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Ethical and Culturally Competent Healthcare for Sexual and Reproductive Health among Refugee Women in Atlanta, Georgia

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2017

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Abstract

Ethical and Culturally Competent Healthcare for Sexual and Reproductive Health among Refugee Women in Atlanta, Georgia

By Autumn Marie Curran

Introduction: Compared to their U.S. born peers, refugee women experience disparate sexual and reproductive health (SRH) outcomes. While the causes of such disparities are multi-faceted, they may be due in part to lack of access and poor provision of culturally competent care. There are few studies which explore SRH in these populations and even fewer whose focus is cultural in healthcare settings.

Objective: This research aims to explore: (1) how refugee women's cultural backgrounds influence SRH service utilization; and (2) what providers identify as effective strategies to deliver culturally competent sexual and reproductive healthcare to refugee women.

Methods: In-depth-interview were conducted with 26 refugee women and 17 SRH providers in Metropolitan Atlanta, Georgia. The data were analyzed using a qualitative thematic approach

Results: Modesty, discomfort discussing SRH issues, and social and gender norms influence refugee women's SRH service utilization. Between women and providers, six strategies for providing culturally competent care were identified: 1) targeted trainings for providers; 2) provision of language services to refugee women; 3) provision of patient navigators to refugee women; 4) group education classes for refugee women; 5) centering refugee women in SRH services; and 6) integration of women's religious practices into care counseling.

Conclusions: Providing quality SRH care goes beyond understanding the multicultural context of refugee women's experience. Rather, it requires introspection on the part of the provider and a commitment to developing the skills needed to provide culturally congruent care that adapts to the needs and context of patients.

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Other than my committee, I would like to thank the women and clinical care providers who volunteered their time and sentiments for this research as well as my sisters- Brianna Curran, Claudia Curran, Danae Lyons, Jamie Caton, and Bailey McCrory- for crossing oceans and countries for our friendship which know no time zones.

Additionally, I would be remiss if I did not acknowledge the Muscogee (Creek) people who lived, worked, produced knowledge on, and nurtured the land where Emory's Oxford and Atlanta campuses are now located. In 1821, fifteen years before Emory's founding, the Muscogee were forced to relinquish this land. I recognize the sustained oppression, land dispossession, and involuntary removals of the Muscogee and Cherokee peoples from Georgia and the Southeast. I seek to honor the Muscogee Nation and other Indigenous caretakers of this land by humbly seeking knowledge of their histories and committing to respectful stewardship of the land.

Furthermore, though not explored in this paper, abortion care is a fundamental part of SRH services. As such, access to safe and legal abortion is vital to the health and wellbeing of all women, refugee women included. Criminalizing abortion has shown no deterrent value and will have a disproportionate impact on particular groups of women and girls. The United States Supreme Court's decision to overturn the precedent set in *Roe v. Wade* jeopardizes the safety of women in Georgia and beyond.

Dedication

To my parents, Robert Curran and Leslie Chioffi-Curran, whose unconditional love and sacrifices have made it possible for me to pursue my dreams. I would not be the women I am today without your unending support.

To my late Grandfather, Anthony Chioffi, whose love supported three generations of women through their graduate education.

Table of Contents

Table of Figures and Tables

Acronyms

AAP: American Academy of Pediatrics

CLAS: Culturally and linguistically appropriate services

HCP: Health care personnel

LEP: Limited English proficiency

SRH: Sexual and Reproductive Health

UNHCR: United Nations High Commissioner for Refugees

UNFPA: United Nations Population Fund

US: United States

STIs: Sexually transmitted infections

SAMHSA: Substance Abuse and Mental health Services Administration

Chapter 1. Introduction

1.1 Rationale

Refugee women experience disparate sexual and reproductive health (SRH) outcomes, including higher rates of unintended pregnancy, and unmet family planning needs compared to the women in their host countries (Alnuaimi et al., 2017; Wanigaratne et al., 2018; Ngum Chi Watts, Liamputtong, & Carolan, 2014; Ngum Chi Watts, McMichael, & Liamputtong, 2015; Barnes & Harrison, 2004; Raymond et al., 2014). Such disparities may be related to a lack of access to culturally competent care (Brach & Fraser, 2002; Brach & Fraserirector, 2000; Betancourt et al., 2005). The existence of SRH disparities among refugee women demonstrates a need for examining women's experiences with SRH care.

Georgia is among the states that receive the highest number of refugees in the U.S., the majority of whom resettle in Metropolitan Atlanta, (U.S. Department of State, 2018). Georgia was first designated as a refugee resettlement center in the 1980's and has since earned the title of "Ellis Island of the South" with over 40,000 refugees resettling in the state in the last three decades (Khan & DeYoung, 2018; New York Times, n.d). Clarkston, a suburb 10 miles from downtown Atlanta and included in the greater Atlanta Metropolitan area, resettled the highest number of refugees per capita in the United States (among cities resettling 100 or more refugees) in the years 2015-2019, averaging 1,359 refugees a year (APM Research Lab via New York Times, n.d). More than 60 nationalities make up the population of Clarkston and refugees account for approximately half of the town's total population (Tudhope, 2020) Additionally, Atlanta has been ranked as one of the top ten cities for Burmese, Nepalese, Sri Lankan, Vietnamese, Bangladeshi, and Pakistani populations (Pew Research Center, 2017).

1.2 Problem statement

The disparate SRH outcomes experienced by refugee women warrant an examination of their experience with SRH services provision. Such disparities may be related, in part, to a lack of access to culturally competent care.

1.3 Purpose statement

Atlanta's unique and longstanding history with and refugee resettlement and high concentration of refugee women makes this an ideal study setting. Currently, there is a lack of research which examining SRH in this population. There are even fewer studies which focus on ethical issues and strategies to deliver culturally competent care SRH care. This work intends fill this gap.

1.4 Research question

1. How do women's cultural backgrounds influence SRH service utilization?
2. What do providers identify as effective strategies to deliver culturally competent sexual and reproductive healthcare to refugee women?

1.5 Significance statement

This study is the first step in understanding current SRH healthcare for refugee women in Metropolitan Atlanta and ultimately improving SRH healthcare service and delivery to refugee populations in this area.

1.6 Definition of terms

Antenatal/prenatal care: scheduled visits to a health care provider during pregnancy which typically include a physical exam, weight checks, urine and blood samples, and ultrasound exams in addition to conversations about the health of the mother and fetus (March of Dimes, 2011).

Cultural competency: (1) "process in which one achieves increasing levels of awareness, knowledge, and skills along a continuum, improving one's capacity to work and communicate effectively in cross-cultural situations" (U.S. Department of Health and Human Services, 2001); (2) "a set of congruent behaviors, attitudes, and policies that … enable a system, agency, or group of professionals to work effectively in cross-cultural situations" (Cross et al. 1989, p. 13).

Cultural humility: (1) "reflective process of understanding one's biases and privileges, managing power imbalances, and maintaining a stance that is open to others in relation to aspects of their cultural identity that are most important to them" (U.S. Department of Health and Human Services, 2001).

Cultural norms: spoken or unspoken rules or standards for a cultural group that indicate whether a certain social event or behavior is considered appropriate or inappropriate (Center for Substance Abuse Treatment, 2014).

Cultural proficiency: involves a deep and rich knowledge of a culture—an insider's view—that allows the counselor to accurately interpret the subtle meanings of cultural behavior (Kim et al. 1992).

Cultural sensitivity: is (1) being aware that cultural differences and similarities between people exist without assigning them a value and have an effect on values, learning and behavior; and (2) a set of skills that allow you to understand and learn about people whose cultural background is not the same as your own (Bronx Partners for Healthy Communities, n.d)

Culturally and linguistically appropriate services: "are respectful of and responsive to the health beliefs, practices and needs of diverse patients" (Agency for Healthcare Research and Quality, 2022).

Culture: '"The conceptual system that structures the way people view the world-it is the particular set of beliefs, norms, and values that influences ideas about the nature of relationships, the way people live their lives, and the way people organize their world." (Center for Substance Abuse Treatment, 2014).

Ethnicity: "refers to the social identity and mutual belongingness that defines a group of people on the basis of common origins, shared beliefs, and shared standards of behavior (culture)" (Center for Substance Abuse Treatment, 2014).

Interpreter: An individual who specializes in converting information shared orally.

Race: "a social construct that describes people with a shared physical characteristic" (Center for Substance Abuse Treatment, 2014).

Racism: attitude or belief that people with certain shared physical characteristics are better than others" (U.S. Department of Health and Human Services, 2001).

Refugee: is someone who "is unable or unwilling to return to their country of origin owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group, or political opinion" (United Nations High Commissioner for Refugees, 1967).

Reproductive Health: A state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes. Reproductive health therefore implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so. Implicit in this last condition are the right of men and women to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice, as well as other methods of their choice for regulation of fertility which are not against the law, and the right of access to appropriate health-care services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant (ICPD, Paragraph 7.2 via UNFPA, 2016).

Reproductive Health Care: The constellation of methods, techniques and services that contribute to reproductive health and well-being by preventing and solving reproductive health problems. It also includes sexual health, the purpose of which is the enhancement of life and personal relations, and not merely counselling and care related to reproduction and sexually transmitted diseases (ICPD, Paragraph 7.2 via UNFPA, 2016).

Sexual health: A state of physical, emotional, mental and social well-being related to sexuality: it is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence. For

sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected and fulfilled (WHO, 2002).

Sexual and reproductive health (SRH): "the physical, mental and social well-being in all matters relating to the reproductive system. It implies that people are able to have a satisfying and safe sex life, the capability to reproduce and the freedom to decide if, when, and how often to do so" (UNFPA, n.d).

Translator: An individual who converts written text from one language to another.

Chapter 2. Comprehensive Review of the Literature

2.1 *Defining relevant concepts and terms*

The literature outlining best practices for improving health outcomes and reducing disparities across ethnic and social groups continues to demonstrate compelling evidence for healthcare providers to meaningfully employ principles of culturally competent care in their practices. The term *cultural competency* is used ubiquitously, yet the meaning differs based on context and intention. This issue is further complicated by the decision on whether and how to employ

cultural competence, *cultural sensitivity*, and/or *cultural humility* and remains convoluted with discordant and non-specific definitions for each of these concepts.

To facilitate understanding of its relationship with the terms that follow culture is defined here as, "the conceptual system that structures the way people view the world- it is the particular set of beliefs, norms, and values that influences ideas about the nature of relationships, the way people live their lives, and the way people organize their world" (Center for Substance Abuse Treatment, 2014).

The seminal work of Cross et al. titled *Toward a Culturally Competent System of Care, Volume 1*, originally published in 1989, has served as a conceptual framework and model for the pursuit of cultural competence (Cross et al., 1989). In this body of work, Cross emphasized three critical elements: 1) self-awareness; 2) culture-specific knowledge; and 3) skills promoting effective socio-cultural interactions by an individual. His work has been extensively cited and serves as the foundation of most renditions of cultural competence models and definitions. For example, the National Council for Cultural Competence (NCCC) has offered the following definition of '*cultural competence'* based on the work of Cross (1989*)*: "Cultural competence is a developmental process that evolves over an extended period. Both individuals and organizations are at various levels of awareness, knowledge and skills along the cultural competence continuum" *(*NCCC, 2009). NCCC further indicates that cultural competence requires that organizations: "have a defined set of values and principles, and demonstrate behaviors, attitudes, policies, and structures that enable them to work effective cross-culturally" and "have the capacity to (1) value diversity, (2) conduct self-assessment, (3) manage the dynamics of difference, (4) acquire and institutionalize cultural knowledge, and (5) adapt to diversity and the cultural contexts of communities they serve. Incorporate the above in all aspects of

policymaking, administration, practice and service delivery, systematically involve consumers, families and communities" *(*National Center for Cultural Competence, n.d.).

Cross et al. stated that cultural competence is a complex framework, and that there is a tendency for systems and organizations to want a textbook solution, a quick fix, a recipe, or a "how to," step-by-step approach. The complexity of achieving cultural competence does not allow for such an easy solution. Cross' framework emphasizes that the process of achieving cultural competency occurs along a continuum and sets forth six stages including: 1) cultural destructiveness, 2) cultural incapacity, 3) cultural blindness, 4) cultural pre-competence, 5) cultural competency and 6) cultural proficiency (Cross et al., 1989). Cross and colleagues further described the characteristics of each stage in the continuum (Figure 1).

Figure 1. Continuum of Cultural Competency

Cultural destructiveness	Destructive attitudes, policies, and practices towards diverse cultures and individuals within an organization. Forced assimilation, subjugation, rights and privileges for dominant group only
Cultural incapacity	racism, maintain stereotypes, unfair hiring practices
Cultural blindness	Ethnocentrism in policies, practices, and attitudes. differences ignored, "treat everyone the same", only meet needs of dominant groups
Cultural Precompetence	Proactive organization and individual, Explore cultural issues, acceptance and respect for differences, cultural assessment, ongoing professional development
Cultural competence	Recognize individual and cultural differences, seek advice from diverse groups, hire culturally unbiased staff
Cultural proficiency	Assertive and proactive agenda and programming to improve services based upon cultural needs

National Center for Cultural Competence (NCCC). Cultural Competence Continuum. Adapted from *Toward a Culturally Competent System of Care, Volume,* Cross et al.

Since 1989, others have re-interpreted Cross' definition to contextualize its meaning in particular fields or disciplines, such as healthcare. Zuwang Shen (2015) exhibited some of the many iterations of how '*cultural competence'* has been defined through application to clinical care (Table 1). It highlights how the definition varies even within similar fields. Theoretical and methodological models of culturally competent care not only vary, but are continuously refined, elaborated, and expanded upon based on earlier conceptions of cultural competence.

Table 1. Definitions for Cultural Competence (in chronological order).

Author	Term	Definition
Orque, 1983	Ethnic nursing care	Nurse's effective integration of the patient's ethnic cultural background into her nursing process-based patient care
AAN Expert Panel on Culturally Competent Nursing Care, 1992	Culturally competent nursing care	Care that is sensitive to issues related to culture, race, gender, and sexual orientation
Andrews & Boyle, 1997	Cultural competence	A process in which the nurse continuously strives to work effectively within the cultural context of an individual, family, or community from a diverse cultural background
Smith, 1998a	Cultural competence	A continuous process of cultural awareness, knowledge, skill, interaction, and sensitivity among caregivers and the services they provide (attributes by concept analysis)
Kim-Godwin, Clarke, & Barton, 2001	Cultural competence	Caring, cultural sensitivity, cultural knowledge, and cultural skill (attributes by concept analysis)
Burchum, 2002	Cultural competence	A process of development that is built on the ongoing increase in knowledge and skill development related to the attributes of cultural awareness, knowledge, understanding, sensitivity, interaction, and skill (attributes via concept analysis)

Leininger, 2002b	Culturally competent nursing care	The explicit use of culturally based care and health knowledge that is used in sensitive, creative, and meaningful ways to fit the general lifeways and needs of individuals or groups for beneficial and meaningful health and well-being or to face illness, disabilities, or death
Campinha-Bacote, 2002b	Cultural competence	"The ongoing process in which the health care provider continuously strives to achieve the ability to effectively work within the cultural context of the client (individual, family, community). …This process involves the integration of cultural awareness, cultural knowledge, cultural skill, cultural encounters, and cultural desire" (p. 181).
Purnell & Paulanka, 2003	Cultural competence	Self-cultural awareness, knowledge, and understanding of the client's culture, acceptance of, and respect for cultural differences, openness to cultural encounter, and adaptation of care to be congruent with the client's culture
Giger & Davidhizar, 2004	Cultural competence	A dynamic, fluid, continuous process whereby an individual, system, or health care agency finds meaningful and useful care delivery strategies based on knowledge of the cultural heritage, beliefs, attitudes, and behaviors of those to whom they render care
Suh, 2004	Cultural competence	An ongoing process with a goal of achieving ability to work effectively with culturally diverse groups and communities with a
		detailed awareness, specific knowledge, refined skills, and personal and professional respect for cultural attributes, both differences and similarities (antecedents via concept analysis)
Papadopoulos, 2006	Cultural competence	The process one goes through to continuously develop and refine one's capacity to provide effective health and social care, taking into consideration people's cultural beliefs, behaviors, and needs, as well as the effects that societal and organizational structures may have on them.
Zander, 2007	Cultural competence	Having three elements: cultural awareness, cultural knowledge, and cultural skills
Jirwe, Gerrish, Keeney, & Emami, 2009	Cultural competence	Five core components common to cultural competence models: cultural awareness, knowledge, skill, encounter, and sensitivity (p. 2638, via concept analysis)
Jeffreys, 2010a	Cultural competence	A multidimensional learning process that integrates transcultural nursing skills in all three dimensions (cognitive, practical, and affective), involves transcultural self-efficacy (TSE; confidence) as a major influencing factor, and aims to achieve culturally congruent care (p. 46)

A relevant selection of published theoretical and methodological models of culturally competent clinical care was also created by Shen (Table 2 and Table 3) (Shen, 2015). This medley of definitions and conceptualizations has created intense discussion around the construct of cultural competence. Those opposing the concept of cultural competence assert that it is an endpoint and assumes that healthcare professionals/providers (HCPs) can learn a quantifiable set of attitudes and skills that will allow them to work effectively within the cultural context of the patient (Prasad et al., 2016). Other criticisms of cultural competence include its strong focus on knowledge acquisition; a lack of social justice issues; its understanding as a technical and communication technique; its potential to stereotype cultural groups; and its use of the concept of culture as merely a substitution for minority racial/ethnic group identity. This discussion has led for calls to replace cultural competence with the concept of cultural humility (Fisher-Borne, Cain & Martin, 2015; Tervalon & Murray-Garcia, 1998).

Table 2. Theoretical Models of Cultural Competence

Authors. Year	Model Name	Components or Constructs or Domains
CampinhaBacote, 2002b	Culturally competent model of care	Five constructs within the cultural context of individual, family, and community (cultural awareness, knowledge, skill, encounters and desire [cultural desire added in 1998])
Papadopoulos et al., 1998	Model for the development of culturally competent health practitioners	Four components (cultural awareness, cultural knowledge, cultural sensitivity, cultural competence)
Kim-Godwin, et al., 2001	Culturally competent community care model	Three constructs (cultural competence, health care system, and health outcomes) with four dimensions (caring, cultural sensitivity, cultural knowledge, and cultural skills)
Jeffreys, 2010a	Cultural competence and confidence model	Transcultural nursing skills in cognitive, practical, and affective dimensions, transcultural self-efficacy, and culturally congruent care

Schim & Doorenbos, 2010; Schim, Doorenbos, Benkert, & Miller, 2007; Schim, Doorenbos, Miller, &, Benkert, 2003	3–D model of culturally congruent care	Three dimensions of provider level (cultural diversity, cultural awareness, cultural sensitivity, and cultural competence behaviors), client level (patient, family, and community attitudes, beliefs, and behaviors) and culturally congruent care as outcome layer (when provider and client levels fit well together)
Campinha-Bacote, 2005	Biblically based cultural competence model	Eighteen intellectual and moral virtues (love, caring, humility, love of truth, teachableness, intellectual honesty, inquisitiveness, wisdom, discernment, judgment, prudence, attentiveness, studiousness, practical wisdom, understanding, temperance, patience and compassion) integrated into the five constructs (cultural awareness, cultural knowledge, cultural desire, cultural skill and cultural encounters)
Papadopoulos & Lees, 2001	Model for the development of culturally competent researchers	Four components (cultural awareness, cultural knowledge, cultural sensitivity, cultural competence) with culturegeneric and culture specific competence as the two layers of cultural competence
Willis, 1999	Framework for cultural competence	Seven-step progression (knowledge of one's own culture, knowledge of others' culture, cultural interaction, cultural tolerance, cultural inclusion, cultural appreciation/acceptance, cultural competence)
Wells, 2000	Cultural development model (for individual and institutional cultural competence development)	A continuum of six stages in two phases (cultural incompetence, cultural knowledge, and cultural awareness as the cognitive phase; cultural sensitivity, cultural competence, and cultural proficiency as the affective phase)
Burchum, 2002	Model for cultural competence	Six attributes (cultural awareness, knowledge, understanding, sensitivity, interaction, and skill): a nonlinear, expansive process of becoming culturally competent

Pacquiao, 2012	Culturally competent model of ethical decisions	Three components: cultural context; compassionate advocacy for social justice and human rights protection for culturally congruent healthcare for vulnerable populations; and culturally competent healthcare by realization of cultural preservation, cultural accommodation, and cultural patterning
Suh, 2004	Model of cultural competence	Four domains as antecedents: cognitive (cultural awareness, knowledge), affective (sensitivity), behavior (skills), and environmental (encounters); three attributes of cultural competence (ability, openness, flexibility); and three variables (receiver based, provider-based, and health outcome)

Source: Shen, 2015

Table 3. Methodological Models of Cultural Competence

Authors, year	Model Name	Components/Constructs/Domains
Giger & Davidhizar, 2004, 2008	Transcultural assessment model	Six cultural phenomena (communication, space, social organization, time, environmental control, and biological variations)
Spector, 2004a, 2009	Health traditions model	Five aspects of heritage consistency (culture, ethnicity, religion, [acculturation and socialization, 2009]) interrelated with six cultural phenomena (communication, space, social organization, time, environmental control, and biological variations) to maintain, protect, and restore the health of the body, mind, and spirit
Orque, 1983	Ethnic/cultural system framework	Eight components applicable to nurses and clients (diet, family life processes, healing beliefs and practices, language and communication process, social groups' interactive patterns, value orientations, religion, art and history) along with two models (intercultural communication model and model of biological, sociological and psychological systems)
Leininger, 1991	Sunrise model	Six domains (culture values and lifeways; religious, philosophical, and spiritual beliefs; economic factors; educational factors; technological factors; kinship and social ties; and political and legal factors) and three modalities (cultural care preservation and maintenance; cultural care accommodation and negotiation; and cultural care repatterning and restructuring)

Purnell, 2003, 2008	Purnell model for cultural competence	Twelve cultural domains (overview, inhabited localities, and topography; communication; family roles and organization; workforce issues; biocultural ecology; highrisk health behaviors; nutrition; pregnancy and childbearing practices; death rituals; spirituality; healthcare practices; and healthcare practitioners)
Andrews & Boyle, 2008	Transcultural nursing assessment guide for individuals and families	Twelve categories of cultural knowledge (cultural affiliations, values orientation, communication, health related beliefs and practices, nutrition, socioeconomic considerations, organizations providing cultural support, education, religion, cultural aspects of disease incidence, biocultural variations, and developmental considerations across the life span, p. 35)

Source: Shen, 2015

Cultural humility, on the other hand, has not historically been accompanied by a construct or model. Rather, it can be considered a theoretical concept which identifies values and actions one should employ. Foronda constructed a definition of cultural humility based on society's use of the term throughout literature; *"*in a multicultural world where power imbalances exist, cultural humility is a process of openness, self-awareness, being egoless, and incorporating self-reflection and critique after willing interacting with diverse individuals. The results of achieving cultural humility are mutual empowerment, respect, partnerships, optimal care, and lifelong learning*"* (Foronda, C., et al., 2016). This differs slightly from cultural sensitivity which is defined as "…the ability to recognize, understand, and react appropriately to behaviors of persons who belong to a cultural or ethnic group that differs substantially from one's own" (Porta & Last, 2018). Though the definition is clear enough, the conditions under which and how it should be engaged remains vague. For this reason, HCP are often asked to employ *culturally sensitive communication* under the guise that this term is more specific than its parent term. Yet a dictionary definition of the term does not exist. However, Foronda defines culturally

sensitive communication as, “effective verbal and nonverbal interactions between individuals or groups, with a mutual understanding and respect of each other’s values, beliefs, preferences, and culture, to promote equity in healthcare with the goal of providing culturally sensitive care” (Foronda, 2008). The literature suggests that the concept of culturally sensitive communication is used in three ways: developing an understanding about one’s own cultural beliefs, values, attitudes, and practices and those of others; to describe open and sensitive communication and to describe strategies to collaborate with the patient and family for optimal care (Claramita et al., 2016; Douglas et al., 2011).

2.2 *Clinical Practice Implications*

Healthcare providers who understand their own cultures and their patients’ cultural values, beliefs, and practices are in a better position to interact with their patients and provide culturally acceptable care that increases opportunities for health promotion and wellness; illness, disease, and injury prevention; and health maintenance (Purnell and Fenkl, 2019). The way providers perceive themselves as competent providers is often reflected in the way they communicate with patients. Before addressing the multicultural backgrounds and unique individual perspective of each patient, healthcare professionals must first address their own personal and professional knowledge, values, beliefs, ethics, and life experiences in a manner that optimizes assessment of any interactions with patients who come from a culture different from that of the healthcare provider. Self-awareness in cultural competence is a deliberate and conscious cognitive and emotional process of getting to know oneself: one’s own personality, values, beliefs, professional knowledge, standards, ethics, and the impact of these factors on the various roles one plays when interacting with individuals who are different from oneself (Purnell and Fenkl, 2019).

Strategies for practicing *cultural competency*, as outlined by the U.S. Department of Health and Human Services Office of Minority Health, include: learning about your own and others' cultural identities, combating bias and stereotypes, respecting others' beliefs, values, and communication preferences, adapting your services to each patient's unique needs, and gaining new cultural experiences (U.S. Department of Health and Human Services Office of Minority Health, n.d.).

Strategies for practicing *cultural humility*, as outlined by the U.S. Department of Health and Human Services Office of Minority Health, include: practicing self-reflection (awareness of your beliefs, values, and implicit biases), recognizing what you don't know and being open to learning as much as you can, being open to other people's identities and empathizing with their life experiences, acknowledging that the patient is their own best authority, learning and growing from people whose beliefs, values, and worldviews differ from yours (U.S. Department of Health and Human Services Office of Minority Health, n.d).

Healthcare providers can demonstrate commitment to cultural competence through the attitudes and behaviors outlined by the Substance Abuse and Mental Health Services Administration (SAMHSA) (Figure 2). Originally developed as a guide for substance abuse counselors, this tool may also be used to provide direction to health care providers (Center for Substance Abuse Treatment, 2014).

Figure 2. Attitudes and Behaviors of Culturally Competent Health Care Providers

Attitude	Behavior
Respect	• Exploring, acknowledging, and validating the client's worldview • Approaching treatment as a collaborative process • Investing time to understand the client's expectations of treatment • Using consultation, literature, and training to understand culturally specific behaviors that demonstrate respect for the client • Communicating in the client's preferred language
Acceptance	• Maintaining a nonjudgmental attitude toward the client • Considering what is important to the client
Sensitivity	• Understanding the client's experiences of racism, stereotyping, and discrimination • Exploring the client's cultural identity and what it means to her/him • Actively involving oneself with individuals from diverse backgrounds outside the counseling setting to foster a perspective that is more than academic or work related • Adopting a broader view of family and, when appropriate, including other family or community members in the treatment process • Tailoring treatment to meet the cultural needs of the client (e.g., providing outside resources for traditional healing)
Commitment to equality	• Proactively addressing racism or bias as it occurs in treatment (e.g., processing derogatory comments made by another client in a group counseling session) • Identifying the specific barriers to treatment engagement and retention among the populations being served • Recognizing that equality of treatment does not translate to equity—that equity is defined as equality in opportunity, access, and outcome (Srivastava 2007) • Endorsing counseling strategies and treatment approaches that match the unmet needs of diverse populations to ensure treatment engagement, retention, and positive outcomes
Openness	• Recognizing the value of traditional healing and help-seeking practices • Developing alliances and relationships with traditional practitioners • Seeking consultation with traditional healers and religious and spiritual leaders when appropriate • Understanding and accepting that persons from diverse cultural groups can use different cognitive styles (e.g., placing more attention on reflecting and processing than on content; being task oriented)

Humility	• Recognizing that the client's trust is earned through consistent and competent behavior rather than the potential status and power that is ascribed to the role of counselor • Acknowledging the limits of one's competencies and expertise and referring clients to a more appropriate counselor or service when necessary • Seeking consultation, clinical supervision, and training to expand cultural knowledge and cultural competence in counseling skills • Seeking to understand oneself as influenced by ethnicity and cultural groups and actively seeking a nonracist identity • Being sensitive to the power differential between client and counselor
Flexibility	• Using a variety of verbal and nonverbal responses, approaches, or styles to suit the cultural context of the client • Accommodating different learning styles in treatment approaches (e.g., the use of role-plays or experiential activities to demonstrate coping skills or alcohol and drug refusal skills) • Using cultural, socioeconomic, environmental, and political contextual factors in conducting evaluations • Integrating cultural practices as treatment strategies (e.g., Alaska Native traditional practices, such as tundra walking and sustenance activities)

Source: Center for Substance Abuse Treatment, 2014

Similarly, SAMSHA compiled a list of behaviors to be avoided. Although it was developed for counselors and clinical supervisors in the substance abuse space, the advice is relevant to clinicians of nearly all specialties (Figure 3).

A variety of culture mapping tools have been used in both clinical and counseling settings. One such tool is the culturagram is an assessment tool that helps clinicians understand culturally diverse clients and their families (Congress 1994, 2004; Congress and Kung). Another tool allows providers to map the interactive influences of cultural identity development among patients. Through this activity, they may better prepare for treatment planning and gain awareness of the many factors that influence culturally responsive treatment. Multicultural intake

checklists, such as the one included as Figure 4, have been used in the diagnostics of psychological disorders and illnesses.

Figure 3. Advice to Counselors and Clinical Supervisors: Behaviors for Counselors to Avoid

Advice to Counselors and Clinical Supervisors: Behaviors for Counselors to Avoid
• Addressing clients informally; counselors should not assume familiarity until they grasp cultural expectations and client preferences. • Failing to monitor and adjust to the client's verbal pacing (e.g. not allowing time for clints to respond to questions). • Using counseling jargon and treatment language (e.g., "I am going to send you to our primary stabilization program and obtain a biopsychosocial and then, afterwards, to partial"). • Using statements based on stereotypes or other preconceived ideas generated from experiences with other clients from the same culture. • Using gestures without understanding their meaning and appropriate context within the given culture. • Ignoring the relevance of cultural identity in the client-counselor relationship. • Neglecting the client's history (i.e., not understanding the client's individual and cultural background • Proving an explanation of how current difficulties can be resolved without including the client in the process to obtain his or her own explanations of the problems and how he or she thinks these problems should be addressed. • Downplaying the importance of traditional practices and failing to coordinate these practices as needed

Source: Center for Substance Abuse Treatment, 2014

Figure 4. Multicultural Intake Checklist

Multicultural Intake Checklist

- Immigration history
- English language fluency
- Bilingual or multicultural fluency
- Racial, ethnic, and cultural identities
- Acculturation level (e.g., traditional, bicultural)
- History of discrimination/racism
- Trauma history
- Gender roles and expectations
- Relationship and dating concerns
- Sexual and gender orientation
- Traditional healing practices
- Help-seeking patterns
- Treatment concerns related to cultural differences
- Cultural group affiliation
- Current network of support
- Review of confidentiality parameters and concerns

Excerpted from Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (American Psychiatric Association [APA] 2013).

The National Standards for Culturally and Linguistically Appropriate Services (CLAS), developed by the US Department of Health and Human Services Office of Minority Health, presents 15 action steps to guide health providers in establishing culturally and linguistically appropriate services. CLAS refers to services that are respectful of and responsive to individual cultural health beliefs and practices, preferred languages, health literacy levels, and communication needs. CLAS helps meet the achievement of six health care quality improvement aims: the delivery of care that is safe, effective, patient-centered, timely, efficient, and equitable. Ideally, this framework would be applied at every patient point of contact (U.S. Department of Health and Human Services Office of Minority Health, n.d). At the provider level, providing CLAS means practicing cultural competency and cultural humility. CLAS stresses that language services (interpreters) must be competent, however, there is no action step ensuring clinicians'

preparedness to work with the language service provider (U.S. Department of Health and Human Services Office of Minority Health, n.d).

Although the Accreditation Council for Graduate Medical Education core competencies include communication across a wide range of cultural backgrounds, and American Academy of Pediatrics (AAP) guidelines emphasize "culturally effective" care, research shows that approaches to cultural competency in medical schools and in residency programs vary dramatically, and training on communicating through interpreters with patients with limited English proficiency (LEP) may be absent from clinical rotations and residency programs where they could be most beneficial (Thompson et al., 2013; Macdonald et al., 2007; Kripalani et al., 2006; Accreditation Council for Graduate Medical Education, 2018; Britton, 2004; American Academy of Pediatrics, 2018)

Organizations may also develop staff recruitment, retention, and promotion strategies that reflect the populations served. Improving the workforce to provide competent services to diverse populations goes beyond merely increasing the number of individuals from each of the respective groups. While this is clearly an important strategy, there is a need not only to increase the frequency, but also to improve the quality of training for all HCPs (Hoge et al. 2007, p. 192). Trainings should increase staff self-awareness and cultural knowledge, review culturally responsive policies and procedures, and improve culturally responsive clinical skills (Anderson et al. 2003; Brach and Fraser 2000; Lie et al. 2011). It is important to note that research evaluating the outcome and effectiveness of cultural competence trainings is limited.

Health-care institutions and individual providers, may refer clients to community resources, collaborate with other community services, elicit support from the community, employ outreach

workers, and select culturally appropriate strategies to provide community education as methods for implementing the principles of cultural competency.

2.3 *Health Implications*

The provision of quality, culturally competent health care is uniquely important to U.S. based refugees. Newly resettled refuges may face substantial challenges to acclimating to a new society, including language barriers, unfamiliar social norms, values, belief systems, practices, health systems, and unwelcoming contexts of reception (Fruja & Rosas, 2016; González et al., 2017 as cited in Bennouna et al., 2021). Over the course of migration and resettlement, newcomers may embrace and draw strength from a plurality of cultural identities, whether based on place, race, ethnicity, religion, nation, or otherwise. However, managing various cultural affiliations may also produce stress, especially in an unsupportive environment, provoking feelings of anxiety, isolation, depression, and other effects on mental health and psychosocial wellbeing (Bennouna et al., 2021). The stress of newly resettled refugees may be exacerbated by the receiving community, through microaggressions or discrimination, and by the heritage community, when some members disapprove of an individual's process of change (Castro-Olivo & Merrell, 2012). Accessing the U.S. healthcare system may also produce acculturative stressors and exacerbate inequalities for newcomers, especially when system is designed around a dominant ethnic group—namely the white, English-speaking, Judeo-Christian majority in the U.S. Such services may heighten social exclusion, contribute to marginalization, or reinforce a pressure to assimilate to the receiving society's dominant group (Bennouna et al., 2021). In the United States, refugees may encounter identity-based discrimination while also being subject to racialization (Frounfelker et al., 2020; Sorrell et al., 2019). Immigrants who are refugees from war, famine, oppression, and other dangerous environments are more vulnerable to

psychological distress (APA, 2010). They are likely to have left behind painful and often life-threatening situations in their countries of origin and can still bear the scars of these experiences. Some refugees come to the United States with high expectations for improved living conditions, only to find significant barriers to their full participation in American society (e.g., language barriers, discrimination, poverty). Reduced federal resources during the Trump administration and a national climate corroded with increasingly common expressions of anti-immigrant sentiment has resulted in practitioners struggling to provide newcomers adequate support, leaving this population particularly vulnerable to disparate health outcomes (Fruja & Roxas, 2016; Ukasoanya, 2014).

2.4 *Reproductive and Maternal Health Outcomes and Attitudes of Refugee Women*

Sexual and reproductive health outcomes of refugee women remain disparate compared to USborn populations. For example, one study found that 86% of those older than 40 years had never had a mammogram compared to only 33% in U.S. born women of the same age. In the same sample, only 24% of refugee women reported having a cervical screening, also known as a Pap test/smear (Barnes and Harrison, 2004). During migration and early resettlement, adolescent refugees have an elevated risk of pregnancy, HIV and other sexually transmitted infections (STIs) while at the same time experiencing unmet needs for family planning services (UNHCR, n.d). Some studies have found the initiation of prenatal care for Somali, Iraqi, and Bhutanese refugees was delayed and had fewer total prenatal visits compared to US women (Kennedy & Murphy Lawless, 2003; Berkowitz, Oo, & Percac-Lima, 2016). If prenatal visits are delayed or infrequent, health concerns such as hypertension and anemia may be left undiagnosed—putting the women at an increased risk for poor obstetrical outcomes (Alnuaimi, Kassab, Ali, Mohammad, & Shattnawi, 2017; Kahler, Sobota, Hines, & Griswold, 1996).

Pregnant refugee women also had higher rates of Cesarean sections, stillbirths, preterm births, and lower birth weights among infants (Alnuaimi et al., 2017; Carolan, 2010; Davis, Goldenring, McChesney, & Medina, 1982; Small et al., 2008; Wanigaratne et al., 2018). Additionally, despite post-partum depression occurring in refugee women, previous studies have found many women were unfamiliar with the clinical diagnosis, preventing them from seeking support from their clinicians (Ahmed, Bowen, & Feng, 2017; Merry, Gagnon, Kalim, & Bouris, 2011; Tobin, Di Napoli, & Beck, 2017). Some studies suggest that traditional beliefs of refugee women surrounding labor may conflict with standard delivery practices in western medical facilities. For, example, the preference for kneeling or squatting during birth rather than the supine position, administration of pain medication or epidurals, and the potential for lack of modesty during childbirth concerned refugee mothers (Higginbottom et al., 2013; Saadi, Bond, & PercacLima, 2015). Because of language barriers and variations in birth practices, refugee women felt that they were not asked or listened to during birth, experienced fear due to lack of understanding of what was happening, and resisted recommendations of Cesarean sections (Khan & DeYoung, 2018). Language and cultural barriers experienced by refugee women with limited English proficiency have also resulted in increased hospitalizations, increased risk of serious obstetrical complications, and general reduced access to health care (Clarke, et al., 2019).

Related, attitudes toward sexuality are culturally defined and affect reproductive health (Center for Substance Abuse Treatment, 2014). Each culture determines how to conceptualize specific sexual behaviors, the degree to which they accept same-sex relationships, and the types of sexual behaviors considered acceptable or not (Ahmad and Bhugra 2010). In any cultural group, diverse views and attitudes about appropriate gender norms and behavior can exist. Additionally,

cultures may define the context in which it is appropriate or within the socially accepted norm to interact with health care systems.

Although strategies to promote cultural competency exist in the literature, the solutions presented do not meet the needs of all U.S. based populations. Much of the information available on the topic was not created with refugee populations in mind. Rather, it was developed generally for non-immigrant minority groups. If the disparate health outcomes of U.S. based refugee populations is any indicator, this "catch all" approach is not sufficient. There is even less material available written with specific attention to SRH, a sphere of health care which remains especially stigmatized and sensitive across cultures, which only furthers the gap between the SRH of refugee women and the SRH of their U.S. born neighbors.

Chapter 3. Manuscript

Contribution of the student

Autumn Curran (student) completed the analysis, writing, figure, and table development included in this manuscript.

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Ethical and Culturally Competent Healthcare for Sexual and Reproductive Health among Refugee Women

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ABSTRACT

Introduction: Compared to their U.S. born peers, refugee women experience disparate sexual and reproductive health (SRH) outcomes. While the causes of such disparities are multi-faceted, they may be due in part to lack of access and poor provision of culturally competent care. There are few studies which explore SRH in these populations and even fewer whose focus is cultural in healthcare settings.

Objective: This research aims to explore: (1) how refugee women's cultural backgrounds influence SRH service utilization; and (2) what providers identify as effective strategies to deliver culturally competent sexual and reproductive healthcare to refugee women.

Methods: In-depth-interview were conducted with 26 refugee women and 17 SRH providers in Metropolitan Atlanta, Georgia. The data were analyzed using a qualitative thematic approach

Results: Modesty, discomfort discussing SRH issues, and social and gender norms influence refugee women's SRH service utilization. Between women and providers, six strategies for providing culturally competent care were identified: 1) targeted trainings for providers; 2) provision of language services to refugee women; 3) provision of patient navigators to refugee women; 4) group education classes for refugee women; 5) centering refugee women in SRH services; and 6) integration of women's religious practices into care counseling.

Conclusions: Providing quality SRH care goes beyond understanding the multicultural context of refugee women's experience. Rather, it requires introspection on the part of the provider and a commitment to developing the skills needed to provide culturally congruent care that adapts to the needs and context of patients.

Background

Refugee women have an increased risk of poor sexual and reproductive health (SRH) outcomes as compared to their U.S. born peers. One study found that 86% of refugee women 40 years and older had never had a mammogram as compared to only 33% in U.S. born women of the same age (Barnes & Harrison, 2004). In the same population only 24% of refugee women reported having a cervical screening in the past three years (Barnes & Harrison, 2004). Adolescent refugees have an elevated risk of unplanned pregnancy, HIV, and other STIs, while also experiencing unmet family planning needs during early resettlement (UNHCR, n.d.). Existing research has identified several important cultural beliefs, practices, and values among refugee women which impact their SRH. Some practices and values may conflict with Western medical practice and health promotion practices thus affecting their treatment (Robertshaw, Dhesi, and Jones, 2017; Sussman, 2004). In previous studies, Somali, Sudanese, and Eritrean women identified medical distrust, language barriers, and modesty concerns (e.g., preferences for female practitioners) as key issues that, if not addressed adequately, can negatively impact women's engagement in SRH systems such as the frequency they visit their clinicians and likelihood of completing recommended treatments (Higginbottom et al., 2013; Saadi, Bond, & PercacLima, 2015). Studies suggest that traditional beliefs of refugee women surrounding labor may conflict with usual delivery practices in western medical facilities; these practices include the preference for kneeling or squatting during birth rather than the supine position, administration of pain medication or epidurals, and the potential for lack of modesty during childbirth concerned refugee mothers (Higginbottom et al., 2013; Saadi, Bond, & PercacLima, 2015). Providers working with these populations thus need to understand patients' backgrounds-including culture and beliefs- and find a way to address culturally incongruent beliefs and values while still

maintaining sensitivity and humility. Despite this, there is insufficient research on ethical issues and strategies in delivering SRH culturally competent care to refugee women based in the U.S.

The high concentration of refugees in Georgia makes this setting ideal for studying SRH health issues among refugees. Clarkston, a suburb ten miles from downtown Atlanta, resettled the highest number of refugees per capita in the United States (among cities resettling 100 or more refugees) between 2015-2019 (Coalition of Refugee Service Agencies, 2018). More than sixty nationalities make up the population of Clarkston and refugees account for approximately half of the town's total population (Tudhope, 2020). Additionally, Atlanta has a history of resettling the large portions of Burmese, Nepalese, Sri Lankan, Vietnamese, Bangladeshi, and Pakistani populations- ranking in the top ten U.S. cities (Pew Research Center, 2017). This research aims to explore ethical concerns and identify current strategies to provide culturally competent care by SRH providers in Atlanta.

Methods

Study Design

A qualitative study exploring; (1) what providers identify as effective strategies to deliver culturally competent sexual and reproductive healthcare to refugee women; and (2) common sexual and reproductive health beliefs, practices, and values among refugee female patients in Metropolitan Atlanta. The study utilized in-depth semi structured interviews with refugee women and healthcare providers using in-depth interview guides (Annex 1).

Instruments

Original in-depth interview guides were developed for use with both refugee women and healthcare providers. The interview guides were developed based on the Socioecological Framework (McLeroy et al., 1988) and Penchansky and Thomas' Theory of Access including; *accessibility*, *availability*, *acceptability*, *affordability*, and *adequacy* (Penchansky & Thomas, 1981).

The guide used with refugee women was designed to explore how their backgrounds and cultures influenced their experiences accessing and utilizing SRH services, including: contraception, HPV vaccinations, cervical and breast cancer screening, and prenatal care. The guide used with healthcare providers covered perceptions of culturally sensitive healthcare, previous trainings and experiences, and strategies to provide culturally sensitive care to women.

Sampling procedure

From July to December 2019, we recruited refugee women living in Metropolitan Atlanta as well as healthcare providers serving refugee women in the same locale. The *a priori* sample sizes for each group (women and healthcare providers) were selected based on recommendations for sample size needed to achieve code and meaning saturation (Hennink et al., 2017).

Refugee women were eligible if they: 1) self-identified as a female, 2) were aged 15-49 years, 3) arrived in the US as a refugee from Democratic Republic of Congo (DRC), Burma, or Bhutan/Nepal. These three geographic locations were selected because they are among the top countries of origin for refugees in Georgia (Refugee Processing Center, 2018). We grouped refugees from Bhutan and Nepal together because many Bhutanese refugees are ethnically

descended from migrants of Nepal (also called Lhotshampas) and may identify as Nepali (Do ETT & Vu M, 2020; Trieu M & Vang C, 2015; Lor et al., 2018). Snowball (Goodman, 1961) and quota-sampling (Coleman, 1959; Frey, 2018) recruitment methods were used to enroll participants. We aimed to enroll roughly equal numbers of refugee women from each of the three groups of origin. Additionally, within each group, both adolescents (aged 13-17) and adults (aged 18-49) were recruited so that experiences across the life course could be explored. Local community-based organizations (CBOs) who served the populations of interest were contacted to gain initial access to the population. Enrolled participants also helped identify and contact other eligible women via further snowball sampling.

Healthcare providers were eligible if they: 1) identified as a healthcare provider and 2) had provided or currently provided SRH services (e.g., family planning, testing for sexually transmitted diseases, HPV vaccination, cervical cancer screening, perinatal care) to refugee women in Metropolitan Atlanta. Snowball sampling and word-of-mouth recruitment was used to identify eligible providers. Providers were recruited from federally qualified health centers (FQHCs) as well as charitable, volunteer operated clinics. The providers cared for women from Burma, Bhutan/Nepal, and the DRC (i.e., the three sampled groups of refugee women) as well as refugees from other countries such as Syria, Rwanda, and Eritrea.

Data collection

Verbal, informed consent was obtained prior to the start of each interview with both refugee women and providers.

For interviews with refugee women consent forms were available in English, Burmese, Nepali, and French. For refugee women who preferred to speak in languages other than English,

female interpreters from similar cultural backgrounds and affiliated with CBOs who were trained in human subjects' research and qualitative methods conducted interviews. For the women that preferred to speak in English, two members of the research team conducted the interviews. Interviews conducted with refugee women were 45 minutes long on average.

All interviews with providers were conducted in English by two authors (MV or GB) and lasted between 30 to 60 minutes. Each interviewed participant, whether a refugee woman or a provider, received a $20 gift card as a compensation. All interviews were audio-taped. The Emory University Institutional Review Board approved the study (Emory IRB: IRB00105414).

Data analysis

Interviews in English were transcribed verbatim by a professional transcription service. If interviews were conducted in a language other than English, interpreters verbally translated the audiotaped interviews while the research team transcribed.

The data collected from both refugee women and healthcare providers was analyzed using a qualitative thematic approach (Nowell et al., 2017). We analyzed the data separately and for each of the two qualitative datasets, using the same six stage procedure: familiarizing ourselves with the data, generating initial codes, searching for themes, reviewing themes, naming and defining themes, and producing the report (Braun & Clarke, 2006 & Braun & Clarke, 2019).

For each of the two qualitative datasets, two members of the research team (MV and GB) independently reviewed selected sample transcripts and developed analytical memos before generating initial codes through both deductive and inductive coding and developing the codebooks. The interview guides and conceptual frameworks guided the deductive coding

process while inductive codes were drawn from emerging themes. After developing the codebooks, two researchers (MV and GB) independently coded several transcripts, compared results, and addressed any discrepancies. Each of these two researchers then independently coded an equal number of remaining transcripts. A third researcher (AC) then reviewed all coded transcripts and noted any remaining discrepancies. Discrepancies were resolved through teambased discussion.

Themes were categorized using the following criteria: themes that appeared in interviews as "all" (100% of interviews); "almost all" (90-99%); "most" (70-89%); "the majority" (50-69%); "several" (20-49%); and "a few" (less than 20%) (Sandelowski, 2001). When employing this operation, refugee women and providers were analyzed separately. The denominator presented in the results represents the sample size for each group.

MAXQDA 2020 (VERBI Software, Berlin, Germany), was used for all data management and analysis. Descriptive statistics of quantitative/demographic data were generated using STATA 16 and Microsoft Excel (StataCorp, 2019; Microsoft Corporation, 2018).

The final sample of refugee women included 26 women: 10 from Burma (38.5%), 10 from Bhutan or Nepal (38.5%), and 6 from DRC (23.1%). Nineteen were adult women (73%), while 7 were adolescents (27%) (Table 1a).

Participants in the final sample of SRH providers included 2 male (11.8%) and 15 female providers (88.2%). Their occupations included: 6 physicians (35.3%), 3 registered nurses (17.6%), 6 advanced practice registered nurses (35.3%), and 2 other providers (11.8%). On average providers had 14.2 years of healthcare experience and approximately 6.5 of that serving refugee women (Table 2a).

Table 1a. Demographic Characteristics of Refugee Women (n=26)[1]

	Age group[3]		Total n (%)
Ethnicity	**Adult**	**Adolescent**	**Total**
Bhutanese/Nepali	7 (26.9%)	3 (11.5%)	10 (38.5%)
Burmese	-	1 (3.8%)	1 (3.8%)
Chin	2 (7.7%)	1 (3.8%)	3 (11.5%)
Congolese	5 (19.2%)	1 (3.8%)	6 (23.1%)
Karen	5(19.2%)	1 (3.8%)	6 (23.1%)
Place of birth			
Bhutan	5 (19.2%)	-	5 (19.2%)
Congo	5 (19.2%)	-	2 (7.7%)
India	1 (3.8%)	1 (3.8%)	2 (7.7%)
Myanmar (Burma)	7 (26.9%)	2 (%)	9 (34.6%)
Nepal	1 (3.8%)	2 (%)	3 (11.5%)
Tanzania	-	1 (3.8%)	1 (3.8%)
Thailand	-	1 (3.8%)	1 (3.8%)
Marital status		-	
Currently married	16 (61.5%)		16 (61.5%)
Never married	2 (7.7%)	7 (26.9%)	9 (34.6%)
Divorced	1 (3.8%)	-	1 (3.8%)
Employment status			
No employment	10 (38.5%)	7 (26.9%)	17 (65.4)
Part-time	5 (19.2%)	-	5 (19.2%)
Full-time	4 (15.4%)	-	4 (15.4%)
Number of children[4]			
0	1 (3.8%)	7 (26.9%)	8 (30.1%)
1	1 (3.8%)	-	1 (3.8%)
2-3	10 (%)	-	10 (38.5%)
4+	6 (23.1%)	-	6 (23.1%)
Health Insurance			
No insurance	7 (26.9%)	1 (3.8%)	8 (30.1%)
Insured through job	2 (7.7%)	-	2 (7.7%)
Medicaid	7 (26.9%)	2 (7.7%)	9 (34.6%)
Insured through	1 (3.8%)	-	1 (3.8%)

spouse			
ACA	1 (3.8%)	-	1 (3.8%)
PeachCare/ PeachState	1 (3.8%)	1 (3.8%)	2 (7.7%)
UNK	-	3 (11.5%)	3 (11.5%)
Total			26 (100%)

[1] Variable distribution reported as n (%)
[2] Variable distribution reported as mean
[3] Calculated from DOB and interview date
[4] Total may not equal total number of participants due to responses of 'unknown'

Table 2a. Demographic Characteristics of Health Care Providers (N=17)[1]

	Total (n=17)
Sex	
Female	15 (88.2%)
Male	2 (11.8%)
Race	
White	9 (52.9%)
Asian	6 (35.3%)
Native Hawaiian or Other Pacific Islander	1 (5.9%)
Other	1 (5.9%)
Occupation	
Physicians	6 (35.3%)
Advanced practice registered nurses	6 (35.3%)
Registered nurses	3 (17.6 %)
Other	2 (11.8%)
	Years[2]
Years of experience in healthcare	14.2
Years of experience working with refugee women	6.5

[1] Variable distribution reported as n (%)
[2] Variable distribution reported as mean
[3] Calculated from DOB and interview date
[4] Total may not equal total number of participants due to responses of 'unknown'

Results

Emergent themes will be presented in two parts. The first explores how women's cultural backgrounds influence SRH service use and the second presents strategies used to deliver culturally sensitive SRH care to refugee women for providers in Metropolitan Atlanta. Both include the women's and providers perceptions. Prior to outlining the emergent themes, we will contextualize what this term means to providers. During the interviews, providers shared their definitions of "culturally sensitive" care; these responses were multi-faceted.

Several providers shared that, to them, *cultural sensitivity* implies putting their patients' priorities first, regardless of background or beliefs. For example, one nurse practitioner stated:

> *"to me, it would mean that every person that you interact with has their own background and beliefs that will likely be different from yours, and just coming in with that knowledge and then not assuming that anyone is thinking a certain way or believes like how you believe...so then it's really asking the patients...what do you think about this or how can I assist you within your practices*" (Provider 05).

Several providers also acknowledged that assumptions should not be made about patients' beliefs. One physician articulated this sentiment by saying,

> "*[cultural sensitivity] is being aware of that person's backgrounds and...belief, which is difficult because it's so variable…even myself being of Indian origin…I should be culturally aware of Indian, but it's so variable from region to region, from family to family, and from person to person…So, I think that one piece of it is the knowledge of the different cultures, but then the second piece of it is...having an open mind and not having any preconceived notions when you're talking to anyone. Because even if the majority of*

> *say Indian people might believe in one thing, this particular person might not believe that"* (Provider 07).

In this case, the physician intentionally avoided making generalizations based on assumed shared experiences during their clinical encounter.

A few providers also discussed their personal responsibility for providing culturally sensitive care and exercising self-awareness while practicing medicine; for example, one midwife even listed "checking [her] privilege" as an action item to exercise (Provider 09). Similarly, a registered nurse shared that*:*

> *"[as a healthcare professional, she] need[s] to set aside whatever negatives [she has] and be willing to learn about [herself] first and what is it that may keep [her] from caring for these people, what…[does she] have that can be a detriment"* (Provider 11).

Part One: How women's cultural backgrounds influence SRH service utilization

The frequency and way in which women engage in SRH care is informed by their culture. In particular, women and providers spoke about how a person's culture, religion, and interpersonal and societal experiences shape their family planning preferences. Four themes emerged: 1) inconsistencies exist regarding the influence of religion on refugee women's health decisionmaking process or priorities across refugee women and providers; 2) preference for modesty influences refugee women's degree of comfort with SRH care; 3) discomfort discussing SRH issues impedes refugee women's ability to access services and 4) gender roles and household decision making dynamics may influence family planning decision making.

Inconsistencies exist regarding the influence of religion on refugee women's health decision-making process or priorities across refugee women and providers.

One Congolese adult woman articulated that the choice to use any method varies by regions in her country, but in her experience,

> *"some regions do not respect birth control and family planning...because they like to do what their ancestors did and because their ancestors birthed a lot of children…"* (Congolese Adult Woman 37).

Between refugee women and providers, inconsistent observations were present regarding the influence of religion on refugee women's health decision-making process or priorities**.** Several refugee women articulated that SRH services are acceptable within their religious beliefs, with one Bhutanese woman even saying, "*It is related to health, so why should we worry about religion?*" (Bhutanese-Nepali Adult Woman 06). Additionally, a few providers indicated that they had not observed any religion-related barriers or come across a refugee woman who explicitly stated that religion was the reason for not pursing certain services.

However, a few other providers expressed that refugee women may not be interested in using birth control because of their religious beliefs. Similarly, a few women shared that religious beliefs do in fact play a role in their reproductive health choices. One Congolese women shared that her denomination of Christianity, *"[does] not like birth control"* (Congolese Adult Woman 40). Additionally, a few women mentioned that SRH information may be best delivered and received through the lens of their religion. For example, one Burmese woman said that "*religion plays a huge and important role when educating [my] community"* (Burmese Adult Woman 24).

However, the providers and women did not expand upon the dynamics and depth of religionfamily planning relationship.

Preference for modesty influences refugee women's degree of comfort with SRH care.

SRH services often require physical examinations of intimate areas of people's bodies. For some women, undressing for physical examinations was described as a great source of discomfort. Additionally, for some participants, the gender of their healthcare provider was also an important factor in their clinical encounter.

The importance of modesty was echoed by several women. For example, as stated by one adult Bhutanese/Nepali woman

> *"In Asian [culture], particularly Nepali, Bhutanese, like we don't like to show our body, we like to cover...so we don't like to show our body or our private part"*
> (Bhutanese/Nepali Adult Woman 09).

Unease in undressing was magnified for several women when their provider was of the opposite gender. The same Bhutanese/Nepali woman continued to say,

> "*my gynecologist was a man, so you know, we don't like to show – if it were a woman, then maybe I would be less uncomfortable…*" (Bhutanese/Nepali Adult Woman 09).

The majority of women indicated that they would prefer a female SRH provider.

Discomfort with discussing SRH issues impedes refugee woman's ability to access those services.

Another widely shared sentiment was women's aversion to speaking about SRH topics. For some this meant avoiding the topics altogether, but for others it meant communicating about the topics in a less direct way.

Several women indicated that they had trouble engaging in all aspects of SRH services "*because in [our] culture, [we] rarely discuss about fertility issues with the doctor"* (Burmese Adult Woman 26). While women may attend their scheduled appointments, they may be uncomfortable to communicate their needs while there. Additionally, several women and a few providers referenced 'shyness' as a reason that refugee women struggle to open up to their providers. One physician contextualized this 'shyness', by setting it comparison to American patients. She said,

> *"…they're…more shy than the American born patients, so they feel a little bit uncomfortable talking about it at first…"* (Provider 07).

A few women shared that they want their provider to speak with them about these topics, but would prefer that they do so in a less direct way.

Gender roles and household decision making dynamics may influence family planning decision making.

In some circumstances, the cultural 'rest period' during menstruation is seen as a valued experience and one that may inform the type of contraceptive choice. One nurse practitioner defined this as,

> *"certain populations are not interested in a long-acting birth control that stops the menses...in some cultures, you kind of like get a break when you're having your*

> *period…you're not as obligated to certain responsibilities…you get to rest a little more…for that five days…So, I've found that they're more interested in [an IUD that does not disrupt menses]"* (Provider 01).

In other instances, the household dynamic or cultural norms may not allow for discussion about family planning. Rather, family expansion is a responsibility assumed by the woman. One physician spoke about how women's reluctance to use contraception may be driven by imposed societal responsibility and expectations,

> *"they may be reluctant to utilize [contraceptives]. There are – some of the groups where culturally…the mother of the household feels that the father will be displeased if she doesn't have more kids and so it may not really be her choice to want to have more children. She kind of feels like it's a responsibility to her husband"* (Provider 07).

Several providers indicated that the women under their care may not have direct or primary influence over family planning decisions. This was most often illustrated by providers when providing examples of their discussions on contraception. A nurse suggested that as the 'head-ofhousehold,' a woman's husband would have ultimate say in whether the family would continue expanding,

> "*understanding that a woman often may not speak for herself…because many of these women have come from areas where women are considered to be under the husband. So, the husband would have a huge say in what the woman does with health care and you…whether or not she's going to pursue birth control or not"* (Provider 11).

Another nurse practitioner reported: *"They're not opposed to using contraception. But I know…despite being…over that advanced maternal age…some of them have said that they want to have another kid, because their husband wants another kid"* (Provider 06).

Notably, this was only observed and shared by HCP, none of the refugee women interviewed mentioned their husbands, spouses, or partners.

Part Two: Strategies to deliver culturally sensitive SRH care to refugee women for providers in Metropolitan Atlanta

Providers and refugee women identified specific strategies to provide culturally sensitive care, including current practices and recommendations for the future. Between women and providers, 6 recurrent strategies were identified, presented in two overarching themes: 1) Provisions that refugee women can receive; and 2) strategies that SRH providers can employ or receive.

Provisions that refugee women can receive*:* *1) language services; 2) patient navigators to refugee women; and 3) group education classes.*

Provision of language services to refugee women is a means of providing culturally-sensitive care.

Most providers and the majority of refugee women identified language services as fundamental to providing culturally sensitive care. The women indicated that even the mere presence of translated written materials fosters a supportive environment. A physician summed up this idea:

> *"I think health care providers can…get access [to] materials in different languages, so that sort of sets a tone even just in your waiting room. I think that identifying a place where [refugee women] can have language services available to them...is also*

> *important…and then making sure that people were aware that there was language services available at all times"* (Provider 12).

In an effort to underscore the importance of language services and availability of translated materials, a midwife stated concisely, "*it's unethical to provide care for somebody who doesn't understand what's going on*" (Provider 09).

One woman articulated the importance of having professional translation services readily available. In her case, her brother was asked to interpret. She shared, "*if in front of a brother, we will not want to talk [about sexual or reproductive health*]" (Bhutanese-Nepali Adult Woman).

Patient navigators can improve the provision of culturally-sensitive care for refugee women seeking SRH services.

Several providers expressed their dependence on patient navigators, who were described as members of refugee communities that supported patients from the same community. Most providers talked about the importance of patient navigators in improving culturally-sensitive care. One NP said,

> "*in maternal health, where they have people within the community partner with providers, that they can kind of bridge that gap of understanding...*" (Provider 05).

A few of the providers indicated that patient navigators were one of their greatest resources to providing high quality SRH care to the refugee women they see. However, despite the asserted vital role that patient navigators play in refugee health care, one physician also recognized that not all clinics have the capacity to support such a program.

Group education classes are a recommended strategy to provide high quality, culturally sensitive care.

Several providers identified group prenatal classes as a potential strategy to providing quality prenatal care to all women, but particularly refugee women. One midwife described what the program would look like,

> *"…women come, you do a teaching session together, it might be done in song, led by someone in the community…everyone gets their measurements checked…their blood pressure, their baby's measurements, and then the midwife will* bring up any issues, give *them treatment" (Provider 10).*

Another midwife shared similar ideas when discussing ways to improve birth outcomes,

> "*those are all improved by group prenatal care or group –it's a midwifery model care that involves eight or ten or however many...pregnant people who are all due in the same calendar month and I mean, this is like the pure form of it...it's instead of regular prenatal visits and it's the same content, but instead of having a quick six minute visit, it's two hours and a variety of topics are discussed, depending on the gestational age and what's...the topics of interest usually are in that gestation...And then some groups continue to meet after delivery...And the people – the families are really well informed, they had less fear I think of labor. They had really good – really good deliveries, I think because of that, having a greater sense of safety and power"* (Provider 09).

Besides providers, several women also shared their interest in group classes on SRH topics, including both prenatal and other aspects of SRH such as sexually transmitted infections and contraception. One classes Bhutanese-Nepali Woman shared,

> "*Classes would be helpful. Word of mouth. Once you get the information, [we can] share it with [our] community"* (Bhutanese-Nepali Adult Woman).

Strategies that SRH providers can employ and receive: *1) targeted trainings for providers; 2) centering refugee women in SRH services; and 3) integration of women's religious practices into care counseling.*

*Providers believe targeted trainings would equip them to better provide care to refugee women***.**

The majority of providers discussed trainings facilitated or sponsored by their employers. They either shared details about the trainings that they attended themselves or identified gaps in training that they believed should be filled by their employer. Some of the trainings attended by these providers include discussions on 'cultural humility' and identification of groups at "high-risk" for gender-based violence. physician said the following,

> *"...we...talk about the different people groups that we serve in our clinic and kind of some of the things that we need to be aware of, so like high risk of mental illness in like this age group, in this particular culture...or these are some of the signs for...trauma and abuse in homes, both for Americans and for our refugees, but particularly in refugees" (Provider 12).*

Similarly, a nurse practitioner (NP) shared that they,

> "*do trainings on cultural humility…and what patient centered care means, and...like with all patients, we should be focusing on their priorities and not yours."* (Provider 2).

However, an NP indicated that while she had been trained in school on working with diverse populations, she had never received training specific to working with refugees. Another NP asserted that training on trauma informed care should be expanded past the practice of screening. They expressed that screening for trauma, without follow-up, including connection to resources, is not supportive.

A few providers outlined what they believe a valuable training should look like. In their definitions, refugee women would be centered and given authority to define the needs of their population. A physician articulated this notion succinctly,

> "*I really think that having the refugee women tell us about their culture…they would be good ones to reach out to and to actually come and talk with us and tell us...how they think that we can better provide more for the refugee population"* (Provider 08).

Centering refugee women in the delivery of SRH care and education will improve the efficacy of those services.

Providers and women articulated the importance of hiring members of the refugee community in clinical and patient education roles. They shared the consensus that women from the communities they serve have the knowledge needed for to ensure that SRH care provision is respectful and acceptable. In the context of clinical care, one NP said,

> "*the more we can empower the communities and…depend on them as partners, not just people that we're giving care to, I think that would really help break down some of the barriers*" (Provider 1).

Several women communicated a similar sentiment by requesting education classes led by their peers and translators from their communities. One Bhutanese-Nepali woman explained that only members from the refugee community will know how address these topics "*in a respectful way since people may take it in different way*s." She continued explaining, *"we have to be very caution in choosing words…*we have to share our personal experiences/stories", in a way that only women with shared cultural backgrounds and experiences may be able to do.

Integration of women's religious practices into care counseling may improve utilization of SRH services.

Some providers shared their experience of intentionally integrating religion into their care counseling. They leveraged the patient's religion in an effort to empower them to adhere to their care recommendations. One nurse practitioner shared how she has implemented this kind of counseling into her practice,

> "w*e'll work with them around...fasting. We'll talk about that you don't have to fast like according to Islam if you're sick...or if you're pregnant, you don't have to fast. But we also encourage them to use their religious support for helping them. So we have a lot of Coptic Christians from East Africa, and we encourage them to, you know, pray or do whatever else they feel would help them" (Provider 02).*

Most patients, refugee women, referenced religion on multiple occasions through the course of

their interview, which underscores the value it has on their decision-making.

Discussion

This novel study explores cultural influences to SRH service utilization among refugee women and strategies to deliver culturally competent SRH care in Georgia.

Four themes which shed context to how a refugee women's culture may influence her use of SRH services: 1) social norms may influence a woman's values and therefore guide contraception choices; 2) between refugee women and providers, inconsistent observations exist regarding the influence of religion on refugee women's health decision-making process or priorities; 3) modesty influences the way refugee women interact with SRH services; 4) discomfort discussing SRH issues impedes refugee women's ability to access services and 5) gender roles and household decision making dynamics may influence family planning decision making.

Between patients and providers, 6 strategies for providing culturally competent care were identified: 1) targeted trainings for providers; 2) provision of language services to refugee women; 3) provision of patient navigators to refugee women; 4) group education classes for refugee women; 5) centering refugee women in SRH services; and 6) integration of women's religious practices into care counseling.

Gender roles were cited as a barrier to contraception utilization by quite a few SRH providers. The providers described how the refugee women to whom they provide SRH care, may not have the marital clout needed contribute to family planning decisions. This finding is similar to that of another study, also set in a high-income country, which found that gender roles influence refugee women's SRH decision-making to the point of reproductive coercion (Mengesha et al., 2017).

Though this sentiment was common among providers, none of the refugee women interviewed mentioned their significant others, whether for contraceptive decisions or otherwise. Interestingly, the findings shared Mengesha's study also included only the provider prospective. If the relationship dynamic is accurate as described by providers, it seems reasonable that the women would not have mentioned their husbands or specifics of their personal decision-making processes, as those details would be considered private. However, it could also be possible that this role was projected by providers based on expected-and possible inaccurate- gender norms for the respective cultures.

Religion and health care in the US are often entirely separate-at least intended to be so- which may differ from patients' country of origin. However, religion is an influential driver in health behavior. Religion provides general orientation in one's life and concrete guidance in decision making, resulting in family planning approaches and contraceptive decisions varying by religion (Hommel, 2010; UNFPA, 2016). This was demonstrated in our findings, where it was common for refugee women to state that religion influenced their interaction with SRH services. This is consistent with the findings of other studies, including that of Neha S. Singh and colleagues who presented a religious opposition to family planning in South Sudanese refugees (Singh S. et al., 2022).

Though we conclude that religion does play a role in SRH decision-making, the details of *how* this is true were not articulated by the refugee women themselves. Therefore, the depth and dynamic of this relationship should be further explored.

Understanding, on the part of the provider, results in a more culturally competent delivery of care. Integrating the patient's religious beliefs into family planning counseling may not only foster a more comfortable clinical experience, but also may serve as a valuable

method to improve patient adherence to care recommendations. Integrating religion into SRH care should not include providers limiting their scope of practice on the basis of their personal faith values. An ethical SRH practice does not involve the censoring of patient education materials or recommendations- especially based on provider beliefs-, but rather requires adapting the delivery method of complete, scientifically accurate information and guidance.

It is not uncommon for providers to practice medicine using a "treat everyone the same" philosophy, inadvertently falling casualty to *cultural blindness.* Yet this philosophy should be avoided in practice as it fails to account for crucial aspects that influence how someone interacts with health systems and therefore promotes inequities in health outcomes.

The onus of demonstrating cultural competence, in practice, has fallen primarily on the individual provider. However, providers, whether working in SRH or another specialty, cannot be expected to sustain culturally responsive care without organizational commitment to support and allocate resources to promote this practice. It is in this vein that the providers interviewed spoke of trainings. Trainings that support providers through the following processes should be employed: introspection, understanding the motivation and rationale for culturally sensitive/competent care, and acquiring cultural knowledge and understanding of population with whom they work.

Limitations

Due to the sensitive and stigmatized nature of SRH topics, it is possible that the refugee women sampled may have withheld portions of their responses in an effort to maintain personal comfort and to protect their perceived self-image, resulting in a response bias.

Additionally, the population studied was sampled from a uniquely specific demographic in the Metropolitan Atlanta area. Refugees were sampled from communities who have a long history of resettling refugees and providers sampled from clinics known to work with refugee populations. The experiences of a refugee women in Clarkson, Georgia may not be comparable to the experience of a women resettled elsewhere. Similarly, the providers sampled may not reflect the experience of a provider outside of Georgia or a provider working in a facility where it is less common to work with refugee women. This therefore poses a concern with generalizability. Related, representativeness in snowball sampling in not guaranteed.

Throughout this study, reflexivity was exercised with the intention of producing an impartial analysis. Even with reflexivity practiced, it may not be possible for one to truly convey participants sentiments without having personal or secondary experience similar to that of the sample (Pillow, 2003). However, we see this position as advantageous in that it positions the participant as the 'subject matter expert'.

Recommendations and conclusions

The themes presented in this manuscript reflect experiences of refugee women living in Atlanta, but it is important to note that while there are commonalities among this group, there are important cultural and religious differences that impact SRH decision making and preferences. For this reason, providers should be mindful that they will not know everything about a specific population or initially comprehend how an individual patient endorses or engages in specific cultural practices, beliefs, and values. For instance, some patients may not identify with the same cultural beliefs, practices, or have the same experiences as other patients from the same country of origin or cultural group. SRH providers should not make assumptions about the patients' race,

ethnic heritage, or culture based on appearance, accents, behavior, or language. Instead, providers should explore the patient's cultural identify, which may involve multiple identities, in partnership with the patient. They should discuss what cultural identify means to their patients and how it may influence their clinical interactions and treatment.

Understanding how cultural values and life experiences influence refugee women's SRH service utilization allows SRH organizations and care providers to prepare themselves to interact with their patients in a respectful, ethical, and effective way. Providing quality SRH care goes beyond understanding the multicultural context of refugee women's experience. Rather, it engages introspection on the part of the provider and a commitment to developing the skills needed to provide culturally congruent care that adapts to the needs and context of their patient.

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Chapter 4. Public Health Implications

Though provider's introspection is a keystone to the delivery of culturally competent care, other tangible measures should be taken to improve the quality of care provided to refugee women resettled in the U.S. Culturally competent attitudes and behaviors should by employed. The

development of an adapted figure specific to SRH, such as the one produced in *Figure 5*, may prove supportive to providers. HCP should identify their strengths and weaknesses and commit to continual improvement, as cultural competence is not something that can be "achieved", but exists on a continuum where improvement is also possible. Where weakness are identified, trainings can be sought and provided by employers or found in self-study.

While *Figure 5* is a tool meant for HCP personal and professional development, *Figure 6* is intended for use in clinical settings. The checklist, originally developed for substance abuse counseling by the Center for Substance Abuse Treatment, has been adapted to provide specific SRH guidance.

While there are resources available to support HCP through cultural competence and/or cultural sensitivity development, resources specific to SRH care are scarce. Further attention should be spent developing materials and trainings for HCP who provide SRH care to refugee women.

Figure 5. Attitudes and Behaviors of Culturally Competent SRH Care Providers

Attitude	Behavior

Respect	• Exploring, acknowledging, and validating the patients' worldview • Approaching family planning counseling as a collaborative process • Investing time to understand the patient's expectations of care • Using consultation, literature, and training to understand culturally specific behaviors that demonstrate respect for the patient • If possible, communicating in the patient's preferred language. Otherwise, prioritizing and securing translation services and/or patient navigators. • Allotting sufficient time for translation (in some cases this could be 2x the normal allotted time for a particular SRH service)
Acceptance	• Maintaining a nonjudgmental attitude toward the patient • Considering what is important to the patient • Recognizing that what the patient prioritizes may be different than what they value themselves
Sensitivity	• Understanding the patient's experiences of racism, racialization, stereotyping, and discrimination • Exploring the patient's cultural identity and what it means to her • Actively involving oneself with individuals from diverse backgrounds outside the clinical setting to foster a perspective that is more than academic or work related • Tailoring treatment, counseling, and guidance to meet the cultural needs of the patient (e.g., catering to gender preferences, allowing women to undress to their comfort level, allow women to speak about sensitive topics using euphemisms if that improves their comfort level)
Commitment to equality	• Proactively addressing racism or bias as it occurs in the clinical setting (e.g., processing derogatory comments made by another HCP or patient) • Identifying the specific barriers to SRH service utilization engagement and retention among refugee women • Recognizing that equality of treatment does not translate to equity—that equity is defined as equality in opportunity, access, and outcome (Srivastava 2007) • Endorsing counseling strategies and treatment approaches that match the unmet needs of diverse populations to ensure treatment engagement, retention, and positive outcomes
Openness	• Recognizing the value of traditional healing and help-seeking practices and support them through those practices
	• Developing alliances and relationships with traditional practitioners • Seeking consultation with traditional healers and religious and spiritual leaders when appropriate

	• Understanding and accepting that persons from diverse cultural groups can use different cognitive styles (e.g., placing more attention on reflecting and processing than on content) • Centering refugee women in the delivery of SRH care and education
Humility	• Recognizing that the patient's trust is earned through consistent and competent care rather than the potential status and power that is ascribed to the role of HCP • Acknowledging the limits of one's competencies and expertise and referring patients to a more appropriate counselor or service when necessary • Seeking consultation, clinical supervision, and training to expand cultural knowledge and cultural competence • Seeking to understand oneself as influenced by ethnicity and cultural groups and actively seeking an anti-racist identity • Being sensitive to the power differential between patient and provider • Recognizing that the patient is the expert in her lived experiences
Flexibility	• Using a variety of verbal and nonverbal responses, approaches, or styles to suit the cultural context of the patient • Accommodating different learning styles in counseling approaches • Using cultural, socioeconomic, environmental, and political contextual factors in conducting evaluations • Integrating cultural practices as treatment strategies

Source: Adapted from the Center for Substance Abuse Treatment's Attitudes and Behaviors of Culturally Competent Health Care Providers (Center for Substance Abuse Treatment, 2014)

Figure 6. Multicultural Intake Checklist for SRH Care

Adapted Multicultural Intake Checklist for SRH Care

- Immigration history
- English language fluency
- Bilingual or multicultural fluency
- Racial, ethnic, and cultural identities
- Acculturation level (e.g., traditional, bicultural)
- History of discrimination/racism
- Trauma history
- Gender roles and expectations
- Relationship and dating concerns
- Sexual health concerns
- Reproductive health concerns
- Birth history (including birthing and labor preferences and expectations)
- Sexual and gender orientation
- Traditional healing practices (current and planned)
- Help-seeking patterns
- Treatment concerns related to cultural differences
- Cultural group affiliation
- Current network of support
- Level of comfort with partial nudity or physical touch
- Review of confidentiality parameters and concerns

Source: Adapted from the Center for Substance Abuse Treatment's Attitudes and Behaviors of Culturally Competent Health Care Providers (Center for Substance Abuse Treatment, 2014)

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Chapter 6. Appendices

Annex 1. In-Depth Semi-Structured Interview Guide for Refugee Women

Introduction:

1. Before we begin, can you just tell me a little bit about yourself?

   Probe for:
   a) hobbies; or
   b) what they like to do; or
   c) what makes them happy

General questions about SRH:

Thank you for sharing! Now I want to ask some general questions about sexual and reproductive health. For the rest of the interview, when I say sexual and reproductive health, I mean the overall well-being related to sexuality and the reproductive system and processes. This includes infections and diseases you can get from sexual contact, HIV, family planning, including birth control, maternal and newborn health, and preventing reproductive cancers, such as cervical cancer. Do you have any questions about any words that I just said?

2. What do you think are some of the main sexual and reproductive health issues or concerns for women from your country living in Georgia?

   Probe:
   a) Do you guys talk about these topics?
   b) Why do you think that is?

3. Typically, where or who would you go if you have questions or problems to do with sexual and reproductive health?

4. In general, how comfortable do you feel about going to the doctor or using services for sexual and reproductive health in Atlanta?

   Probe:
   a) Can you tell me why?
   b) Can you explain more?
   c) if you go to the doctor for any of the services we talked about, do you feel 100% comfortable, 50% comfortable, or not comfortable at all?

5. Thank you for sharing that information. What are important sexual and reproductive health services you need?

6. Do you know if these services are generally available for women from your country, or if it's lacking here in Georgia?

   Probe:
   a) Can you tell me about any sexual and reproductive health services that are not available to you or women from your country here in Georgia?

   b) Do you know some of the places where these services are offered?

7. Describe what is most important for you when you choose to go to a provider or clinic for sexual and reproductive health services.

   Probe:
   a) For example, is it important to have someone who speaks your language?
   b) Is it important for it to be close to your home?
   c) Do you have access to transportation?
   d) How about the interactions with the doctors or the staff, what would you want it to be like?
   e) Is cost important?

<u>Barriers and facilitators to accessing care</u>:

8. Can you tell me what kind of sexual and reproductive health services you have looked for in Georgia?

   Probe:
   a) Can you tell me more about the time when you…?
   b) How about STD testing or testing for sexually transmitted disease, have you ever used that service or talked about it to anyone?
   c) How about testing for HIV? Have you talked about it with anyone?
   d) How about birth control services, have you talked about it with anyone?
   e) How about pap smears?
   f) HPV vaccination?

9. [If no to Question 8, ask the following;] Can tell me some reasons for why you haven't used these services?

10. Can you tell me the names of any clinics or doctors' offices you visit?

11. What made you decide to go?

12. How did you find out about that clinic?

13. How easy was it to find transportation to get there?

14. How easy was it to make an appointment?

15. Who was with you during your appointment?

16. Was there a patient navigator or interpreter? [If 'YES' to question 15]

17. Were they with you or on the phone?
18. Were there any benefits using interpreters?

19. How did you feel about talking about this sexual and reproductive health service with your healthcare providers?

20. Did the provider give you enough information and the opportunities to ask questions?

21. Were there any other issues related to language barriers with the doctor?

22. Were there any issues related to cultural differences?

23. At the clinic or service, what kind of written materials, like brochures or papers about pregnancy or pregnant women were available?

24. If none were available, would you have liked to be able to access these written materials?

25. Was it easy for you to understand?

26. Describe how well your sexual and reproductive health needs, problems or concerns were met. Probe:
    a) Can you describe how they were met?
    b) What percent of your needs were met?

27. Overall, describe how you were treated during this visit.

28. Thinking about the visit, what was most helpful for meeting your health needs, problems or concerns?

29. Was the clinic or office staff responsive to you and your needs throughout your visit?

30. Was there anything that made your appointment difficult in meeting your needs?

31. Describe any barriers you faced before getting to the office or clinic. Probe:
    a) Did you face barriers in scheduling your appointment?
    b) Did you face barriers in scheduling your appointment?
    c) Did you face barriers in getting to your appointment?
    d) Did you face any barriers issues related to language or communication?

32. Would you recommend it to your friends or other women like you?

<u>Improving services for refugee women</u>:
Thank you for sharing your experiences with sexual and reproductive health services. Now I want to talk to you about your thoughts on how services can be improved and reach refugee women.

33. How could sexual and reproductive health services be improved for refugee women like you?

34. What do you think are the best ways of advertising and promoting services for women from your country?

35. What would be the best ways to advertise and promote these services to refugee women?

36. Do you feel like there's a place in your community that you could go to and get information about these services?

    Probe:
    a) What would that be?
    b) Who would you talk to, to find out more information?

Religion and culture:

37. What would be some of the aspects of your religion or culture that you think doctors in hospital need to keep in mind when they serve women from your country?

    Probe:
    a) Can you tell me a little bit more, like give me some examples?

38. Are these services respectful to your religion?

39. Are these services respectful to your culture?

Conclusion:
Thank you for sharing your experiences with me today. Those are all the questions I had for our conversation today.

40. Is there anything else that you would like to add about sexual and reproductive health services?

Annex 2. In-Depth Semi-Structured Interview Guide for SRH Providers

Introduction and provider demographic information:

1. Before we begin with the interview questions, So can you just start with can you tell me a little bit about who you are, what is your role, title, and what are your main responsibilities?

    Probe:

    a) How long have you worked in sexual and reproductive health?
    b) How did you become interested in working with refugee populations in Atlanta?

Patient demographic information:

2. What can you tell me about the populations of refugee patients that you typically see?

3. What proportion of the refugee population is female?

4. What do you say the typical age range you see is?

5. What are the combinations of origins for refugees you typically see?

6. What is their economic and educational background typically?

7. From your experience, what are some sexual and reproductive health issues commonly encountered by female refugee populations?

   Probe for:
   a) STI testing and screening; and
   b) cervical cancer screenings; and
   c) HPV vaccinations;
   d) and other SRH issues

8. What extent do your patients typically come back for future services?

Experience with counseling women on sexual and reproductive health services:
When we talk about sexual and reproductive health service, we were talking about STDs testing, birth control, family planning, pregnancy and childbirth, cervical cancer screening, HPV vaccine.

9. Of those topics, which one would you say you have engaged in, either health education or referral service most often?

10. In terms of cervical cancer screening, what would you say is the general level of knowledge of your patient about that service?

11. When you bring up the service, are there typically questions or concerns that patients often ask you?
12. When you're giving them counsel or health information, is it typically verbal or in written form, or both?

Facilitators and barriers regarding access to SRH service:
I just asked you about some of your experience with counseling women on sexual and reproductive health service, so now I'm going to move on and ask about some of the facilitators and barriers that you've observed in this population with regards to access to this service.

13. What do you think makes it difficult for women to access sexual and reproductive health service at the particular clinic or office that you work in?

14. Are interpreter services available?

15. I just asked you about the barriers. Now I wanted to ask you what do you think are some of the things that make it easy or convenient for women to access sexual and reproductive health service at your office or clinic?

16. At the clinic level, what do you think are some of the things that, you know, for example, offering of interpreter service, is there anything else that clinics can do to increase use of service by women?

17. How well do you think the [clinic where you work] currently meets the sexual and reproductive health needs of women?

I asked you some questions about the women in the clinic, now I want to ask about you as a provider.

18. For you, what would you say are some of the barriers that you face in recommending or educating women about sexual and reproductive health service?

19. Do you face any barriers related to either time constraint or language differences at all?

20. What are some of the things that are useful or has helped you with working with this population to provide counseling in sexual and reproductive health?

21. In your experience, how do patients, refugee patients, women's cultural and religious beliefs influence the health service that you recommend and provide for them?

22. So now I also want to ask a question about particularly patient navigator or interpreter service. So how do you think the presence of the navigator or interpreter in general influenced your interaction with the patients?

23. What would you say are some of the special training or education that you've received in working with refugee populations?

24. for health care providers working with refugee women, what kind of training or education do you think are essential for them to be able to successful work with this population?

<u>Defining culturally sensitive care</u>:

25. How would you in your own words define culturally sensitive care?

26. What do you think health care providers as well as health clinics around Atlanta can do, to improve the provision of sexual and reproductive health and to improve women's access and use of these services?

Conclusion:

Thank you so much. Is there anything else that you would like to add?