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

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UCDAVIS UNIVERSITY OF CALIFORNIA

DISCLOSURES

- 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 :

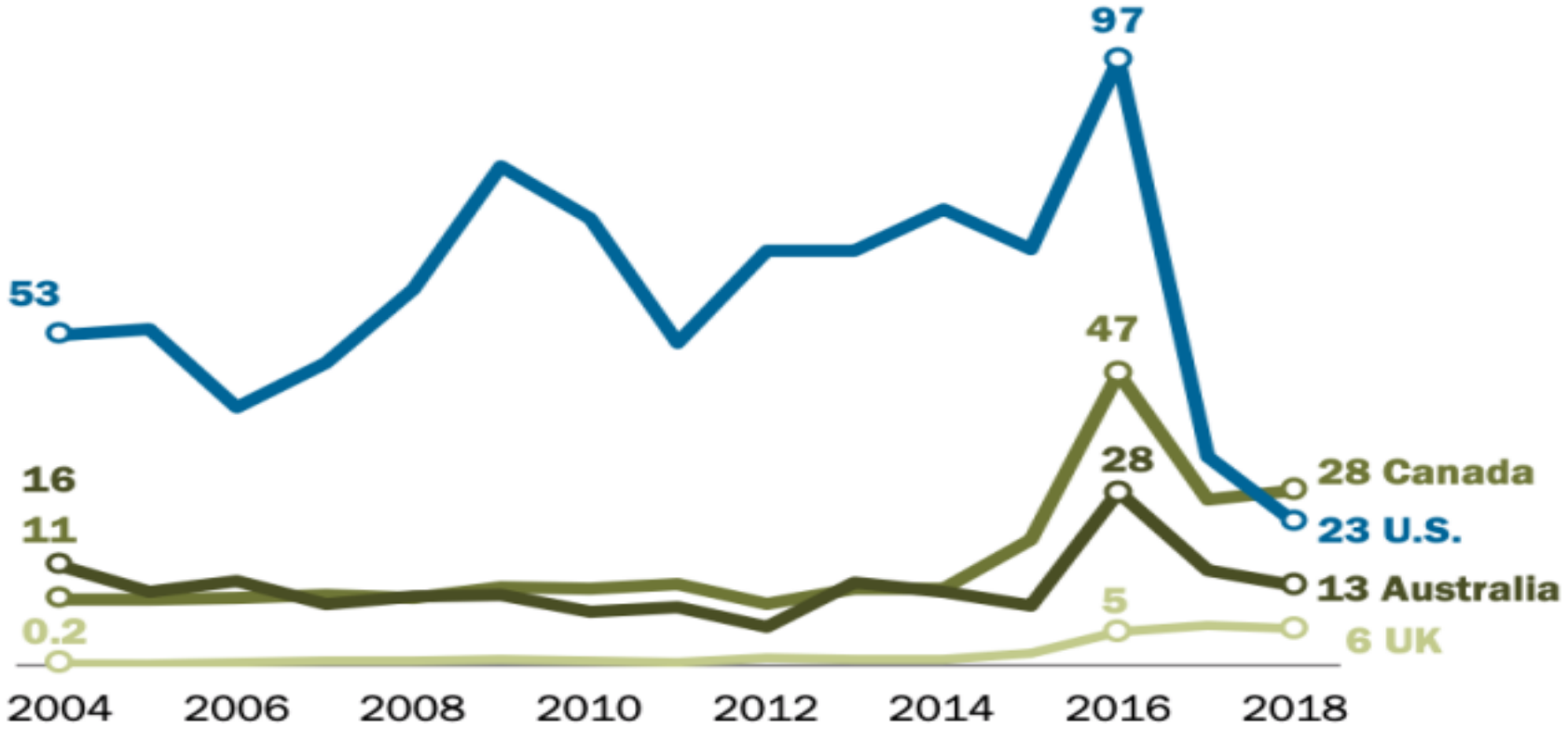
- **WHICH REFUGEE GROUP(S) ARE YOU WORKING WITH?**

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.

PEW RESEARCH CENTER

GUIDELINES CMAJ

Evidence-based clinical guidelines for immigrants and refugees

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Competing interests: See end of document for competing interests.

Coauthors of the Canadian Collaboration for Immigrant and Refugee Health: Deborah Assayag, Elizabeth Barnett, Jennifer Blake, Beverly Brockest, Giovani Burgos, Glenn Campbell, Andrea Chambers, Angie Chan, Maryann Cheetham, Walter Delpero, Marc Deschenes, Shafik Dharamsi, Ann Duggan, Nancy Durand, Allison Eyre, Jennifer Grant, Doug Gruner, Sinclair Harris, Stewart B. Harris, Elizabeth Harvey, Jenny Heathcote, Christine Heidebrecht, William Hodge, Danielle Hone, Charles Hui, Susan Hum, Praseedha Janakiram, Khairun Jivani, Tomas Jurcik, Jay Keystone, Ian Kitai, Srinivasan Krishnamurthy, Susan Kuhn, Stan Kutcher, Robert Laroche, Carmen Logie, Michelle Martin, Dominique Elien Massenat, Debora Matthews, Barry Maze, Dick Menzies, Marie Munoz, Félicité Murangira, Amy Nolen, Pierre Plourde, Hélène Rousseau, Andrew G. Ryder, Amelia Sandoe, Kevin Schwartzman, Jennifer Sears, William Stauffer, Brett D. Thombs, Patricia Topp, Andrew Toren, Sara Torres, Ahsan Ullah, Sunil Varghese, Bilkis Vissandjee, Michel Welt, Wendy Wobeser, David Wong, Phyllis Zelkowitz, Jianwei Zhong, Stanley Zlotkin.

Editor's note: See Appendix 1, available at www.cmaj.ca/lookup/suppl/doi:10.1503/cmaj.090313/-/DC1, for affiliations and contributions of coauthors.

This document has been peer reviewed.

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CMAJ 2011. DOI:10.1503/cmaj.090313

KEY POINTS

- Clinical preventive care should be informed by the person'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, child maltreatment, intimate partner violence, diabetes mellitus and unmet contraceptive needs should be individualized to improve detection, adherence and treatment outcomes.

CANADIAN REFUGEE HEALTH SCREENING GUIDELINES

- 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**

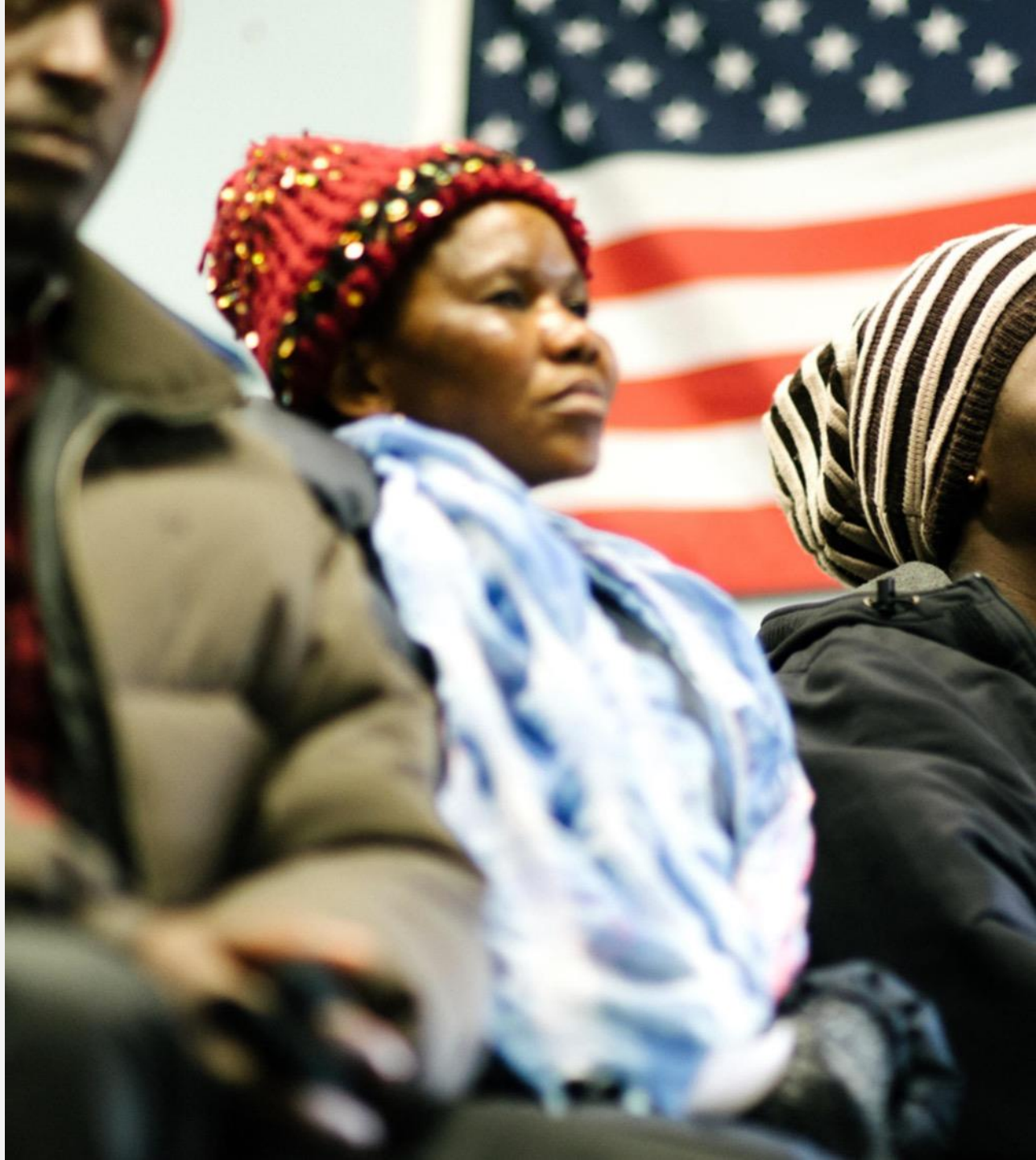
CANADIAN REFUGEE HEALTH GUIDELINES

- "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

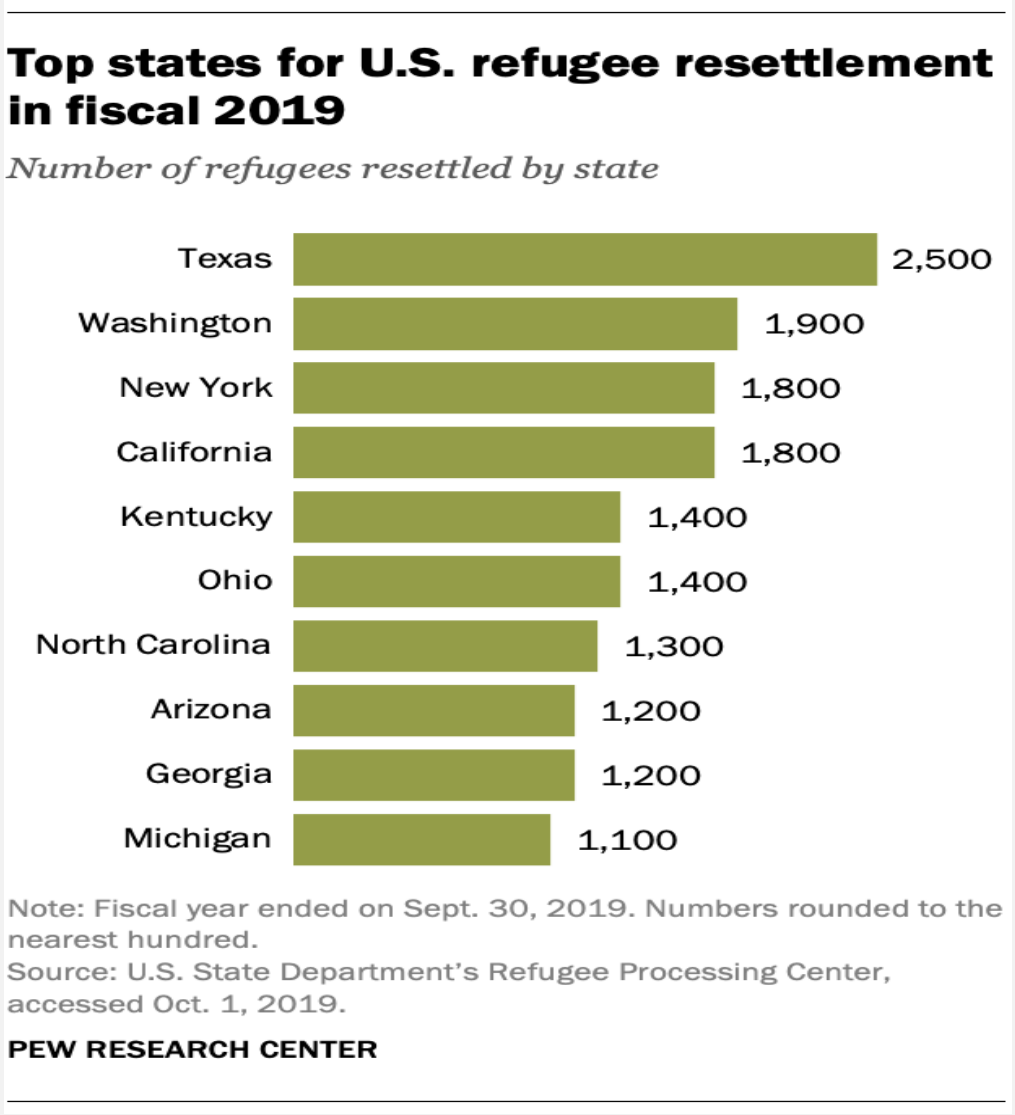
www.cmaj.ca/lookup/suppl/doi:10.1503/cmaj.090313/-/DC1

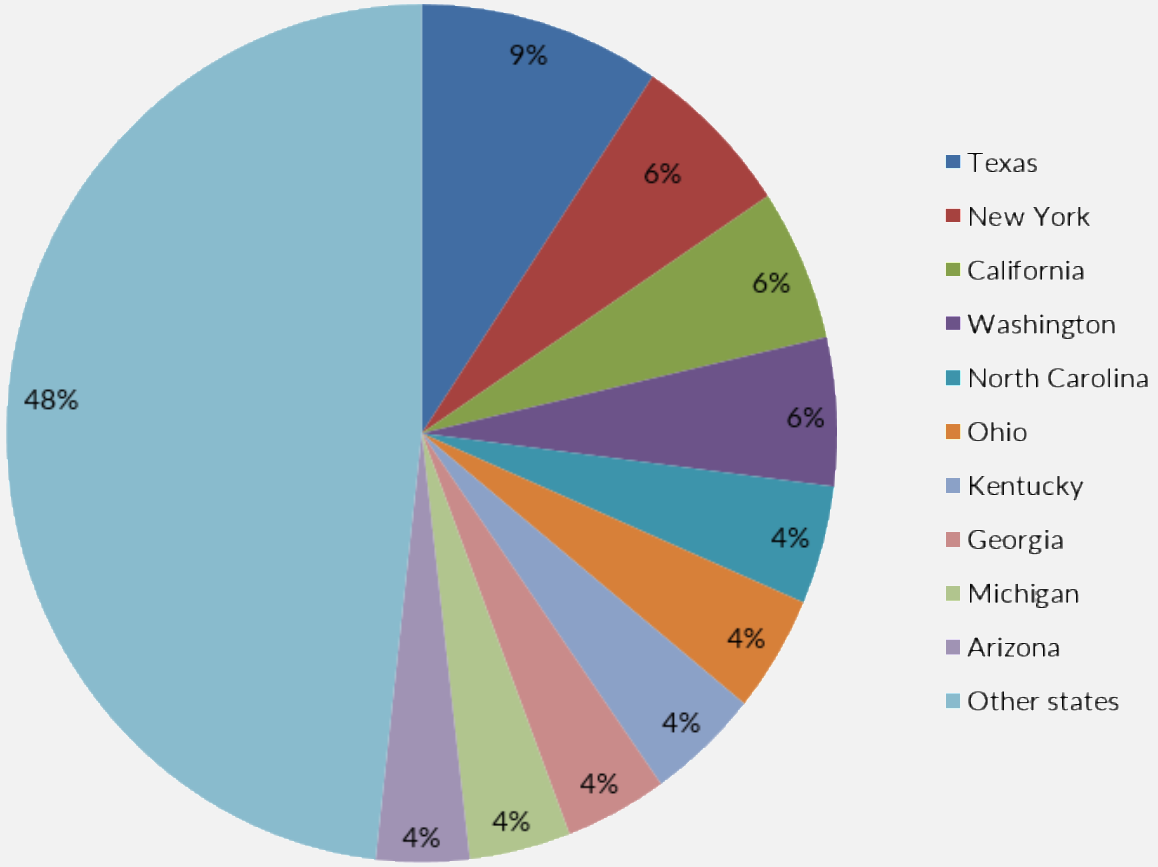
ASSISTANCE TO REFUGEES AFTER ARRIVAL TO THE UNITED STATES

- 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



US REFUGEES BY STATE, 2019





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https://www.migrationpolicy.org/article/refugees-and-asylees-united-states

County	Refugee Arrival, 2012-2016[1]	SIV arrival, 2012-2016[2]	Total
San Diego	13,153	1,490	14,643
Los Angeles	7,818	511	8,239
Sacramento	4,348	3,775	8,123
Other	5,982	3,389	9,371
California	31,301	9,165	40,466

[1] Refugee Processing Center. *Admissions and Arrivals*. U.S. Department of State http://www.wrapsnet.org/admissions-and-arrivals/.

[2] California Refugee Arrivals Data. California Department of Public Health. http://www.cdss.ca.gov/inforesources/Refugees/Reports-and-Data/Arrivals-Data

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 IN REFUGEE SCREENING GUIDELINES

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]

CDC CENTERS OF EXCELLENCE IN REFUGEE HEALTH

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**.

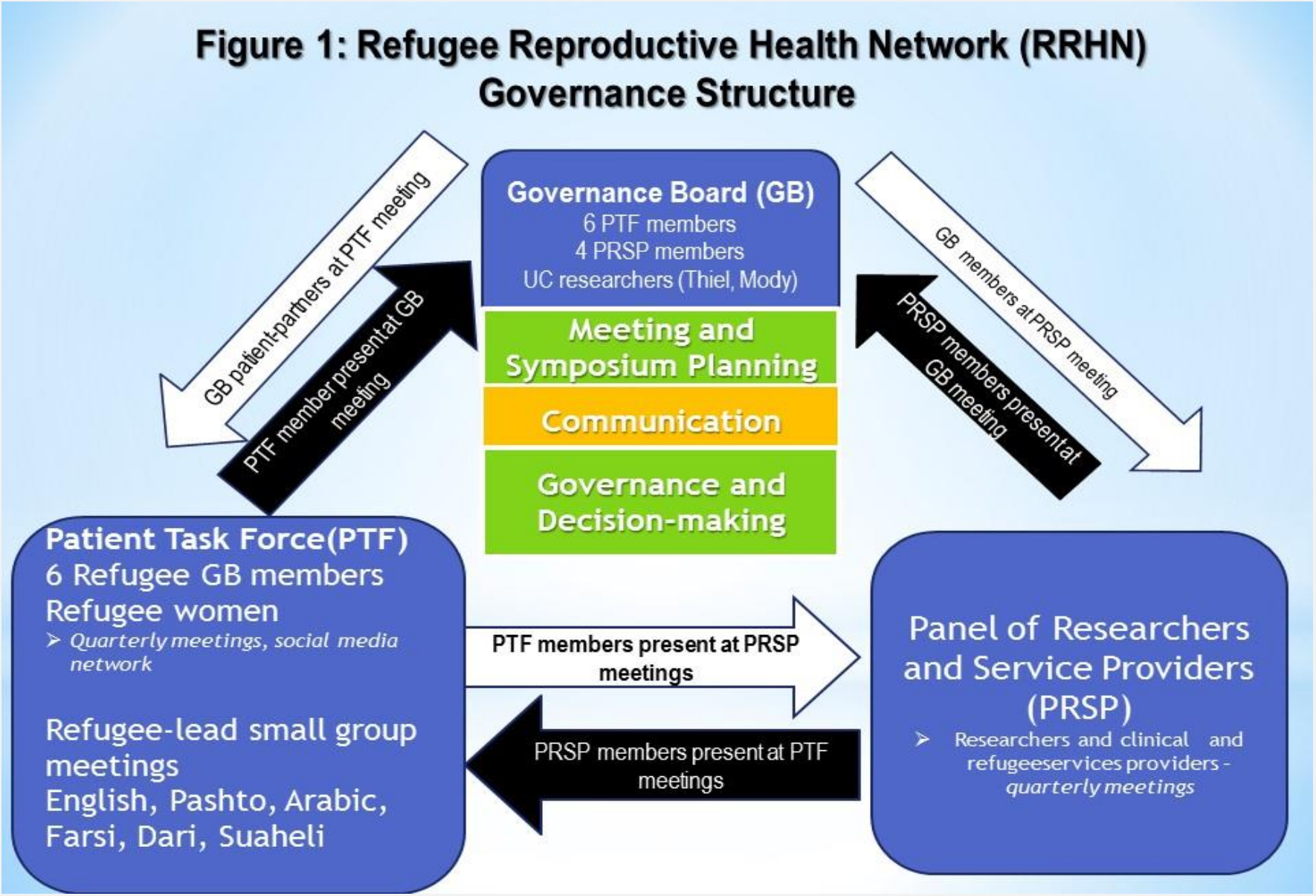
COE-RH in Colorado:

- 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



LOCAL LEVEL: INTEGRATION OF REFUGEE ASSESSMENT IN PRIMARY CARE

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

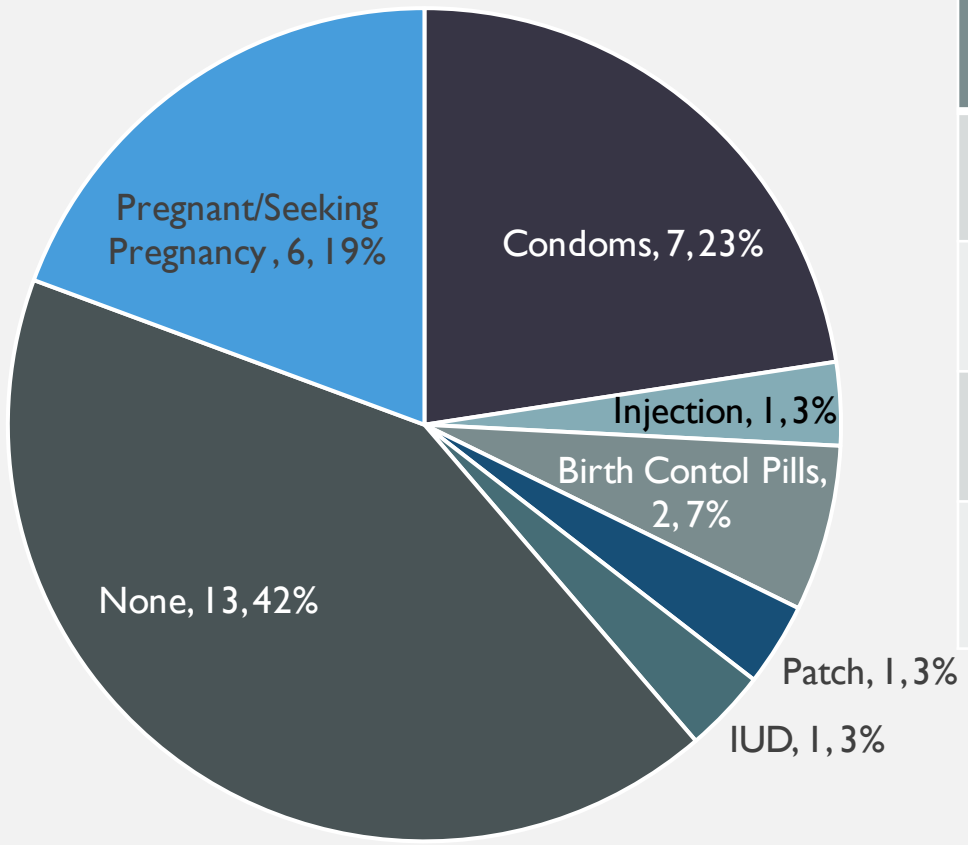
47 new refugee families with health appointment on hold

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

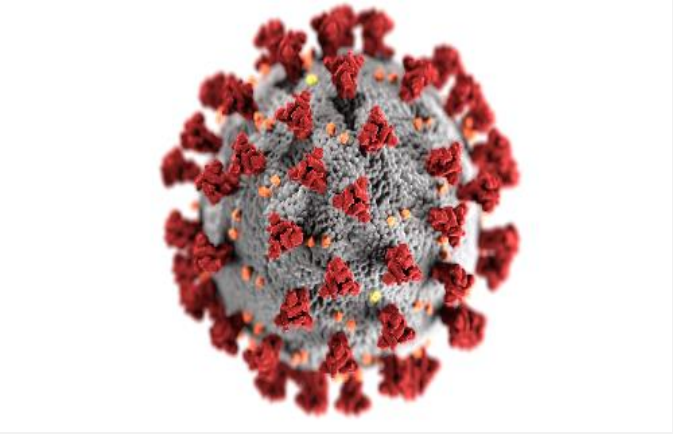
Methods on Contraception Among Afghan Newly Arrived Refugee Women (n=31)



Method of Contraception	Number	Percent
First/Second Tier	5	16%
Condoms	7	23%
None	13	42%
Pregnant/Seeking Pregnancy	6	19%

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



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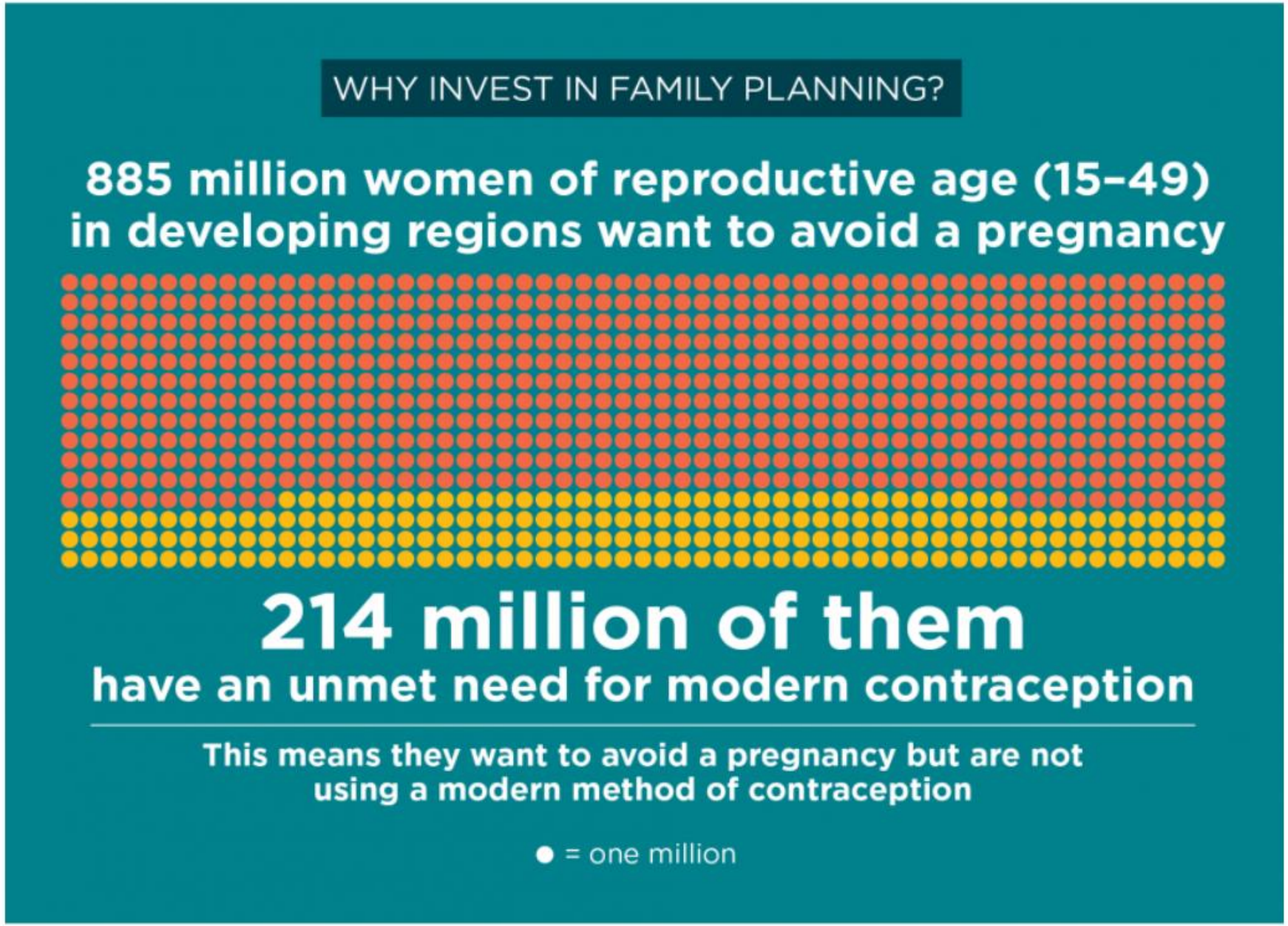

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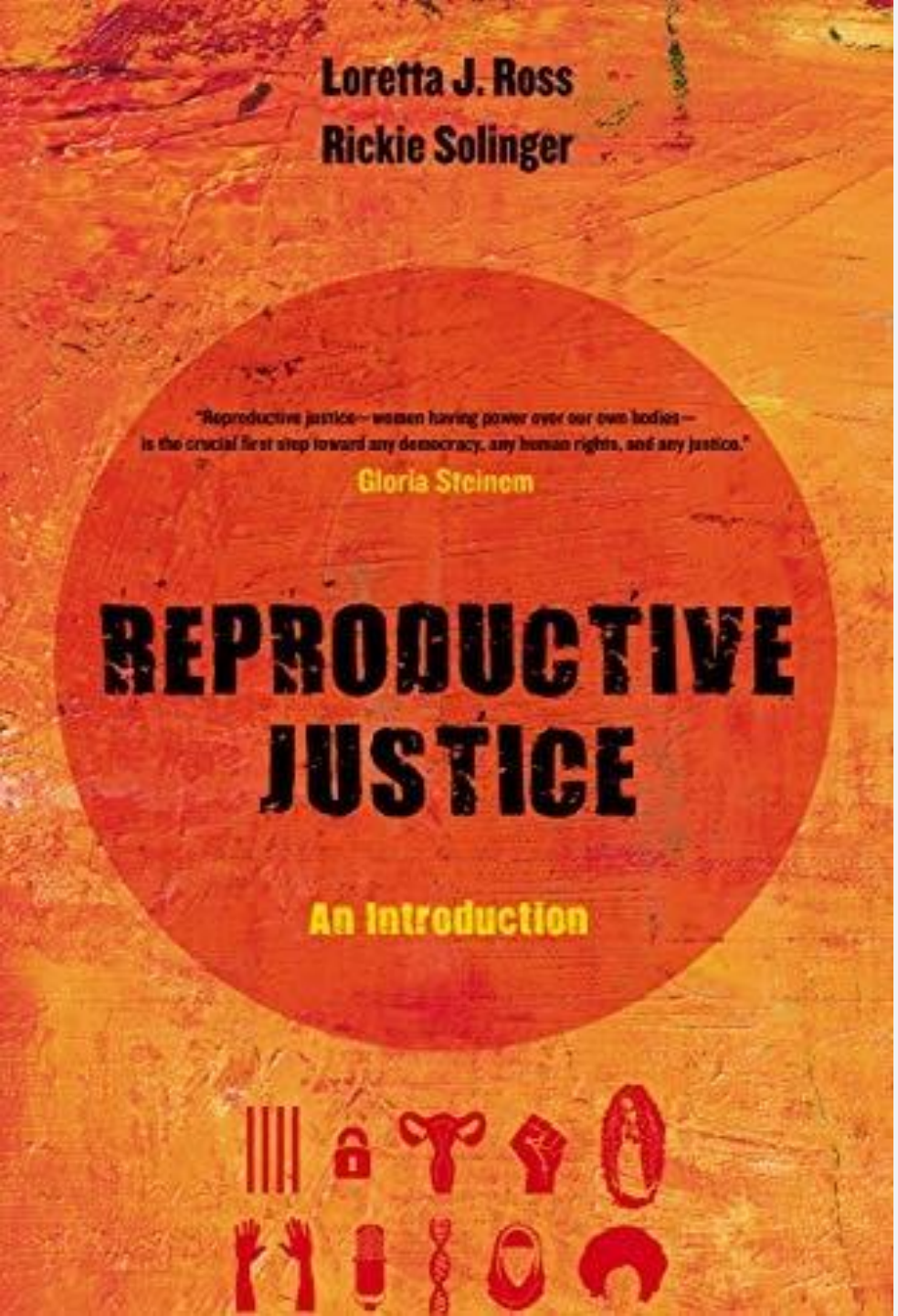
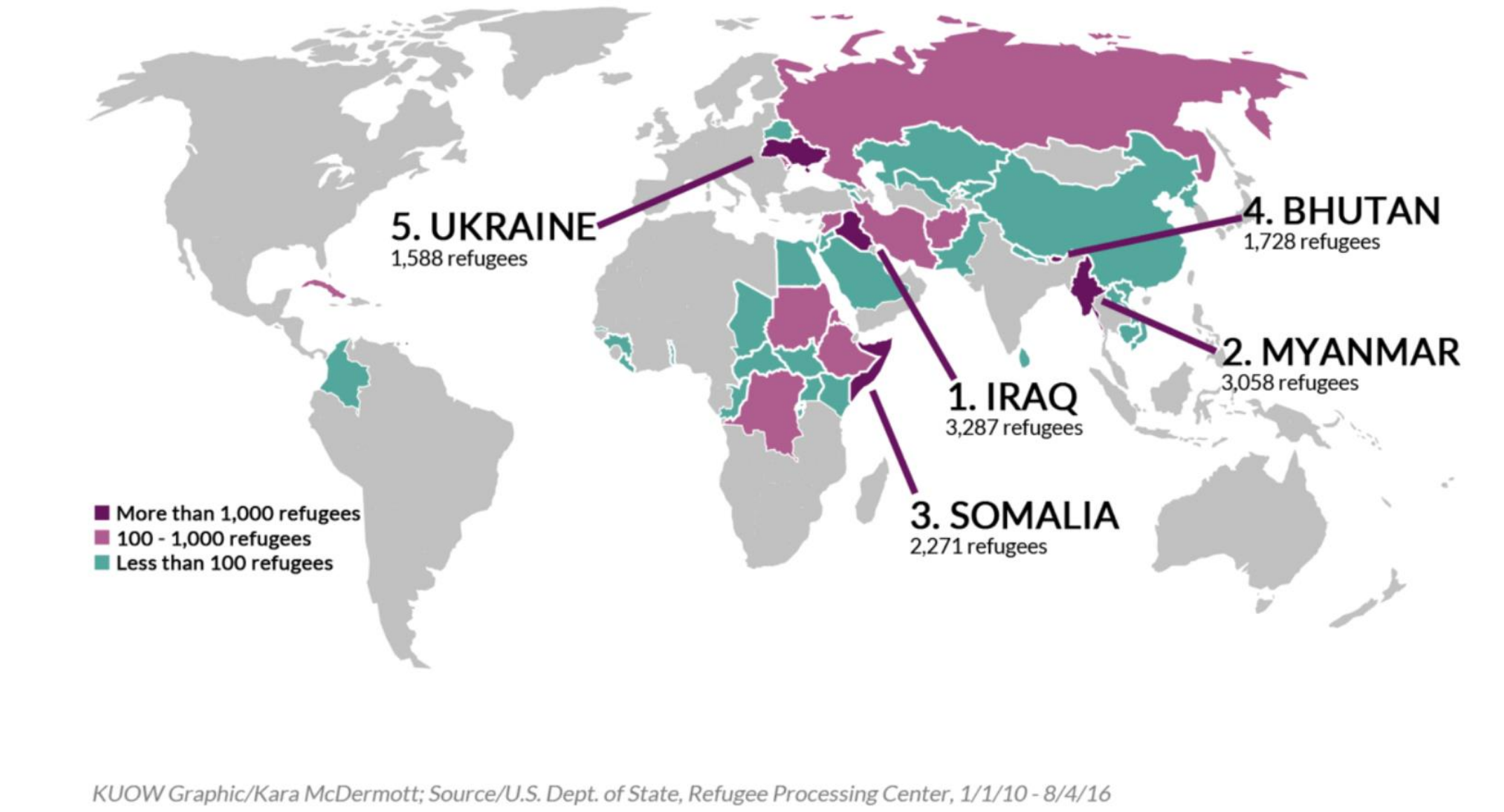


REPRODUCTIVE JUSTICE FRAMEWORK

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

WASHINGTON STATE REFUGEE RESETTLEMENT



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ORIGINAL PAPER

A Qualitative Exploration of Somali Refugee Women's Experiences with Family Planning in the U.S.

Ying Zhang[1] · Erin E. McCoy[2] · Roda Scego[3] · William Phillips[4] · Emily Godfrey[5]

Published online: 2 April 2019

Table 1 Demographic characteristics of focus group participants by language groups

	Somali language focus group participants N = 35	English language focus group participants N = 18	All participants N = 53
	Mean ± SD	Mean ± SD	Mean ± SD
Age	35 ± 9.1	27 ± 6.7	32.2 ± 8.95
Years in U.S.	15.2 ± 5.3	14.6 ± 6.0	15.0 ± 5.48
Number of children	3.14 ± 2.45	1.06 ± 1.43	2.43 ± 2.37

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Number of children	3.14 ± 2.45		1.06 ± 1.43		2.43 ± 2.37	
	n	%	n	%	n	%
Age[#]						
< 20	1	2	1	6	2	4
20–34	17	49	15	83	32	60
≥ 35	17	49	2	11	19	36
Years in U.S.						
≤ 5	4	11	2	11	6	11
6–10	2	6	2	11	4	8
> 10	29	83	14	78	43	81
Years of formal education*						
< high school	9	28	0	0	9	18
Some high school	17	53	0	0	17	34
> high school	6	19	18	100	24	48
Marital status						
Yes	26	74	10	56	36	68
No	9	26	8	44	17	32
Parity (# of live born children)						
0	6	17	11	61	17	32
1–2	10	29	3	17	13	25
3–5	12	34	4	22	16	30
> 5	7	20	0	0	7	13
Birth Country						
Somalia	33	94	15	83	48	91
Other	2	6	3	17	5	9
Muslim religion						
Yes	35	100	18	100	53	100
No	0	0	0	0	0	0

[#]1 participant declined to report age

*3 participants did not report educational level

THEMES

- **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."

THEMES

- **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."**

THEMES

- **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 you take back from this workshop to your organization?

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