Chapter 15
Refugee Women's Health

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Introduction

Women's health encompasses care provided to women across their reproductive life course and involves not only their reproductive health but also sexual function, cancer screening, and overall psychosocial health. The emphasis placed on women's health is a reflection of available resources and the value placed on women in society. In many war-torn countries, where medical care is limited, women's health hardly exists. In discussing refugee women's health it is prudent to recognize that there are a host of pre-migratory and post-migratory stressors that may impact a woman's health throughout her process of resettlement from conflict regions around the world [1]. Beyond the psychosocial challenges of immigration and assimilation, these women have suffered traumatic experiences, often have been abused as victims of war, and have not received appropriate medical care in their country of origin.

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Many refugees have lived in refugee camps for years prior to emigration. In these camps they have suffered physical violence, malnutrition, and unsanitary living conditions, as well as rape, sexual abuse, extortion, and physical insecurity [2]. Consequently, there is a high incidence of post-traumatic stress disorder (PTSD) [3].

Post-migration, refugees suffer from increased barriers to care including poverty, insurance status, transportation, language barriers, and lack of understanding of its importance [4]. Additionally there are social differences that may impact health-seeking behavior, such as conservative cultures in which a pelvic exam is unacceptable, or the belief that only the sick need to seek care [5]. Refugees underutilize preventive and primary care, as these facets of health care may not exist in developing countries [6]. Moreover, this lack of familiarity with navigating the health care system increases patient anxiety when faced with accessing care in the hospital setting.

Sweeping generalizations can be made regarding refugee health because of the shared experience of war and immigration. However, it is important to distinguish that refugees come from many different countries, ethnic and cultural backgrounds, have highly varied experiences in their host countries of resettlement, and have widely varying beliefs on reproductive health. The following list delineates important risk factors that may impact women's health and should be identified when caring for refugee women:

- Identify a patient's host country and endemic risks.
- What was her path to immigration? Was she imprisoned in a refugee camp prior to reaching the US?
- Was she a victim of violence or rape?
- Has she lost family in the war (specifically children or her husband)?
- How many children has she already had and how many more does she want? Is she interested in contraception?
- How is her mental health? Is she suffering from PTSD or depression?
- What kind of psychosocial support does she have?
- Does she have religious beliefs that may impact her health or health-seeking behavior?
- Has she been screened for cervical cancer or breast cancer in the past?
- Has she undergone Female Genital Cutting (FGC)? Is she interested in defibulation, if indicated?
- Has she utilized preventive care in the past? Does she have a primary care provider?

Identifying these key factors will guide patient care. Additionally, a keen understanding of her psychosocial background and risk factors can facilitate in providing culturally sensitive and medically complete care.

Preventive Health

Pelvic Exams

Pelvic exams can be stress-inducing for any woman. For refugee women, pelvic exams can be even more anxiety-provoking due to histories of sexual violence or abuse, FGC, and cultural backgrounds that demand modesty and deem such an exam inappropriate. Some cultures view a pelvic exam as a violation of virginity [7]. A history of sexual trauma has been shown to decrease cervical cancer screening due to an aversion to pelvic examination [8]. Suggestions to improve the experience include fostering appropriate communication, safety, trust, and patient control of the situation [8]. A professional interpreter is highly recommended when needed. It is standard practice to have a chaperone present for patient comfort and liability concerns. Female health care providers are preferred when possible. While a pelvic exam may be deferred on the initial visit if the patient is uncomfortable, if indicated, it should still be performed once trust has been established between the patient and her provider. A pelvic exam is essential in identifying pathology, classifying cultural practices such as FGC, performing a Pap test, and testing for sexually transmitted infections. At the time of a pelvic exam, providers should also educate the patient on the value of preventive care [9]. Although a pelvic exam is standard in the female physical exam, patient autonomy and the right to refuse should be respected, provided the patient is appropriately counseled on its importance.

Sexually Transmitted Infection Screening

Screening for Human Immunodeficiency Virus (HIV) is not mandated except in prenatal care. Prior to January 2010 refugees were required to be screened for HIV prior to entry into the US [10]. Current practice is to offer such screening; a potential diagnosis may be missed due to stigma, cultural taboos, and lack of awareness [11]. Given the prevalence of HIV and rape as a weapon of war in refugees' native countries, they are considered a high-risk and vulnerable population. Thus, patients should be screened for these risk factors and tested when indicated. However, there is minimal data in regard to incidence of gonorrhea, chlamydia, and syphilis in refugee populations. A recent study in Minnesota of 18,000 refugees showed very low incidence of these STIs. Thus, routine screening may not be indicated [12]. For a discussion on STI testing in refugees, see Chap. 9.

Cancer Screening

Female cancer screening is primarily composed of pap tests for evidence of cervical dysplasia and mammography for breast cancer. Many refugee women have never had any screening prior to immigration, primarily due to lack of access to care. There is limited data on screening rates in the refugee population. However, immigrants in general tend to be under-screened post-migration due to secondary barriers to care [13]. These barriers include fatalistic attitudes regarding cancer, lack of knowledge about cancer itself and the screening modalities available, fear of Pap tests threatening one's virginity, as well as beliefs that a Pap test is not indicated unless one is ill [7]. Access to a regular source of primary care and, ideally, access to a female health professional have been advocated as a means to increase screening rates [14]. Moreover, patient education about the importance of cancer screening can promote regular health-seeking behavior and reduce the stigma of such screening [15]. Pap tests are regularly performed as part of prenatal screening. Breast cancer screening is less taboo than cervical cancer screening. However, refugee women are still under-screened [16, 17].

Mental Health

Refugee women are at increased risk for depression, anxiety, and PTSD [18]. Given the additional obstacles refugee women face in maintaining their health and well-being [19], high rates of violence and trauma persist post-migration [20]. When appropriate, women should be referred for psychiatric services and/or therapy [21]. There is lack of a valid screening measure for common mental health conditions across multiple refugee populations; however, a new validated screening modality holds promise for utility across varied ethnic and linguistic refugee populations in primary health care settings [22].

Reproductive Health

Nutrition

For pregnant refugee women, malnutrition may be observed due to lack of access to food in war-torn areas and refugee camps. These women are at high risk for nutritional deficiencies such as folic acid, iron, and vitamin D. Iron-deficiency anemia is also commonly seen among Sub-Saharan African refugees arriving in host countries [23]. Anemia is of specific concern during pregnancy and could result from chronic blood loss due to intestinal parasites, menstruation, malabsorption, high parity, prolonged breastfeeding, sickle cell anemia, and malaria [24].

Lower amounts of physical activity and poor diet are commonly seen among refugee populations as they adjust to a "westernized" lifestyle and diet [25], and may give rise to obesity. A lack of familiarity with or knowledge of healthy foods and food preparation techniques are also concerns [26]. Providing nutritional support, counseling, and early intervention will promote healthy diet choices and physical activity, which could prevent obesity and diabetes as well as fetal macrosomia [27].

Cultural and religious practices may create challenges for pregnant women. During Ramadan, providers should assess for any medical and pregnancy-related conditions that may be contraindicated for safe fasting. Education regarding proper nutrition and hydration during fasting periods is also important [28]. Other dietary factors such as vegetarianism or food restrictions during the antepartum, intrapartum, and postpartum period should also be discussed to determine any risk for poor outcomes.

Prenatal Care/Antepartum

An opportunity arises to improve maternal and neonatal health outcomes prior to pregnancy with preconceptional care. Infectious disease is an important area to assess prior to pregnancy with refugee populations as infections in the preconceptional period can affect fertility. Spontaneous abortions and fetal congenital birth defects due to infections can also occur [29]. In some cultures, marriage and childbearing begins at an early age [30, 31]. Higher rates of teenage pregnancy among recent arrivals have been seen among refugee populations from Africa and Asia [32]. High parity may also be common as societal importance is placed on women's ability to have many children [5, 23].

Due to the lack of health care infrastructure and preventative care in some developing countries, refugee women may not understand the importance of prenatal care. Refugee women may have had prior pregnancies without prenatal care with good outcomes in their countries of origin. Some women may also delay or avoid prenatal care due to a fear of unnecessary tests or interventions that will cause problems during pregnancy and adverse birth outcomes. Providers should also be aware of the fear that women may have in regard to cesarean delivery causing severe complications, even death. This fear leads some women to avoid and/or delay seeking care as well as refuse interventions that could involve cesarean delivery [33].

During prenatal visits, providers should assess patient expectations and provide education and counseling on topics such as the importance of prenatal visits, the delivery room experience, pain medication options, interpreter services, and the possible indications for cesarean sections, as well as the risks and benefits of this surgical procedure. Tours of the hospital should be organized and highly encouraged as well [34]. Prenatal care visits are also an appropriate time for providers to discuss mental health and nutrition practices. Attention should be given to obtaining information regarding complications with prior pregnancies and deliveries,

abortions, or issues with menstruation [24]. Providers can also begin to discuss postpartum issues such as postpartum depression, contraceptive options, and breastfeeding.

Pelvic and cervical examinations can cause extreme shame and embarrassment for some refugee women and there may be confusion regarding the necessity of these exams [5]. A pelvic examination may need to be deferred, particularly in women who have undergone infibulation (the most extensive form of FGC) as use of a speculum exam may not be possible or may cause extreme pain to the patient [27].

Routine laboratory tests according to the American College of Obstetricians and Gynecologists standards should be performed [35]. Additional tests recommended for refugee populations include: [27]

- Domestic violence/intimate partner violence or other forms of gender-based violence (see Appendix).
- Immunization history including verification of vaccines for influenza (seasonal vaccine administration is safe during pregnancy), measles/mumps/rubella (MMR), varicella, and tetanus/diphtheria/pertussis (TDaP). If there is no evidence of vaccination or immunity, provide all of the above mentioned vaccines except MMR and varicella, which are live vaccines and thus should be given postpartum.
- Hemoglobin Electrophoresis (for women of African, Southeast Asian, and Mediterranean ancestry) to screen for thalassemia or sickle cell anemia.
- Tuberculin skin test (TST) or Interferon-Gamma Release Assay (IGRA), as indicated, and screening for symptoms. Any patient suspected of having TB disease should receive a complete evaluation that includes medical history, physical examination and chest X-ray. Pregnant women with a positive TST or IGRA should have a shielded posterior–anterior chest X-ray. If asymptomatic and in the first trimester of pregnancy, the chest X-ray may be postponed until the second trimester [36].
- Malaria screening if patient recently emigrated from malaria-endemic region and displays clinical signs and symptoms such as fever.
- Substance use including exposure to tobacco, alcohol, and illicit drugs. Also check for exposure to herbal and other traditional/alternative medications or substances.

Intrapartum

The experience of delivering in a hospital can be extremely overwhelming for refugee women who may be experiencing childbirth in a Western health care setting for the first time. Refugee women who have had successful deliveries at home in their countries of origin with very little to no assistance may find this experience unnecessary or overwhelming. Multiple pelvic examinations, intravenous lines, fetal

monitoring equipment, and blood pressure cuffs may be considered disruptive and cause major distress during the birthing process. Aversion to interventions such as labor induction and augmentation, epidural placement, and cesarean delivery procedures may be expressed. A growing number of studies demonstrate that refugee women have a profound fear of cesarean delivery [33, 34, 37]. There is also a common misconception that epidurals will cause paralysis or chronic back pain. Providers should strive to provide anticipatory guidance, education, counseling, and appropriate language interpretation, while empowering refugee women to incorporate traditional health behaviors and/or practices such as walking during labor or specific delivery positions as long as it is deemed safe for both the mother and fetus [27].

Verbal informed consent for procedures in lieu of written consent should be allowed through the assistance of a trained medical interpreter for those patients who have low literacy in English or in their native language [27].

The presence of family and social support should be encouraged. Evidence also suggests that the support of labor coaches or doulas may be beneficial to some refugee women in terms of increasing a positive attitude and experience with labor while decreasing the likelihood of obstetrical interventions [38]. Special attention should be paid to the role of men as it may or may not be culturally appropriate for men to be present during delivery [39, 40].

Decision-making in some cultures may be very different than in US. Health care decisions affect the patient, the family, and the community. Gender roles in some cultures also dictate that men are the decision-makers for the family. During labor, health care providers should assess the level of autonomy of the patient in decision-making and the role that a pregnant woman's spouse and/or matriarchal familial support may play in decision-making [20].

Maternal and Infant Outcomes

While there is conflicting evidence regarding maternal and infant outcomes among refugee populations, some studies have demonstrated poorer maternal and infant outcomes for certain refugee populations [1, 41]. For example, evidence shows that Somali women may be at increased risk for adverse maternal obstetrical outcomes including emergency cesarean delivery for fetal distress, failed induction of labor, post-dates delivery, oligohydramnios, perineal lacerations, and gestational diabetes [34, 42–44].

Adverse neonatal outcomes have been reported including prolonged hospitalization, lower 5-min Apgar scores, meconium aspiration, and assisted ventilation [41, 43, 44]. Low birth weight has been seen among neonates born to some refugee groups, and this trend has continued among refugees following immigration possibly due to psychosocial factors and social determinants of health [41, 45].

Higher infant morbidity and mortality are also seen among certain refugee populations [46]. While the reasons for this association are unclear, differences in

mortality are not described solely by maternal risk factors [47]. The association between poor neonatal outcomes, poor access to care, and late prenatal care may explain some of these higher rates among refugees [23, 48].

Postpartum

Refugee women may bring postpartum customs, rituals, and remedies from their home countries. In some cases this dictates when women may leave home, when the infant may be exposed to the sun (40 days for some cultures in Africa and 28 for some Asian cultures), and when it is appropriate to resume intercourse [28]. This period may be disrupted due to economic strains or medical appointments [28]. Speaking with women regarding their cultural rituals and having some flexibility and/or explaining why the appointment timeline is important can go a long way towards enhancing compliance with follow-up care.

Recovering from c-sections may be a new experience for many refugees as they may have neither personal experience nor historical social traditions. Educating women on what to expect during recovery from a c-section is important. A decrease in fertility has been noted after c-sections in Somali women [49]. It is postulated that this may be attributed to the considerable fear of death from c-section in Somali women, but the data to substantiate this is inconclusive [33].

Inquiring about certain variables that put women at risk for poor infant health outcomes (i.e., worry about their infant's health, a mother's educational level, prenatal class attendance, marital status and their comprehension of the host country's official language) may result in effective use of postnatal home visits [50]. Having an open discussion with patients both in the prenatal period and the postpartum period, and providing anticipatory guidance about expectations and worries can help to dissuade fears or misinformation [51].

Postpartum Depression

Underlying mental health issues are relatively high in refugee women in relation to traumatic events in their home country or on their journey to their host country. They may also be under considerable stress to acculturate and adapt to the customs, language, culture, and daily life of their adopted new home [52]. In addition, social isolation and domestic violence may trigger significant distress [52]. The addition of an infant to this environment, without the familiar assistance and social support from family and community members, and the cultural rituals surrounding childbirth, may precipitate a crisis or significantly increase stress levels. However, deeply religious perspectives among some refugees may facilitate greater resiliency and decrease the risk of harming the infant [53].

It is important to note that refugee women with distress or psychosocial disorders may often present with somatization and physical findings rather than complaints of affective or psychological symptoms [52, 54]. Cultural and religious stigma towards mental health issues may adversely affect women's access to therapy or medication. Providers should be aware of this and provide a comfortable place for communication of stressors and incorporate stress-relieving strategies realizing that they may be the patient's only source of intervention [53, 55].

Breastfeeding

In general, breastfeeding is more common among refugee women than among American women. Depending on the region of origin, women may be accustomed to breastfeeding for up to two and a half years [53]. However, there is a noted decrease in the percentage and length of breastfeeding in relation to how long women have been in US [5, 56]. This has been related to changing economic activity and sociocultural values, the need to return to work, and the discomfort refugee women may experience with pumping. Newly arrived refugee women may believe that formula is better for their infant because they see American children as larger than infants born in their countries of origin, while refugees who have been in the host country for a period of time may feel that breastfeeding is socially unacceptable and thus minimize the practice in order to acculturate [53].

Women may be accustomed to using breastfeeding as a form of natural family planning. However, they should be educated on its failure rate and the availability of additional contraceptive methods. This is especially true for women who are supplementing with formula [28]. Muslim women will often continue to breastfeed during the fasting period of Ramadan and providers should monitor the nutritional status of both the mother and child and encourage women to consume extra liquids before and after fasting [57]. Inquiring about breastfeeding practices with previous children, expectations for breastfeeding and assessing progress at visits will yield valuable information.

Contraception

Refugee women have variable exposure to contraceptive methods which may vary based on their region of origin and previous access to health care. Some women may have religious objections to manipulating their fertility, while for others fertility may be a sign of pride and wealth in a community [28]. Furthermore, it may be necessary for women to consult their husbands regarding contraception in order to conform to cultural ideals in decision-making and gender norms [20]. Providers should offer time and space for this to occur and reengage the conversation on subsequent visits.

Women may be more open to discussing contraception if "family spacing" or "family planning" is used instead of "birth control." However, many women, due to cultural or religious beliefs, may still have an extreme aversion to any form of birth control. Refugee women have been shown to be more successful in using the calendar rhythm method and keeping track of their menstrual cycles very closely [5]. Offering support for this method and providing cycle beads or calendars for women to use can be helpful. However, it is still important to educate women on the failure rate of natural family planning methods.

If women are interested in initiating a hormonal method of birth control and have never previously used one, making sure to outline potential side effects and expected changes in menstruation is important. Unwelcome changes may perpetuate the fear and misinformation surrounding contraception use and side effects, and lead to noncompliance [28, 58].

Intimate Partner Violence

Violence against women is a global public health phenomenon that affects millions of women across racial, ethnic, social, economic, religious, and cultural lines [59, 60]. There are many different kinds of violent acts against women [61]. IPV is the most prevalent form of violence among women, and comprises a pattern of assaultive and coercive behaviors which may include physical assault, psychological or emotional abuse, sexual assault, progressive social isolation, stalking, deprivation, intimidation, and threats. There is some evidence showing high prevalence of IPV among refugee populations, and it often occurs within the context of immigration, acculturation, and rapid changes in family and social structures [62]. Refugee women are distinctly vulnerable in having survived pre-migratory experiences of sexual violence during war/armed conflicts. Upon resettlement in host countries, refugee women may continue to face risks of IPV within the context of language barriers, confusion over their legal rights, and the stress of acculturation to new cultural and social norms.

Beyond the immediate trauma of violence, IPV can have a profound impact on a woman's overall health and well-being. Women who have survived IPV may display psychological symptoms of fear, anxiety, depression, PTSD, insomnia, feelings of hopelessness, and somatization, while physical symptoms may manifest as chronic pelvic pain, menstrual irregularities, sexual dysfunction, musculoskeletal symptoms, and distorted body image. Providers may face difficulty managing chronic illnesses such as diabetes and hypertension, and alcohol and substance abuse issues may become apparent. General perceptions of poor health and worsened health status are also common [61]. While maintaining cultural beliefs and norms may confer protective coping mechanisms through community-centered values, resiliency, and social support, cultural context may also exacerbate the consequences of violence by imbuing psychosocial conflicts in traditional gender roles. Moreover, cultural values and practices may constrain women from seeking help,

which when compounded by stigma and shame, may limit women's health-seeking behavior and health care utilization. Institutional racism, sexism, and socioeconomic barriers may further contribute to disparities in refugee women's health.

Hence developing trust with refugee communities is critical. Survivors of IPV need culturally appropriate interventions and programs that address the many challenges specific to refugee communities. Female providers and female interpreters are often at the front lines in being able to help identify concerns for IPV [63]. Culturally tailored interventional programs should support women's self-sufficiency, offer comprehensive services including shelter, safety planning, coordination with police and the judicial system, medical as well as social support (including employment, housing, and services for children) [64].

There are many challenges encountered by health care systems, service organizations, and programs addressing IPV in refugee communities including difficulty getting victims to talk about personal and shameful experiences and convincing them of availability of support and safety if they confront their abusers. Some strategies include changing cultural norms regarding IPV and using advocates who can provide leadership and raise awareness in the community [65].

A growing body of evidence supports the efficacy of routine screening in identifying women who are victims of or at risk for IPV, which provides a primary starting point for early identification of IPV in order to reach women regardless of whether symptoms are immediately apparent. In addition, screening for IPV provides an opportunity for disclosure and provides a woman and her health care provider the chance to develop a plan to protect her safety and improve her health. The Family Violence Prevention Fund has developed National Consensus Guidelines on Identifying and Responding to Domestic Violence Victimization in Health Care Settings [66]. Health care providers and health systems should be aware of and have collaborative relationships with culturally competent resources in the community that are specific to patients' cultural groups and countries of origin [61].

Female Genital Cutting

Female genital cutting (FGC), otherwise known as Female Genital Mutilation (FGM) or Female Circumcision (FC), is an ancient cultural practice that has gained global attention due to immigration from FGC-affected regions of the world. FGC is defined as any procedure that involves partial or total removal of external female genitalia or other injury to female genital organs whether for cultural or nontherapeutic reasons [67]. FGC is often performed as a ritual initiation into womanhood: ensuring one's chastity and eligibility for marriage and instilling pride, honor, value, and aesthetics. FGC affects up to 140 million women worldwide. Each year three million girls are at risk of undergoing this practice [67]. FGC is documented in 28 countries throughout sub-Saharan Africa, and in regions of Southeast Asia and the Middle East. Prevalence rates vary between and within nations, with some regions possessing rates higher than 90 %.

Table 15.1 2007 WHO classification of female genital cutting

Type	Definition
I	Partial or total removal of the clitoris and/or the prepuce *(clitoridectomy)* *Type Ia*—removal of the clitoral hood or prepuce only *Type Ib*—removal of the clitoris with the prepuce
II	Partial or total removal of the clitoris and the labia minora, with or without excision of the labia majora *(excision)* *Type IIa*—removal of the labia minora only *Type IIb*—partial or total removal of the clitoris and the labia minora *Type IIc*—partial or total removal of the clitoris, the labia minora, and the labia majora
III	Narrowing of the vaginal orifice with creation of a covering seal by cutting and appositioning the labia minora and/or the labia majora, with or without excision of the clitoris *(infibulation)* *Type IIIa*—removal and apposition of the labia minora *Type IIIb*—removal and apposition of the labia majora
IV	Unclassified: All other harmful procedures to the female genitalia for nonmedical purposes (i.e., pricking, piercing, incising, scraping, and cauterization)

World Health Organization. *Eliminating Female Genital Mutilation: An Interagency Statement.* Geneva, Switzerland. 2008. Accessed 2/12/13: https://docs.google.com/a/asu.edu/viewer?url=http://www.unifem.org/attachments/products/fgm_statement_2008_eng.pdf

FGC is divided into four categories (Table 15.1; Fig. 15.1). Type I is the partial or total removal of the prepuce or clitoris (clitoridectomy). Type II is the partial or total removal of the clitoris and the labia minora, with or without excision of the labia majora (excision). Type III involves cutting and appositioning the labia minora and/or majora to create a covering that restricts the vaginal introitus (infibulation). This is the most extreme category, but only comprises 10 % of all cases of FGC [68]. However, recent immigration and refugee resettlement from countries where Type III FGC predominates (e.g., Somalia) have resulted in an increased prevalence of females with Type III FGC throughout North America and Europe. Type IV includes other alterations to the genitals that do not remove tissue, such as piercing, pricking, or cauterization [67].

Women who have undergone FGC may experience short and long-term complications. Immediate complications may include pain, infection, laceration of adjacent structures (i.e., the bladder, urethra, vagina, or rectum), and uncontrolled hemorrhage. Long-term complications, seen mostly in women with type III FGC, include chronic urinary tract infections, severe dysmenorrhea, and dyspareunia, which in severe cases may lead to infertility. The extent of long-term morbidity depends on the type, extent, and severity of tissue excised [69–71]. A prospective study across six African countries has demonstrated a trend towards adverse obstetric and neonatal outcomes with increasing severity of FGC when compared to those without FGC; including cesarean delivery, postpartum hemorrhage, extended maternal hospital stay, resuscitation of the infant, and inpatient perinatal death [72]. Sexual function may also be affected [73]. However, more research is needed to further elucidate the impact of varying types of FGC on a woman and her partner's sexual health.

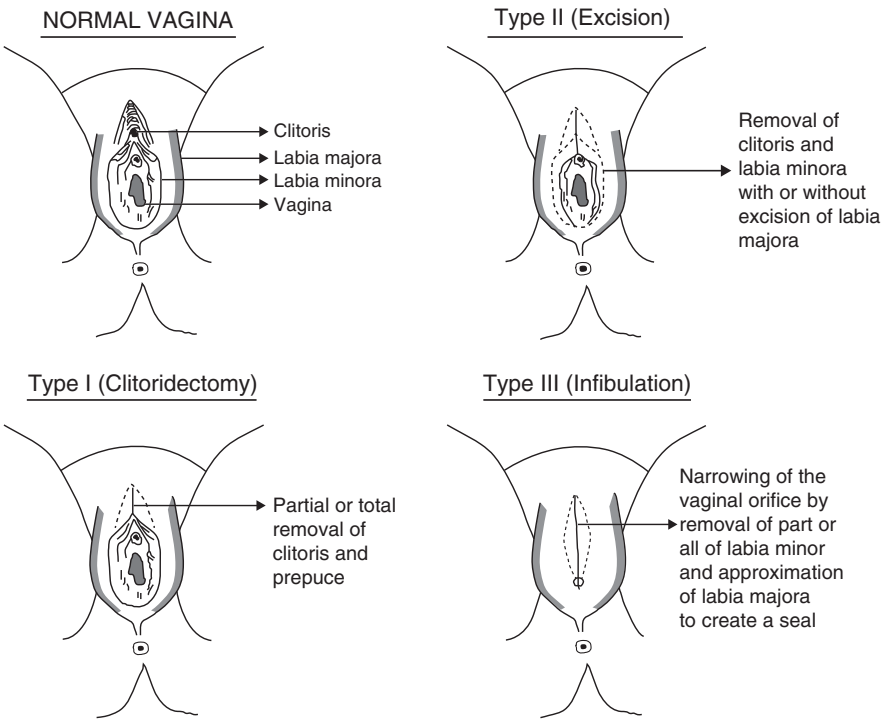

Fig. 15.1 Classification of female genital cutting

For women with Type III FGC, a defibulation procedure can relieve FGC-related morbidity prior to coitus or pregnancy, or during the antepartum or intrapartum period. Defibulation entails the surgical release of the vulvar scar tissue by making a vertical incision along the infibulation to expose the urethral meatus and introitus, followed by approximation of the raw edges on each labia majora. Reconstructive surgery can also be performed to restore clitoral anatomy and function. Local anesthesia should be avoided as this may cause posttraumatic stress symptoms [74, 75]. Excellent postoperative results have been reported with improvement in both sexual function and pain [76].

For pregnant women with type III FGC, cesarean delivery should only be performed for obstetrical indications, and precautions taken to ensure a safe vaginal delivery. Counseling is needed during the antepartum period to discuss what to expect during labor, as well as to determine the most appropriate timing of defibulation (antepartum during the second trimester or intrapartum). Antepartum defibulation avoids excessive blood loss at the time of delivery, facilitates the assessment of cervical dilation, and allows for urethral catheterization and the placement of intrauterine devices, while minimizing patient discomfort.

Counseling should be provided in a nonjudgmental manner; engendering trust and encouraging open dialogue. Women suspected of being at risk for or who have

undergone FGC should be asked about their history in a culturally sensitive matter, with careful use of the patient's own terminology [77]. An exploration of the cultural significance ascribed to FGC should ensue along with elicitation of any medical sequela experienced. An interpreter should be available if necessary along with the woman's partner to aid in medical decision-making. During the physical exam, it is important to gain the trust of women who may feel uncomfortable with gynecologic exams. Pelvic exams may pose a challenge in women with a narrowed opening, and a pediatric speculum may be needed. Likewise, performing a bimanual exam may be difficult, and a rectovaginal exam may be required. Visual aids/diagrams illustrating vulvar anatomy should also be incorporated, and sexual health counseling made available for both the woman and her partner.

Legislation and educational campaigns against FGC have led to a significant decline in its prevalence over the last 25 years, although support for its continuation varies widely between and within countries [78]. In December 2012, the United Nations General Assembly passed a resolution banning FGC which is intensifying global efforts to eliminate the practice [79]. Notwithstanding, intense controversy abounds surrounding the medicalization of genital cutting performed on minors (whether male or female) [80]; the confluence of double-standards around female genital cosmetic surgery and an adult woman's ability to choose genital modification procedures [73]; and the Western media's portrayal of FGC without attention to rigorous evidence-based research and balanced public policy debates [81]. Thus, FGC provides a window of opportunity through which health care providers can impart culturally appropriate counseling and education, enabling women to make informed decisions regarding their reproductive health care and circumcision of their daughters.

Appendix: Suggested Assessment Questions and Strategies for Routine Screening of Violence Against Women

The following sample assessment questions can also be used to develop a strategy most comfortable for each individual:

Framing Questions

- "Because violence is so common in many people's lives, I've begun to ask all my patients about it."
- "I am concerned that your symptoms may have been caused by someone hurting you."
- "I don't know if this is (or ever has been) a problem for you, but many of the patients I see are dealing with abusive relationships. Some are too afraid or uncomfortable to bring it up themselves, so I've started asking about it routinely."

Direct Verbal Questions

- "Are you in a relationship with a person who physically hurts or threatens you?"
- "Did someone cause these injuries? Was it your partner/husband?"
- "Has your partner or ex-partner ever hit you or physically hurt you?"
- "Do you (or did you ever) feel controlled or isolated by your partner?"
- "Do you ever feel afraid of your partner? Do you feel you are in danger?"
- "Is it safe for you to go home?"
- "Has your partner ever forced you to have sex when you didn't want to? Has your partner ever refused to practice safe sex?"
- "Has any of this happened to you in previous relationships?"

Effective Assessment Strategies When Working Cross-culturally

It is important to adapt your assessment questions and approach in order to be culturally relevant to individual patients. Listen to patients, pay attention to words that are used in different cultural settings and integrate those into assessment questions. Focusing on actions and behaviors as opposed to culturally specific terminology can also help, or some groups may be more willing to discuss abuse if you use general questions. Be aware of verbal and nonverbal cultural cues (eye contact or not, patterns of silence, spacing, and active listening during the interview).

Some examples include:

- Use your patient's language: "Does your boyfriend disrespect you?"
- Be culturally specific: "Abuse is widespread and can happen even in lesbian relationships.
- Does your partner ever try to hurt you?"
- Focus on behaviors: "Has you partner ever hit, shoved, or threatened to kill you?"
- Begin by being indirect: "If a family member or friend was being hurt or threatened by a partner, do you know of resources that could help them?"

(Adapted from the National Consensus Guidelines on Identifying and Responding to Domestic Violence Victimization in Health Care Settings. The Family Violence Prevention Fund, 2004. Accessed 2/12/2013: http://www.futureswithoutviolence.org/userfiles/file/Consensus.pdf)

References

1. Gagnon AJ, Tuck J, Barkun L. A Systematic review of questionnaires measuring the health of resettling refugee women. Health Care Women Int. 2004;25:111–49.
2. Beyani C. The needs of refugee women: a human-rights perspective. Gend Dev. 1995;3(2):29–35.

3. Momartin S, Silove D, Manicavasagar V, et al. Dimensions of trauma associated with post-traumatic stress disorder (PTSD) caseness, severity and functional impairment: a study of Bosnian refugees resettled in Australia. Soc Sci Med. 2003;57(5):775–81.
4. Asgary R, Segar N. Barriers to health care access among refugee asylum seekers. J Healthcare Poor Underserved. 2011;22(2):506–22.
5. Kornosky J, Peck J, Sweeney A, et al. Reproductive characteristics of Southeast Asian immigrants before and after migration. J Immigr Minor Health. 2008;10:135–43. doi:10.1007/s10903-007-9064-8.
6. Morrison TB, Wieland ML, Cha SS, et al. Disparities in preventive health services among Somali immigrants and refugees. J Immigr Minor Health. 2012;14(6):968–74.
7. Johnson CE, Mues KE, Mayne SL, et al. Cervical cancer screening among immigrants and ethnic minorities: a systematic review using the Health Belief Model. J Low Genit Tract Dis. 2008;12(3):232–41.
8. Cadman L, Waller J, Ashdown-Barr L, et al. Barriers to cervical screening in women who have experienced sexual abuse: an exploratory study. J Fam Plann Reprod Health care. 2012;38(4):214–20.
9. U.S. Center for Disease Control and Prevention. General refugee health guidelines. http://www.cdc.gov/immigrantrefugeehealth/guidelines/general-guidelines.html#cancer_screening. Published 2011. Accessed 2013.
10. U.S. Center for Disease Control and Prevention. Immigrant and refugee health. Screening for HIV infection during the refugee domestic medical examination. http://www.cdc.gov/immigrantrefugeehealth/guidelines/domestic/screening-hiv-infection-domestic.html. Published 2012. Accessed 2013.
11. Lowther SA, Johnson G, Hendel-Paterson B, et al. HIV/AIDS and associated conditions among HIV-infected refugees in Minnesota, 2000–2007. Int J Environ Res Public Health. 2007;9(11):4197–209.
12. Stauffer WM, Painter J, Mamo B, et al. Sexually transmitted infections in newly arrived refugees: is routine screening for *Neisseria gonorrheae* and *Chlamydia trachomatis* infection indicated? Am J Trop Med Hyg. 2012;86(2):292–5.
13. Burnley J, Johnson-Agbakwu CE. Pap tests. In: Loue S, Sajatovic M, editors. Encyclopedia of immigrant health. New York: Springer; 2012. p. 1172–5.
14. Lofters AK, Moineddin R, Hwang SW, et al. Predictors of low cervical cancer screening among immigrant women in Ontario, Canada. BMC Womens Health. 2011;7(11):20.
15. Redwood-Campbell L, Fowler N, Laryea S, et al. 'Before you teach me, I cannot know': immigrant women's barriers and enablers with regard to cervical cancer screening among different ethnolinguistic groups in Canada. Can J Public Health. 2011;102(3):230–4.
16. Percac-Lima S, Milosavljevic B, Oo SA, et al. Patient navigation to improve breast cancer screening in Bosnian refugees and immigrants. J Immigr Minor Health. 2012;14(4):727–30.
17. Saadi A, Bond B, Percac-Lima S. Perspectives on preventive health care and barriers to breast cancer screening among Iraqi women refugees. J Immigr Minor Health. 2011;14(4):633–9.
18. Davidson GR, Murray KE, Schweitzer RD. Review of refugee mental health and well-being: Australian perspectives. Aust Psychol. 2008;43s:160–74.
19. Gagnon AJ, Van Hulst A, Merry L, et al. Cesarean section rate differences by migration indicators. Arch Gynecol Obstet. 2012 [Epub ahead of print] doi: 10.1007/s00404-012-2609-7.
20. Redwood-Campbell L, Thind H, Howard M, et al. Understanding the health of refugee women in host countries: lessons from the Kosovar re-settlement in Canada. Prehosp Disaster Med. 2008;23(4):322–7.
21. Elklit A, Ostergard Kjaer K, Lasgaard M, et al. Social support, coping and posttraumatic stress symptoms in young refugees. Torture. 2012;22(1):11–23.
22. Hollifield M, Verbillis-Kolp S, Farmer B, et al. The refugee health screener-15 (RHS-15): development and validation of an instrument for anxiety, depression, and PTSD in refugees. *General Hospital Psychiatry.* 2013; 35(2):202–9.
23. Harris M, Humphries K, Nabb J. Asylum seekers: delivering care for women seeking refuge. RCM J. 2006;9:190–2.

24. Costa D. Health care of refugee women. Aust Fam Physician. 2007;36(3):151–4.
25. Willis M, Buck J. From Sudan to Nebraska: Dinka and Nuer refugee diet dilemmas. J Nurs Educ Behav. 2007;39:273–80.
26. Barnes D, Almasy N. Refugees' perceptions of healthy behaviors. J Immigr Health. 2005;7(3):185–93. doi:10.1007/s10903-005-3675-8.
27. John Snow Institute. Refugee Health Technical Assistance Center: Pregnancy. http://www.refugeehealthta.org/physical-mental-health/health-conditions/womens-health/pregnancy/. Published 2011. Accessed 2013.
28. Bruce H. Women's health issues. In: Walker PF, Barnett ED, editors. Immigrant medicine. Philadelphia, PA: Saunders Elsevier; 2007. p. 567–96.
29. Coonrod DV. Infectious diseases in preconceptional care. In: Karoshi M, Newbold S, B-Lynch C, Keith L, editors. Textbook of preconceptional medicine. London: Global Library of Women's Medicine; 2011.
30. Gupta N, Mahy M. Sexual initiation among adolescent girls and boys: trends and differentials in Sub-Saharan Africa. Arch Sex Behav. 2003;32(1):41–53.
31. Doyle A, Mavedzenge S, Plummer M, et al. The sexual behaviour of adolescents in sub-Saharan Africa: patterns and trends from national surveys. Trop Med Int Health. 2012;17(7):796–807.
32. Goosen S, Uitenbroek D, Wijsen C, et al. Induced abortions and teenage births among asylum seekers in The Netherlands: analysis of national surveillance data. J Epidemiol Community Health. 2009;63:528–33. doi:10.1136/jech.2008.079368.
33. Brown E, Carroll J, Fogarty C, et al. "They get a C-section…they gonna die": Somali women's fears of obstetrical interventions in the United States. J Transcult Nurs. 2010;21(3):220–7.
34. Herrel N, Olevitch L, DuBois DK, et al. Somali refugee women speak out about their needs for care during pregnancy and delivery. J Midwifery Womens Health. 2004;49(4):345–9. doi:10.1016/j.jmwh.2004.02.008.
35. American College of Obstetricians and Gynecologists. Frequently asked questions: routine tests in pregnancy. http://www.acog.org/~/media/For%20Patients/faq133.pdf?dmc=1&ts=20120529T1704217092. Published 2011. Accessed 2013.
36. U.S. Center for Disease Control and Prevention. Guidelines for screening for tuberculosis infection and disease during the domestic medical examination for newly arrived refugees. http://www.cdc.gov/immigrantrefugeehealth/pdf/domestic-tuberculosis-refugee-health.pdf. Published 2012. Accessed 2013.
37. Halvorsen T. Pregnancy and birth in Minnesota's Hmong population. Minn Med. 2012;95(5):49–52.
38. Dundek L. Establishment of a Somali doula program at a large metropolitan hospital. J Perinat Neonatal Nurs. 2006;20(2):128–37.
39. Wiklund H, Aden A, Hogberg U, et al. Somalis giving birth in Sweden: a challenge to culture and gender specific values and behaviours. Midwifery. 2000;16:105–15.
40. Erwin A. A physician's guide for understanding Hmong health care beliefs. http://www.d.umn.edu/medweb/Erwin/hmong.html#Pregnancy. Accessed 2013.
41. Cripe SM, O'Brien W, Gellaye B, et al. Maternal morbidity and perinatal outcomes among foreign-born Cambodian, Laotian, and Vietnamese Americans in Washington state, 1993–2006. J Immigr Minor Health. 2011;13(3):417–25.
42. Vangen S, Stoltenberg C, Johansen RE. Perinatal complications among ethnic Somalis in Norway. Acta Obstet Gynecol Scand. 2002;81(4):317–22.
43. Johnson EB, Reed SD, Hitti J, et al. Increased risk of adverse pregnancy outcome among Somali immigrants in Washington State. Am J Obstet Gynecol. 2005;193:475–82.
44. Small R, Gagnon A, Gissler M, et al. Somali women and their pregnancy outcomes postmigration: data from six receiving countries. BJOG. 2008;115:1630–40.
45. Dejin-Karlsson E, Ostergren P. Country of origin, social support and the risk of small for gestational age birth. Scand J Public Health. 2004;32:442–9. doi:10.1080/14034940410028172.
46. Gissler M, Alexander S, Macfarlane A, et al. Stillbirths and infant deaths among migrants in industrialized countries. Acta Obstet Gynecol Scand. 2009;88:134–48.

47. Essen B, Hanson BS, Ostergren PO, et al. Increased perinatal mortality among sub-Saharan immigrants in a city-population in Sweden. Acta Obstet Gynecol Scand. 2000;79:737–43.
48. Treacy A, Byrne P, Collins C. Pregnancy outcome in immigrant women in the Rotunda Hospital. Ir Med J. 2006;99:22–3.
49. Salem W, Flynn P, Weaver A, et al. Fertility after cesarean delivery among Somali-born women resident in the USA. J Immigr Minor Health. 2011;13:494–9.
50. Edwards NC, Boivin JF. Ethnocultural predictors of postpartum infant-care behaviours among immigrants in Canada. Ethn Health. 1997;2(3):163–76.
51. Carroll J, et al. Caring for Somali women: implications for clinician–patient communication. Patient Educ Couns. 2007;66:337–45.
52. Allotey P. Travelling with 'excess Baggage': health problems of refugee women in Western Australia. Women Health. 1998;28(1):63–81.
53. Hill N, Hunt E, Hyrkas K. Somali immigrant women's health care experiences and beliefs regarding pregnancy and birth in the US. J Transcult Nurs. 2012;23(1):72–81.
54. Lin EH, Carter WB, Kleinman AM. An exploration of somatization among Asian refugees and immigrants in primary care. Am J Public Health. 1985;75(9):1080–4.
55. Hammoud M, White C, Fetters M. Opening cultural doors: providing culturally sensitive health care to Arab American and American Muslim patients. Am J Obstet Gynecol. 2005;139:1307–11.
56. Carpenter S, Vaucher Y. Cultural transition and infant-feeding practices among Somali immigrant women in San Diego, California. Pediatr Res. 1999;45:279A.
57. Rakicioglu N, Samur G, Topcu A, et al. The effect of Ramadan on maternal nutrition and composition of breast milk. Pediatr Int. 2006;48:278–83.
58. Skidmore M. Menstrual madness: women's health and well-being in urban Burma. Women Health. 2008;35(4):81–99.
59. Watts C, Zimmerman C. Violence against women: global scope and magnitude. Lancet. 2002;359:1232–7.
60. World Health Organization. Multi-country study on women's health and domestic violence against women: summary report of initial results on prevalence, health outcomes and women's responses. http://www.who.int/gender/violence/who_multicountry_study/summary_report/summary_report_English2.pdf. Published 2005. Accessed 2013.
61. Ekblad S, Kastrup MC, Eisenman DP et al. Interpersonal violence towards women. In: Walker PF, Barnett ED, editors. Immigrant medicine. Philadelphia, PA: Saunders Elsevier; 2007. p. 567–596.
62. Nilsson JE, Brown C, Russell EB, Khamphakdy-Brown S. Acculturation, partner violence, and psychological distress in refugee women from Somalia. J Interpers Violence. 2008;23(11):1654–63.
63. Foster J, Newell B, Kemp C. Women. In: Kemp C, Rasbridge LA, editors. Refugee and immigrant health: a handbook for health professionals. Cambridge, UK: Cambridge University Press. 2004; p. 67–79.
64. Bureau of Justice Statistics, U.S Department of Justice. Intimate partner violence in the United States. https://docs.google.com/a/asu.edu/viewer?url=http://bjs.ojp.usdoj.gov/content/pub/pdf/ipvus.pdf. Published 2007. Accessed 2013.
65. Runner M, Yoshihama M, Novick S. Intimate partner violence in immigrant and refugee communities: challenges, promising practices and recommendations. A report by the family violence prevention fund for the Robert Wood Johnson Foundation. https://docs.google.com/a/asu.edu/viewer?url=http://www.futureswithoutviolence.org/userfiles/file/ImmigrantWomen/IPV_Report_March_2009.pdf. Published 2009. Accessed 2013.
66. National consensus guidelines on identifying and responding to domestic violence victimization in health care settings. The family violence prevention fund. http://www.futureswithoutviolence.org/userfiles/file/Consensus.pdf. Published 2004. Accessed 2013.
67. World Health Organization. Eliminating female genital mutilation: an interagency statement. https://docs.google.com/a/asu.edu/viewer?url=http://www.unifem.org/attachments/products/fgm_statement_2008_eng.pdf. Published 2008. Accessed 2013.

68. Yoder PS, Khan S. Numbers of women circumcised in Africa: the production of a total. Macro International Inc: Calverton; 2007.
69. Fernandez-Aguilar S, Noel JC. Neuroma of the clitoris after female genital cutting. Obstet Gynecol. 2003;101:1053–4.
70. Nour NM. Urinary calculus associated with female genital cutting. Obstet Gynecol. 2007;107:521–3.
71. Almroth L, Elmusharaf S, El Hadi N, et al. Primary infertility after genital mutilation in girlhood in Sudan: a case–control study. Lancet. 2005;366:385–91.
72. World Health Organization. Study group on female genital mutilation and obstetric outcome. WHO collaborative prospective study in six African countries. Lancet. 2006;367(9525): 1835–41.
73. Johnsdotter S, Essén B. Genitals and ethnicity: the politics of genital modifications. Reprod Health Matters. 2010;18(35):29–37.
74. Johnson C, Nour NM. Surgical techniques: defibulation of Type III female genital cutting. J Sex Med. 2007;4(6):1544–7.
75. Foldes P. Reconstructive surgery of the clitoris after ritual excision. J Sex Med. 2006;3: 1091–4.
76. Foldes P. Reconstructive plastic surgery of the clitoris after sexual mutilation. Prog Urol. 2004;14:47–50.
77. Rosenberg LB, Gibson K, Shulman JF. When cultures collide: female genital cutting and U.S. obstetric practice. Obstet Gynecol. 2009;113(4):931–4.
78. Center for Reproductive Rights. Female genital mutilation (FGM): legal prohibitions worldwide. http://reproductiverights.org/en/document/female-genital-mutilation-fgm-legal-prohibitions-worldwide. Published 2000. Accessed 2013.
79. World Health Organization. Female genital mutilation. http://www.who.int/mediacentre/factsheets/fs241/en/#. Published 2013. Accessed 2013.
80. Darby R, Svoboda JS. A Rose by any other name? Med Anthropol Q. 2007;21(3):301–23.
81. The Public Policy Advisory Network on Female Genital Surgeries in Africa. Seven things to know about female genital surgeries in Africa. Hastings Cent Rep. 2012;6:19–27.