the U.S
  
  “I give birth to my kids in Somalia…Three of my kids were born over there. They are a year apart each… I didn’t care for the spacing at that time. There were people there that was helping me take care of them…After coming to America, I noticed the hardships with raising the kids. That no one was there to help.”

  One woman discussed her concern about the stigma and side effects of contraception: “There’s a lot stigma so it’s like, ‘Oh my God the pill, what is it going to do to me? Is it going to make me lose my hair? Does it have hormones? Is it going to make me crazy?”

  Belief that contraceptives cause infertility: “Many people who are religious…have this belief that if you use…contraceptives, that you will never have kids anymore.”
IMPLICATIONS

• Call for culturally informed & patient centered approach to family planning counseling and education

• For Somali women, framing contraceptive counseling discussions on the promotion of healthy mothers and infants may be more acceptable than focusing on long term pregnancy prevention or use of the most highly effective contraceptive methods.
QUESTIONS AND ANSWERS

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DISCUSSION

A. What is your organization's experience screening (or not) newly arrived refugees for family planning needs and integrating them into women's healthcare?

B. To what extent do resettlement agencies or community-based organizations address women's reproductive health needs in their programs?

C. What are some reproductive health topics that come up frequently in the communities you work with? What topics are discussed rarely?
DISCUSSION

D. What are facilitators and barriers in the refugee communities you work with to seeking and obtaining family planning counseling and contraception?

E. How might contraceptive preferences and choices change after arrival to the U.S.?

F. From this talk, what reflections do you have (key points/learning points) that you will take back from this workshop to your organization?


