Improving Access to Reproductive Health Services Among Somali Refugees

Kaylee Hopkins BSN, RN

Oregon Health and Science University

NURS 703B: DNP Project

Winter Term, 2023

Submitted to: Rebecca Martinez, DNP Project Chair

This paper is submitted in partial fulfillment of the requirements for

the Doctor of Nursing Practice degree.

Abstract

As a result of relocation and displacement, refugees are at an increased risk of experiencing inadequate reproductive health care and are likely to underutilize available reproductive health resources (Davidson et al., 2022 & Maheen et al., 2021). Inadequate reproductive care increases the risk of unintended pregnancies, preterm births, sexually transmitted infections, sexual violence, and lower breast and cervical cancer screening rates (Agbemenu et al., 2019 & Fung et al., 2019 & Ivanova et al., 2018). This Doctor of Nursing practice capstone project paper outlines how the Multnomah County Health Department partnered with the Center for African Health and Education to increase Somali refugee breast cancer awareness and improve access to reproductive health services through a culturally congruent education session. Rooted in a Community Based Participatory Research approach, this project began by focusing on a topic of need within the community and involved community partners in the development of the session (Wallerstein et al., 2003). Through a series of participant surveys, data results show that education sessions are an effective group reproductive health education method. Interventions for this project are easily adaptable for other refugee health-focused education sessions.

Improving Access to Reproductive Health Services Among Somali Refugees

Introduction

Problem Description:

The refugee population continues to grow globally, with the number of individuals forcibly displaced increasing by more than 50% in the last ten years (Davidson et al., 2022). Refugees or displaced persons (DPs) are individuals fleeing their country of nationality due to fear of persecution related to aspects of their identity or due to conflict, violence, or natural disasters (Davidson et al., 2022; Oregon Department of Human Services). Globally, an estimated 68.5 million individuals are displaced, with 80% of these individuals estimated to be women or children (Royer et al., 2020). Somalia is a deeply divided country with a sustained humanitarian crisis, and an estimated 1.5 million Somalis have been displaced as a result (Centers for Disease Control and Prevention [CDC], 2021 & Royer et al., 2020). An average of 9,000 Somali refugees relocate to the United States annually, and Oregon has welcomed approximately 1,500 Somali refugees, with the majority of individuals under the age of 45 and nearly equal numbers of males and females (CDC, 2021). Somali DPs relocating to Portland, Oregon, are directed to specific county healthcare facilities for initial health screening and healthcare needs, including reproductive health services (RHS) (Multnomah County Health Department [MCHD], n.d.a).

Due to factors related to relocation, DPs are an inherently vulnerable population at high risk of receiving inadequate reproductive healthcare, and it is well supported that DPs consistently underutilize available reproductive health services (RHS) (Davidson et al., 2022 & Maheen et al., 2021). Gaps in care increase the risk for adverse sexual and reproductive health outcomes (Davidson et al., 2022). Displaced women are particularly endangered by unmet reproductive health needs (Ivanova et al., 2018). These unmet needs increase the risk of unintended pregnancies, preterm births, sexually transmitted infections, sexual violence, and

lower breast and cervical cancer screening rates (Agbemenu et al., 2019 & Fung et al., 2019 & Ivanova et al., 2018). While conversely, increased reproductive health literacy is associated with informed health decision-making, improved mental health outcomes, and greater overall quality of life (Hawkey et al., 2021).

Breast cancer is the most diagnosed cancer among females worldwide (World Health Organization [WHO], 2021). Analogously, breast cancer is the most common cancer among Somali females, accounting for approximately 18.7% of all new cancer diagnoses in 2020 (Al-Amoudi et al., 2015 & Omar, 2021 & WHO, 2020). The incidence is likely higher than this as Somalia does not have a national cancer registry system limiting incidence data (Tahtabasi et al., 2020). Additionally, specific data on breast cancer rates among Somali women living in the U.S. is limited; however, foreign-born immigrant women are more often diagnosed with late-stage disease compared to both Non-Hispanic Whites and other racial minorities (Al-Amoudi et al., 2015 & Fung et al., 2019). Low breast cancer screening rates among African-born immigrants likely influences increased initial diagnosis at late-stage disease in this population (Fung et al., 2019).

Displaced women are less likely to utilize preventative RHS, such as breast or cervical cancer screenings, compared to native-born persons (Hawkey et al., 2021). Various traumatic experiences may influence DPs prior to displacement; it is essential for healthcare providers caring for displaced Somali women to understand how these experiences contribute to sexual and reproductive health practices (Royer et al., 2020). Understanding the beliefs and customs as well as common questions and concerns around reproductive health and specifically breast cancer screening for Somali DPs is essential to increasing culturally sensitive care, minimizing adverse reproductive health outcomes, and promoting Somali refugee reproductive health well-being.

This project aimed to provide a culturally respectful breast cancer awareness education session for Somali women with the intent of increasing knowledge of breast cancer screenings, breast cancer symptoms, and available RHS in the area, ultimately increasing access to care for this population.

Available Knowledge

To identify themes of reproductive health views, breast cancer screening practices, and RHS utilization in Somali culture, the PubMed and Scopus databases were searched for English-language articles published between 2010 and the present. Keywords included *breast, neoplasm, cancer, reproductive health, sexual health, health education, health promotion, group education, refugee(s), displaced person(s), Somali, Somalian, Somalis, West Africa, West African,* and *the United States.* The Ovid database was searched for English-language articles published between 2000 and the present. Key search words included *refugee(s), immigrant(s), asylum(s), displaced, person(s), people(s), reproductive, breast, sexual, health, well-being, cancer, neoplasm, literacy, understand, understanding, aware, awareness, education, educate, teach, teaching, teacher, instruct, instructor, instructions, taught, and learn*. To assess for effective health education tools and questionnaire outlines the PubMed and Ovid databases were searched for English-language articles published between 2010 and the present. Keywords included *health education, health promotion, survey(s), questionnaire(s), healthcare survey(s),* and *women(s) health.* Systematic reviews, qualitative studies, and cluster-randomized trial data were reviewed for effective reproductive health education methods and Somali cultural themes around breast cancer awareness and the use of RHS.

Barriers to DPs utilizing RHS, including breast cancer screening services, are multifactorial and subject to intersections of various systems (Kumar et al., 2021). Evidence

supports that the availability of a service does not guarantee utilization, and a robust conceptualization of Somali DPs' understanding of reproductive health and specifically breast cancer screening will support the utilization of available services (Maheen et al., 2021). Common themes among barriers include power dynamics, social, cultural, economic, and educational barriers (Davidson et al., 2022 & Kumar et al., 2021 & Maheen et al., 2021). These barriers can be categorized into three principal themes: health system factors, sociocultural factors, and patient encounter factors (Davidson et al., 2022 & Kumar et al., 2021 & Maheen et al., 2021). These principal themes can be further divided into subgroups of influences on DPs' access to RHS. Health system factors include provider characteristics, health system navigation, clinic hours, financial barriers, and lack of quality resource availability (Davidson et al., 2022 & Maheen et al., 2021). Provider characteristics preferred among Somali women for both reproductive health services and breast cancer screening included preference for female providers and Muslim providers (Fung et al., 2019 & Maheen et al., 2021). Common provider characteristics identified as a barrier to breast cancer screening care includes a lack of provider cultural competency and commitment to culturally sensitive care (Maheen et al., 2021). Sociocultural factors include religious and cultural influences, while patient encounter factors include communication barriers, knowledge of available resources, transportation barriers, confidentiality concerns, and limited sexual health literacy (Davidson et al., 2022 & Kumar et al., 2021 & Maheen et al., 2021& Mohamed & Sundberg, 2022). Social identity, religious, and cultural beliefs strongly influence Somali DP women's views on reproductive healthcare (Mohamend & Sundberg, 2022 & Zhang et al., 2020). Religious and faith beliefs are noted as barriers to breast cancer screening for Somali women; as breast cancer may be perceived as a

punishment from God, diminishing the perceived benefits of breast cancer screening (Fung et al., 2019).

Healthcare providers caring for Somali DPs must understand the cultural norms, customs, attitudes, and practices to provide patient-centered, culturally sensitive care (Royer et al., 2020). In Somali culture, sexual and reproductive health is commonly viewed as an unmentionable topic; however, reproductive health education is essential to empowering Somali DPs in making informed health decisions (Hawkey et al., 2021 & Mohanmed & Sundberg, 2022). Hawkey and colleagues found that displaced women, including those from Somali, preferred reproductive health education provided in a group education session format; participants also shared the importance of the education session being embedded with other programs to increase accessibility (2021). Further, involving community members in education session development supports the importance of community ownership of the session (Hawkey et al., 2021). Multiple studies show that focused education sessions specific to an aspect of reproductive health are an effective format for improving knowledge of available resources (Lee et al., 2020 & McGinn & Allen, 2007 & Nasir et al., 2020). Additionally, it is well supported that Somalis are greatly influenced by cultural and religious factors when making reproductive health decisions (Mohamed et al., 2022 & Royer et al., 2020). Therefore, it was essential to consider cultural customs in the design of the session (Mohamed et al., 2022 & Royer et al., 2020).

Rationale:

Sexual and reproductive health are vital components of overall well-being (Guttmacher Institute, 2020). Ensuring individuals have access to and awareness of sexually transmitted infection care, contraceptive services, pregnancy-related care, and reproductive cancer screenings, supports reproductive and sexual well-being (Guttmacher Institute, 2020). A lack of

access or utilization of RHS negatively impacts individuals, families, and communities, ultimately adversely impacting social and economic development (Guttmacher Institute, 2020).

The Model for Improvement (MFI), developed by the Institutes for Healthcare Improvement (IHI), is a quality improvement tool commonly utilized in the healthcare setting (IHI, n.d.). The MFI is grounded in three principles outlining the specific aims of a project, the measures defining improvement, and the ideal method for change (IHI, n.d.). Testing interventions follow these initial steps via the Plan-Do-Study-Act (PDSA) cycle (IHI, n.d.). The PDSA cycle allows for adaptive learning allowing maximal improvement opportunities with the minimal time necessary for trial and knowledge acquisition (IHI, n.d.).

A Community-Based Participatory Research (CBPR) approach alongside the MFI framework were utilized for this project. CBPR is appreciated for increasing health equity as it is a community-based approach rather than a community-placed method (Wallerstein et al., 2003). This approach begins with focusing on a matter of importance or need within the community of focus and involves community partners in research design and knowledge acquisition (Wallerstein et al., 2003). Collaboration with community partners allows research design to build on community goals, priorities, and strengths (Johnson et al., 2009 & Wallerstein et al., 2003). CBPR knowledge is directed at equitable social change to eliminate health disparities and promote community well-being (Johnson et al., 2009 & Wallerstein et al., 2003). CBPR method aids in creating culturally congruent research, which ultimately improves data outcomes and validity (Wallerstein et al., 2003). The Agency for Healthcare Research and Quality supports equitable healthcare as an essential theme of high-quality healthcare, further emphasizing the importance of a quality improvement project focused on increasing access to care among vulnerable populations (Department of Health and Human Services, n.d.).

Specific Aims

The aim of this project was to increase local Somali women's breast cancer awareness and awareness of available reproductive health services within Oregon state through a group education session presented on October 22nd, 2022. The overall goal was to improve reproductive health literacy, specifically around breast cancer and to improve access to reproductive health services among local Somali women.

Methods

Context

The healthcare clinics of MCHD include eight clinics based in Portland, Oregon. MCHD receives funding from the Health Resources and Services Administration (HRSA) and served 34,639 patients in 2021, with 10,694 patients seen at the Mid-County Health Center (MCHC), one of the MCHD clinics. The MCHC provides low-cost primary care for patients throughout their lifespan. MCHC staff includes 14 providers, two social workers, four community health workers, two pharmacists, five registered nurses, and nine administrative staff. Services provided in addition to primary care include reproductive health care, mental health care, and refugee health screening. 58.4% of patients seen at MCHD identify as female, and 41.4% as male. MCHD cares for a diverse population, with 39% of patient visits in 2021 requiring an interpreter. In 2021, 22 different languages, aside from English, were spoken by patients seen at MCHC. Of the 22 languages MCHC patients speak, the top five languages are English, Spanish, Russian, Chinese-Cantonese, and Somali. 3.9% or 332 patients at MCHC speak one of two Somali dialects, either *Af Maay* (pronounced "af my") or *Al Maxaa* (pronounced "af mahah") (National African Language Resource Center, n.d.). A 2021 listening session with MCHD Somali patients

identified communication barriers as the most common impediment to accessing all forms of healthcare.

This project fulfilled requirements for Program Element 46 (PE46), titled *Community Partnerships and Assurance of Access to Reproductive Health Services* (Oregon Health Authority [OHA]., n.d.). This program provides funding for RHS throughout Oregon state, focusing on enhancing access to reproductive care, specifically for marginalized communities (OHA., n.d.). Providing culturally congruent reproductive health education to Somali DPs promotes equitable healthcare, aligning with the goal of the PE46 program. Additionally, this project was led by a Doctor of Nursing Practice (DNP) student in fulfillment of the requirements of the DNP degree. Contributory team members included the Deputy Medical Director of MCHD, the Medical Director's Office Program Specialist, and community-based partners, including the Center for African Health and Education and members affiliated with this organization.

Interventions

This project consisted of 4 phases outlined as follows. Phase 1 included establishing relationships with Somali community-based organizations (CBOs) to recruit local Somali women for an initial needs assessment to determine which RHS available through the PE46 program lacks most awareness or understanding within the local Somali community. Involving Somali CBOs helped to establish a culturally sensitive education session and ensured that local needs were addressed. Once the topic of focus, was identified, the education session aimed to provide an overview of breast cancer including risk factors, signs and symptoms, breast cancer screening utility, what to except with breast cancer screening, and steps a woman can take to decrease her breast cancer risk factors (Appendix A).

Phase 2 consisted of recruiting participants and promoting the session. Promotion of the session included informational flyer dissemination at MCHC and Somali CBOs (Appendix B). Participant recruitment also relied on word-of-mouth communication based on the strong community social networks of Somali DPs. This form of education session promotion aligns with CBPR methods. Phase 3 comprised of a 30-minute education session focused on breast cancer awareness. The session took place at the Center for African Health and Education (CAHE), and participants received a $50 VISA gift card as well as lunch from a local Somali restaurant as a sign of appreciation for their attendance. Participants completed pre- and post-surveys to assess session effectiveness in increasing breast cancer awareness, understanding of available reproductive health resources, the cultural sensitivity of the session, and the session effectiveness in promoting equitable access to reproductive healthcare. Phase 4 included a longitudinal analysis of participant views of the education session through a 2-month follow up survey. All survey findings and utilized education materials were then shared with MCHC providers at an all-staff meeting.

Study of the Interventions:

The study of this intervention included analysis of participant completed pre- and post-surveys to assess education session effectiveness. A longitudinal analysis was completed through a 2-month follow-up survey which assessed the continued impacts of the session (Appendix C). Surveys focused on baseline knowledge of breast cancer screening compared to post-session awareness and knowledge; post-surveys also assessed the cultural appropriateness and sensitivity of the session. The initial pre-and post-surveys were developed utilizing evidence-based methods and adapted through CBO, MCHD, and DNP student collaboration. Per CBO advice, surveys were provided in written English with a translator present for interpretation.

Measures

The primary outcome measure for this quality improvement project was the portion of participants who felt the education session increased their knowledge of breast cancer awareness and the availability of resources to support reproductive health provided by the PE46 program. Assessing education session effectiveness also determined the significance of reproductive health-focused education sessions in promoting awareness of services and increasing access to reproductive healthcare. Process measures for this project included tracking the number of participants in attendance for the education session. A critical balancing measure for this project included the increased time and effort burden for CBO partners related to attending the education session, promoting the session, and aiding in the educational material development. The balancing measures will not be formally assessed for this project.

Analysis

Qualitative data was collected via a total of four surveys including the initial needs assessment, pre- and post- session surveys, and a long-term follow up survey. These surveys were completed by members of the local Somali community and education session participants. All results were organized in an Excel spreadsheet and data analysis was completed with support from a statistician affiliated with Oregon Health and Science University. Pre-, post-, and long-term survey results were scored to organize and create proportions for analysis of data which were then used to create bar graphs (Appendix D). ‘Yes’ responses were scored a one, ‘no’ a two and ‘not sure’ a three.

Ethical Considerations

Ethical considerations for this project included voluntary participation, the confidentiality of participant responses, and the appropriate handling of collected data. Participants were read a

consent script and provided verbal agreement for participation. The consent script outlined the session's goals, purpose of the survey responses, as well as potential risks and benefits to session participation (Appendix E). All surveys related to the session include pre-, post-, and 2-month follow-up surveys were de-identified and grouped for analysis. Additionally, by partnering with Somali community members and CBOs, this project aimed to provide a culturally sensitive and patient-centered education session. A female certified medical Somali translator was available during the session. The use of a female interpreter further supports the sessions cultural awareness. The clinic site provided consent to the project by signing a letter for support, and the project was submitted to the Oregon Health & Science University Investigational Review Board (Study #00024633), and the MCHD Review Board. Both review boards found the project exempt from further review.

Results

Results

Nine local Somali women completed the initial surveys to determine which topic derived from the available Program Element 46 RHS was of most interest among the local community. Seven of nine (77.78%) responded with an interest in breast cancer awareness (Appendix F). This concluded Phase 1 of the project which took place from September 1st – 16th, 2022.

While 46 women attended the event, only 40 participants completed the pre-survey and only 39 completed post-surveys. Of the 40 pre-surveys, only 19 were fully completed with information provided for age, number of years lived in the U.S. and an answer for each survey question. However, all 40 surveys were included in response analysis as the four pre-survey questions not related to demographic data were each answered. Pre-survey results showed that 41% of participants had heard of breast cancer awareness prior to the education session, while

49% had not previously heard of the topic and 10% were unsure. 45% initially responded yes to knowing the benefits of breast cancer screening with 43% responding no and 13% responding as unsure. Pre-survey results showed 37% of respondents selecting 'yes' to knowing the risks to breast cancer screening, while 50% of respondents answer no and 13% answering unsure. 32% of respondents shared they had previously discussed breast cancer screening with their healthcare provider, while 61% of respondents share they had not and 8% were unsure.

Of the 39 returned post-surveys, 32 respondents provided both age and number of years they had lived in the U.S.; however, all 39 surveys were grouped and included in response analysis as all respondents completely answered the survey questions. Overall, post-survey results show an improvement in respondents understanding of the topic. 92% of respondents responded yes to feeling they knew more about breast cancer awareness after the education session with 5% answering no and 3% answering unsure. 97% of respondents answered yes to having an improved understanding of the risk and benefits associated with breast cancer screening, while 3% answered no. All participants answered yes to question three, sharing that after the education session they would bring this topic up with their healthcare provider. 97% of respondents found the education session a helpful way to learn about breast cancer, while 3% did not. All respondents, 100%, found the goal of education session to be clear, culturally respectful, and beneficial in increasing awareness of available RHS. 97% of respondents would recommend this education session to others, and 3% of respondents answered unsure. Assessing pre- and post-survey age and years lived in the U.S. responses, participants on average were 44.l years old and had lived for an average of 15.9 years in the U.S.

Results from the long-term 2-month follow-up surveys further support that participants felt the education session was a helpful way to learn about a health education topic. Follow-up

surveys were completed over the first two weeks of December 2022 and grouped for analysis thereafter. 11 participants completed long-term follow-up surveys, while this is substantially fewer than then number of event participants, survey results were still analyzed. Each of the long-term follow-up surveys were completed entirely with information for age, number of years spent in the U.S., and a response for each question. On average respondents had spent 11.8 years in the U.S. and were an average of 37.9 years of age. All respondents, 100%, answered yes to each follow-up question, supporting that they would attend another health education session, that education sessions are a helpful way to increase health literacy, and that they had shared with others what they learned at the event.

Discussion

Summary

This DNP project aimed to promote local Somali women's breast cancer awareness and knowledge of available RHS through a culturally congruent education session. Rooted in a CBPR approach, this project began with focusing on a topic of need within the community and involved community partners in the development of the session (Wallerstein et al., 2003). The desired results of the intervention were to support reproductive health equity by increasing health literacy specific to breast cancer. Pre-, post-, and long-term survey data were collected and analyzed; overall participants felt the education session increased their breast cancer awareness, was culturally respectful, and that group education sessions are a helpful way to learn about various health topics. A majority of this project would be easily adapted for education sessions specific to various DPs, as a key finding was the value of partnering with CBOs.

Focused and culturally appropriate breast cancer awareness education sessions are an effective education tool for patient education in diverse populations (Al-Amoudi et al., 2015; Fisher et al., 2019; Khapre et al., 2021).

Interpretation

Comparison of pre-survey and post-survey results demonstrate an increased knowledge of breast cancer, breast cancer screening, and available RHS within the community. Similarly, long-term survey results support continued benefit from the education session. While this project does not assess the rates of increased breast cancer screenings completed because of this intervention, survey results suggest an increased likelihood that participants will discuss screening with their healthcare provider. Key to the success of the session was the involvement of the Somali CBO and a CBPR approach. This translated into all participants feeling the education session was culturally appropriate likely supporting participant engagement in the event. By first assessing which reproductive health topic was of interest among the local Somali women, this project supported a CBPR approach and further validates the survey results (Wallerstein et al., 2003). Additionally, the incentives of a free lunch and $50 VISA gift card likely supported event attendance.

The average age of participants ranged from 23 to 78 years of age with participants having lived in the U.S. for an average of 15-16 years. While this is a wide age range of participants, evidence supports Somali patients have more readily completed screening mammograms when a younger family member encourages them to (Ravindran et al., 2015). This supports the wide age range of participants that attended the session. Participants on average had lived in the U.S. for multiple years prior to attending session; however, health literacy and English proficiency are the greatest predictors of refugee health status in the U.S., regardless of

time spent in the country (Feinberg et al., 2020). This unsurprising finding supports providing health education opportunities for refugees regardless of time spent in the U.S.

Participants follow-up questions after the session included questions about radiation exposure risks with mammography, risk of breast cancer related to breast injury, and impact of storing items such as a phone or wallet near the breast. Future breast cancer awareness education sessions should include information on these topics. Though 3% of participants felt the education session was not a helpful way to learn about breast cancer awareness and 3% of survey respondents were unsure if they would recommend the education session to others; the majority of participants expressed interest in additional sessions focused on hypertension, diabetes, and other cancer screenings.

Limitations

Limitations of this project include the number of participants lost to follow up for long-term follow-up survey completion. Additionally, multiple pre- and post-surveys did not include complete demographic information. It is unclear why respondents did not complete surveys entirely, although this may have been avoided had multiple translators been available compared to one.

Conclusions

Influences on reproductive healthcare access and outcomes are multifactorial and often interconnected; these variables influence and often amplify healthcare inequities. Barriers specific to Somali DPs include the role of health systems factors, sociocultural factors, and patient encounter factors (Davidson et al., 2022 & Kumar et al., 2021 & Maheen et al., 2021). These barriers, translate to increased risk of sexually transmitted infections, sexual violence, preterm births, unintended pregnancies, and lower rates of cervical and breast cancer screening

(Agbemenu et al., 2019 & Fung et al., 2019 & Ivanova et al., 2018). Breast cancer is the most common female cancer in both Somalia and the United States, and it is well established that women from developing countries typically present with late-stage disease (Al-Amoudi et al., 2015 & National Cancer Institute [NIH], 2022). This education session aimed to increase local Somali DPs breast cancer awareness and familiarity of available RHS. Overall, survey results demonstrate the effectiveness, cultural appropriateness, and utility of the education session.

Other Information

Funding

This project was funded through the PE 46 Reproductive Health Program Element tilted, *Community Partnerships and Assurance of Access to Reproductive Health Services.*
Material fees included $630.00 for food, $1500.00 for VISA gift cards, and $180.00 for language services for a total of 2,310.00 spent for this intervention.

References

Al-Amoudi, S., Cañas, J., Hohl, S.D., Distelhorst, S.R., & Thompson B. (2015). Breaking the silence: Breast cancer knowledge and beliefs among Somali Muslim women in Seattle, Washington. *Health Care Women International, 36*(5), 609-616. doi:10.1080/07399332.2013.857323.

Agbemenu, K., Mencia, J.J., Rosa, C., Aidoo-Frimpong, G., & Ely, G. (2022). Family planning research in African immigrant and refugee women: A scoping review. *Journal of Transcultural Nursing, 33*(3). https://doi.org/10.1177/10436596211072891

Agbemenu, K., Auerbach, S., Murshid, N.S., Shelton, J., Amutah-Onukagha, N. (2019). Reproductive health outcomes in African refugee women: A comparative study. *Journal of Women's Health, 28*(6). https://doi.org/10.1089/jwh.2018.7314.

Centers for Disease Control and Prevention [CDC]. (n.d.). *Goal: Promote health and well-being for women.* https://health.gov/healthypeople/objectives-and-data/browse-objectives/women.

Centers for Disease Control and Prevention [CDC]. (2021, March 18). *Somali refugee health profile.*https://www.cdc.gov/immigrantrefugeehealth/profiles/somali/index.html#background.

Davidson, N., Hammarber, K., Romero, L., & Fisher, J. (2022). Access to preventive sexual and reproductive health care for women from refugee-like backgrounds: a systematic review. *BMC Public Health* 22 (403). https://doi.org/10.1186/s12889-022-12576-4

Department of Health and Human Services. (n.d.). *Agency for healthcare research and quality: Six domains of health care quality.* https://www.ahrq.gov/talkingquality/measures/six-domains.html.

Egeh, A.A., Dugsieh, O., Erlandsson, K., Osman, F. (2019). The views of Somali religious leaders on birth spacing: A qualitative study. *Sexual and Reproductive Healthcare. 20.* 27-31. 10.1016/j.srhc.2019.02.003.

Feinburg, I., O'Connor, H., Owen-Smith, A., Orgrodick, M.M., Rothenberg, R. (2020). The relationship between refugee health status and language, literacy, and time spent in the United States. Health Literacy Research and Practice, 4(4). https://doi.org/10.3928/24748307-20201109-01.

Fung, J., Vang, S., Margolies, L.R., Li, A., Blondeau-Lecomte, E., Jandorf. J. (2019). Developing a culturally and linguistically targeted breast cancer educational program for a multicultural population. *Journal of Cancer Education. 36,* 395-400. https://doi.org/10.1007/s13187-019-01643-x.

Gebrecherkos, K., Gebremariam, B., Gebeyehu, A., Siuym, H., Kahsay, G., & Abay, M. (2018). Unmet need for modern contraception and associated factors among reproductive age group women in Eritrean refugee camps, Tigray, north Ethiopia: A cross-sectional study. *BMC Research Notes. 11*(851). https://doi-org.liboff.ohsu.edu/10.1186/s13104-018-3956-7.

Guttmacher Institute. (2020). *Adding it up: Investing in sexual and reproductive health 2019.* https://www.guttmacher.org/report/adding-it-up-investing-in-sexual-reproductive-health-2019?utm_source=Guttmacher+Email+Alerts&utm_campaign=f2f2c89da2-AIU2020+gUpdate+no+usintlonly&utm_medium=email&utm_term=0_9ac83dc920-f2f2c89da2-244263581#.

Ivanova, O., Rai, M & Kemigisha, K. (2018). A systematic review of sexual and reproductive health knowledge, experiences, and access to services among refugee, migrant, and displaced girls and young women in Africa. Environmental Research and Public Health, 15(8). https://doi.org/10.3390/ijerph15081583

Johnson, C.E., Ali, S.A., & Shipp, M.P. (2007). Building community-based participatory research partnerships with a Somali refugee community. *American Journal of Preventative Medicine, 37*(6). 230-236. https://doi.org/10.1016/j.amepre.2009.09.036.

Kumar J.L., Chan, W.Y., & Spitz, A. (2021). Pathways to sexual health among refugee young women: A contextual approach. *Sexuality & Culture,* 25. 1789-1807. https://doi.org/10.1007/s12119-021-09850-9.

Langley, G. J., Moen, R. D., Nolan, K. M., Nolan, T. W., Norman, C. L., & Provost, L. P. (2009). *The improvement guide: a practical approach to enhancing organizational performance*. John Wiley & Sons.

Maheen, H., Chalmers, K., Khaw, S., & McMichael, C. (2021). Sexual and reproductive health service utilization of adolescents and young people from migrant and refugee backgrounds in high-income settings: A qualitative evidence synthesis (QES). *Sexual Health, 18*. 283-293. https://doi.org/10.1071/SH20112.

McGinn, T, & Allen, K. (2007). Improving refugees' reproductive health through literacy in Guinea. *Global Public Health, 1*(3), 229-248. https://doi-org.liboff.ohsu.edu/10.1080/17441690600680002.

Mohamed, A.F., & Sundeberg, L.R. (2022). "Using contraceptives is abandoning our culture": A qualitative study of contraceptive use among Somali women in Finland. *Sexual & Reproductive Healthcare, 32.* https://doi.org/10.1016/j.srhc.2022.100718.

Multnomah County Health Department, (n.d.a). Refugee health. https://www.multco.us/global/refugee-health.

Multnomah County Health Department (n.d.b). Immigrant and refugee health. https://www.multco.us/global/immigrant-and-refugee-health.

Multnomah County Health Department, (n.d.c.). Scope of reproductive health program: Policy ICS.08.05.

Nasir S., Goto R., Kitamura A., Alafeef, S., Ballout, G., Hababeh, M., Kiriya, J., Seita, A., & Jimba, M. (2020). Dissemination and implementation of the *e-MCHHandbook*, UNRWA's newly released maternal and child health mobile application: A cross-sectional study. *BMJ Open.*10. doi: 10.1136/bmjopen-2019-034885.

National African Language Resource Center (NALRC)., (n.d.) *Somali Language and Culture.* https://nalrc.indiana.edu/doc/brochures/somali.pdf.

National Cancer Institute [NIH]. (2022). *Cancer stat facts: Female breast cancer.* Surveillance, Epidemiology, and End Results Program. https://seer.cancer.gov/statfacts/html/breast.html.

OHSU Knight Cancer Institute. (n.d.). *Community partnerships program grants.* https://www.ohsu.edu/knight-cancer-institute/community-partnership-program-grants.

Omar, A.I. (2021). Frequency of cancer distribution in Somalia: A four-year retrospective epidemiological study. *African Journal of Health and Medical Sciences. 6*(1), 6-12. https://www.researchgate.net/publication/352488534_Frequency_of_cancer_distribution_in_Somalia_A_four-year_retrospective_epidemiological_study.

Oregon Department of Human Services. (n.d.). Who is a refugee. https://www.oregon.gov/dhs/ASSISTANCE/REFUGEE/Pages/who-is-refugee.aspx

Oregon Health Authority [OHA]. (n.d.). *Reproductive health provider resource.* https://www.oregon.gov/oha/PH/HEALTHYPEOPLEFAMILIES/REPRODUCTIVESEXUALHEALTH/RESOURCES/Pages/Program-Element-46.aspx#:~:text=What%20is%20Program%20Element%20(PE,and%20approved%20in%20February%202018.

Pei, L., Hsiang-Ru L., Pi-Chu L., Shu-Yu K., Yen-Kuang L., Su-Ru C., & Pi-Hsia L. (2020). Effects of a parenting sexual education program for immigrant parents: A cluster randomized trial. *Patient Education and Counseling,103*(2), 343-349. https://doi.org/10.1016/j.pec.2019.08.027.

Ravindran, R., Huntingon, J., Jackson, C., & Levine, Y. (2015). *Provider guide for Somali slideshow, "Whare are mammograms and breast cancer?".* EthnoMed. https://ethnomed.org/resource/provider-guide-for-somali-slideshow-what-are-mammograms-and-breast-cancer/#background.

Royer, P., Olson, L.M., Jackson, B., Weber, L.S., Gawron, L., Sanders, J.N., & Turok, D.K. (2020). *"In Africa, there was no family planning. Every year you just give birth.": Family planning knowledge, attitudes, and practices among Somali and Congolese refugee women after resettlement to the United States.* Qualitative Health Research. 30*(3)*, 391-408. 10.1177/1049732319861381.

Tahtabasi, M., Mohamud Abdullahi, I., Kalayci, M., Gedi Ibrahim, I., & Er, S. (2020). Cancer incidence and distribution at a tertiary care hospital in Somalia from 2017 to 2020: An

initial report of 1306 Cases. *Cancer Management and Research, 12*, 8599–8611. https://doi.org/10.2147/CMAR.S277202.

Wallerstein, N., Duran, B., Oetzel, J.G., & Minkler, M. (2003). *Community based participatory research for health: Advancing social and equity.* Jossey-Bass Publishers.

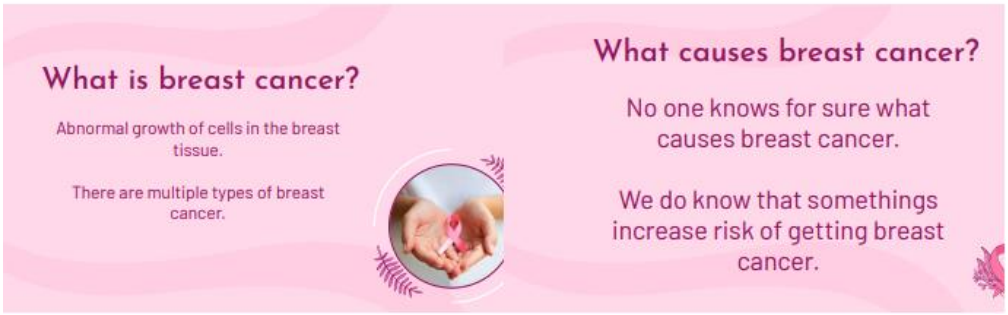
World Health Organization. (2020). *International Agency for Research on Cancer, Breast.* The Global Cancer Observatory. https://gco.iarc.fr/today/data/factsheets/cancers/20-Breast-fact-sheet.pdf.

World Health Organization. (2021). *International Agency for Research on Cancer, Somali.* The Global Cancer Observatory. https://gco.iarc.fr/today/data/factsheets/populations/706-somalia-fact-sheets.pdf.

Zhang, Y., McCoy, E.E., Scego, R., Phillips, W., & Godfrey, E. (2020). A qualitative exploration of Somali refugee women's experiences with family planning in the U.S. *Journal of Immigrant and Minority Health, 22.* 66-73. https://doi.org/10.1007/s10903-019-00887-5.

Appendix A

Education Session Slides



Risk factors for breast cancer

Having a risk factor does not mean you will get the disease.
Sometimes the reason women get breast cancer is unknown.

What does ***not*** cause breast cancer?

You ***cannot*** catch breast cancer from someone else.

You ***cannot*** get breast cancer from an injury to your breast.

You ***cannot*** get breast cancer by breastfeeding or not breastfeeding.

What are signs something might be wrong?

Signs something might be wrong:

- Pain in any area of the breast
- Fluid coming out of the nipple that is not breast milk
- A new lump in your breast or under your arm
- Any change in the size or shape of the breast
- Change of the breast skin such as looking thickened or like an orange peel

Sometimes NO signs at all

How can I protect myself?

How can I protect myself?


Screening Mammograms


Self Breast Exams


Consider breastfeeding your child


Healthy Lifestyle Choices

Breast Cancer Screening

Breast cancer screening means checking the breast tissue for cancer ***before*** signs of the disease show.

Breast cancer screening ***cannot*** prevent cancer but it can help us find it earlier making it easier to treat.

What is a mammogram?

Raajada naasku waa baaritaanka ugu fiican ee dhakhaatiirtu sameyn karaan si goor hore loo helo kaansarka naaska.

A mammogram is the best test doctors have to find breast cancer early.

Raajada naasku waxay heli kartaa kansarka naaska marka cabbirkiisu la'eg yahay iniin yar. Fud ama buro ku jira naaska waa in cabbirkiisu la qiyaas yahay hal xabbo oo ah jeeri (cherry) ka hor inta aan haweenaydu iskeed u dareemin.

Mammograms can find breast cancer when it is the size of a small seed. A breast lump needs to be about the size of a cherry before a woman can feel it herself.

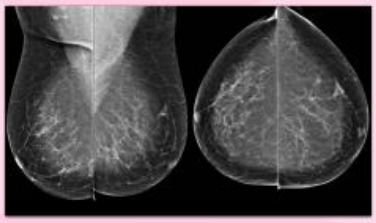
What is a mammogram?

Mishiinkan raajada naaska wuxu sawiro ka qaadaa gudaha naaska.

This mammogram machine takes pictures of the inside of the breast.

Uma keenaya wax dhaawac ah naasahaaga.

It will not cause injury to your breast.



What is a mammogram?

Mararka qaarkood raajada naasku waxay heli kartaa buro ama fud aanan kansar aheyn. Ama waxaa laga yaabaa iney gafto ama aaney arkin kansar meesha ku jira. Raajada naasku ma aha mid aad kaamil u ah laakiin isbedel weyn ayey ku sameyn kartaa haweenka qaarkood.

Sometimes a mammogram finds a lump that is not cancer. Or it may miss cancer that is there. Mammograms are not perfect but they can make a big difference for some women.

When to get a mammogram?

Women 50 - 74 years old should get a mammogram to screen for breast cancer.

If a woman has multiple risk factors, she should talk to her healthcare provider about getting a mammogram around age 40.

Talk to your healthcare provider about the best time for you to get a mammogram.

What is the cost of a mammogram?

Inta badan hey'adaha caymiska iyo Medicare ayaa bixiya qarashka raajada naaska. Isla markaana, meelo badan oo ah Maraykanka ayaa laga bixiyaa raajada naaska oo kharash yar ama bilaash ah iyada oo la adeegsanayo barnaamijyada qaranka iyo hay'adaha beeshada.

Most insurance companies and Medicare cover the cost of mammograms. And, in many parts of the U.S., low cost or free mammograms are offered through national programs and community organizations.

Mammogram Video

How else can I protect myself?

Self-Breast Exam

Know how your breasts normally look and feel.

This way you can notice any changes such as lumps or pain.

If you notice any changes tell your healthcare provider.

Breastfeeding

Breastfeeding can reduce risk of breast cancer.

Breastfeeding does not cause cancer.

Healthy Lifestyle Choices

Healthy Weight

Physical Activity and Exercise

Balanced Diet

Resources for You

Breast Cancer Screening:

- ScreenWise Home - Health Screening
  - Call: 971-673-0581
- Breast Center | OHSU
  - Call: 503- 494- 4673
- Breast Cancer Screening | Reducing Risk | Legacy Health
  - Call: 503-413-7600
- Breast Cancer Screening and Risk Reduction | Providence
- Oregon Free Mammograms
- American Cancer Society Resources

Reproductive Health Services:

- Oregon Reproductive Health Program: State of Oregon
  - Call: 971-673-0355
- Oregon Reproductive Health Resources
  - Call: 211

General Healthcare Resources:

- Mid County Health Center
  - Call: 503-988-5558

Talk to your healthcare provider about breast cancer screening today!

Survey #2

Your Age:

Number of years in the U.S.:

After the education session, do you feel you know more about breast cancer awareness?

□ Yes | □ Not sure | □ No

Do you feel you have a better understanding of the benefits and harms of the breast cancer screening?

□ Yes | □ Not sure | □ No

Would you bring up this topic with your healthcare provider?

□ Yes | □ Not sure | □ No

Do you feel like the education session was a helpful way to learn about the topic?

□ Yes | □ Not sure | □ No

Survey #2

Do you have a better understanding of available reproductive health resources?

□ Yes | □ Not sure | □ No

Do you think the education session was culturally respectful?

□ Yes | □ Not sure | □ No

Was our message and goal of the education session clear to you?

□ Yes | □ Not sure | □ No

Would you recommend this education session to others?

□ Yes | □ Not sure | □ No

Appendix B

Promotional Flyer

Appendix C

Participant Pre-Survey

Pre-Survey: Assessment of Participant Breast Cancer Awareness

Your age:
Number of years in the U.S.:

Have you heard of this topic before?
☐ Yes | ☐ Not sure | ☐ No

Do you know of the benefits of the breast cancer screening?
☐ Yes | ☐ Not sure | ☐ No

Do you know of the possible risks with breast cancer screening?
☐ Yes | ☐ Not sure | ☐ No

Have you talked about the topic with your healthcare provider?
☐ Yes | ☐ Not sure | ☐ No

Participant Post-Survey

Post-Survey: Assessment of Participant Views of Education Session

Your age:
Number of years in the U.S.:

After the education session, do you feel you know more about breast cancer awareness?
☐ Yes | ☐ Not sure | ☐ No

Do you feel you have a better understanding of the benefits and harms of the breast cancer screening?
☐ Yes | ☐ Not sure | ☐ No

Would you bring up this topic with your healthcare provider?
☐ Yes | ☐ Not sure | ☐ No

Do you feel like the education session was a helpful way to learn about the topic?
☐ Yes | ☐ Not sure | ☐ No

Do you have a better understanding of available reproductive health resources?
☐ Yes | ☐ Not sure | ☐ No

Do you think the education session was culturally respectful?

☐ Yes | ☐ Not sure | ☐ No

Was our message and goal of the education session clear to you?
☐ Yes | ☐ Not sure | ☐ No

Would you recommend this education session to others?
☐ Yes | ☐ Not sure | ☐ No

Participant Follow-up Survey

2 Month Follow-up Survey: Breast Cancer Awareness Education Session

Your age:
Number of years in the U.S.:

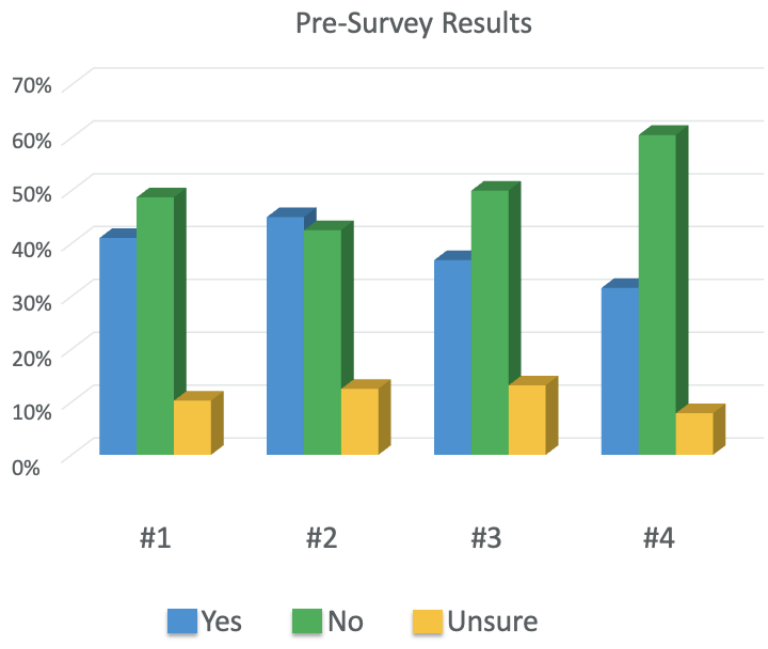
Do you think an education session is a helpful way to learn about health topics and resources?
☐ Yes | ☐ No

Would you attend another health education session?
☐ Yes | ☐ No

Have you told friends and/or family about what you learned at the (topic) education session?
☐ Yes | ☐ No

Appendix D

Pre-Survey Results



Questions:

1. Have you heard of this topic before?

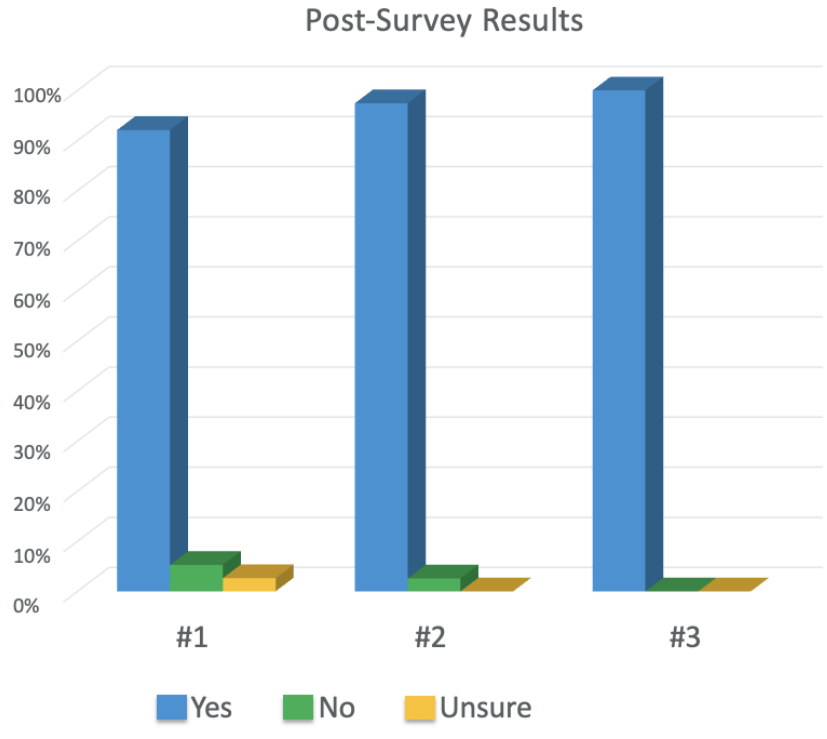
2. Do you know of the benefits of the breast cancer screening?

3. Do you know of the possible risks with breast cancer screening?

4. Have you talked about the topic with your healthcare provider?

OHSU

Post-Survey Results



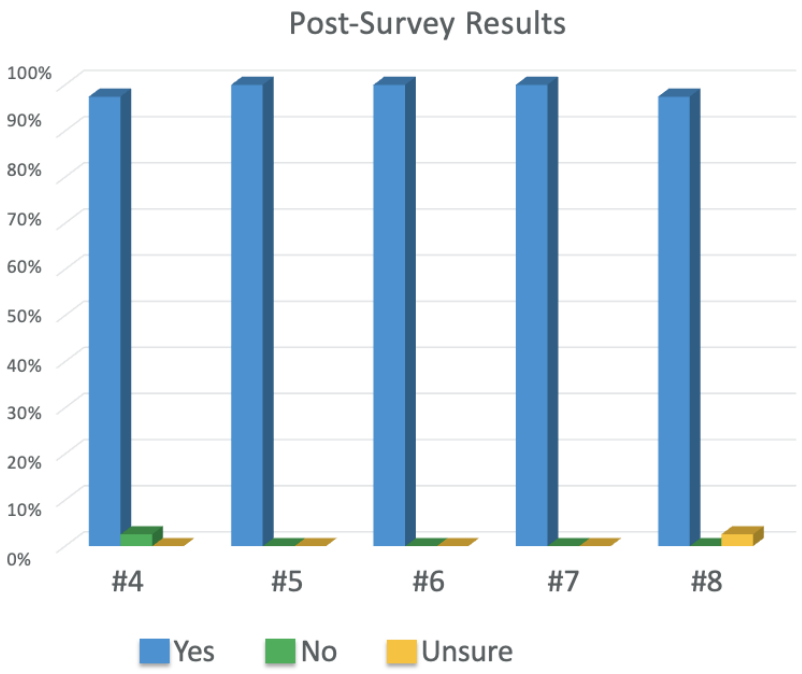
Questions:

1. After the education session, do you feel you know more about breast cancer awareness?

2. Do you feel you have a better understanding of the benefits and harms of the breast cancer screening?

3. Would you bring up this topic with your healthcare provider?

OHSU



Questions:

4. Do you feel like the education session was a helpful way to learn about the topic?

5. Do you have a better understanding of available reproductive health resources?

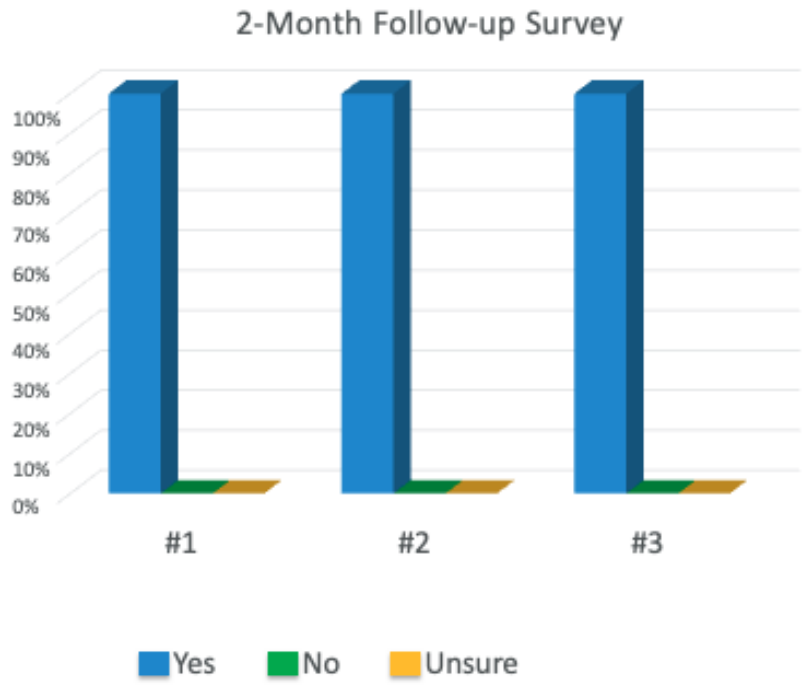
6. Do you think the education session was culturally respectful?

7. Was our message and goal of the education session clear to you?

8. Would you recommend this education session to others?

OHSU

2-Month Follow-Up Results



Questions:

1. Do you think an education session is a helpful way to learn about health topics and resources?

2. Would you attend another health education session?

3. Have you told friends and/or family about what you learned at the (topic) education session?

OHSU

Appendix E:

Consent Script

Reproductive Health Education Session for Somali Refugees

STATEMENT OF CONSENT FOR PARTICIPATION IN THE HEALTH EDUCATION SESSION

Purpose: This project aims to improve understanding of the education session topic and awareness of available reproductive health services in the local Multnomah County area.

Education Session: This session will consist of one 30-minute education session for interested Somali women like yourself. The participants will receive a $50-dollar Visa gift card. The education session will be led by an Oregon Health and Science University Family Nurse Practitioner, Doctor of Nursing Practice Student, and supported by the Center for African Health and Education community partners. The education session is evidence-based and aims to be culturally appropriate. An interpreter will be available and assisting throughout the education session.

Evaluation: You will be asked to complete a pre-and post-survey at the end of the education session. Pre- and post-education surveys will help us determine if education sessions help increase awareness of the specific topic and available reproductive health services within the community. We will also provide long-term follow-up surveys available in January 2023 at the Center for African Health and Education. The long-term surveys will help us learn how you used the information at the education session. A sign-in sheet will be necessary to account for gift care distribution; however, the sign-in sheet will be separate from the education session, the included session surveys, and all Center for African Health and Education resources.

Risks: Participation is entirely voluntary; if you choose not to participate in the education session or the surveys, it will not affect any Multnomah County or Center for African Health and Education services you receive. You do not have to answer any questions or comment on anything that makes you uncomfortable. Please only share information you are comfortable with others hearing. All participants must agree to respect the privacy and confidentiality of others in the group. No personal information will be collected as part of the education session. The education session facilitators and interpreter must respect the confidentiality and privacy of all participants.

Benefits: Participating in this education session and the surveys will assist Multnomah County Health Department and the reproductive health program, PE 46, titled Community Partnerships and Assurance of Access to Reproductive Health Services, determine if education sessions are an effective way to increase awareness of available reproductive health services. The goal is to help improve awareness and access to reproductive health care for vulnerable communities.

Incentives: Lunch from Namaste Indian Cuisine will be provided at the end of the education session to show our appreciation for your participation. The first 30 participants to complete the pre- and post-surveys will receive a $50-dollar Visa gift card.

Questions: Your participation is entirely voluntary, and you may leave at any time for any reason. If you have any questions about your participation in this education session and the evaluation, please feel free to ask them no or at any time during the session.

By participating in today's education session, you are agreeing to participate and respect the privacy of all individuals taking part in today's education session.

Appendix F

Initial Topic Survey

A Survey to Assess Reproductive Health Topics of Interest Among Somali Refugee Women: Somali Health Education Topics

Age:

What is your comfort level with asking about these topics to your healthcare provider?

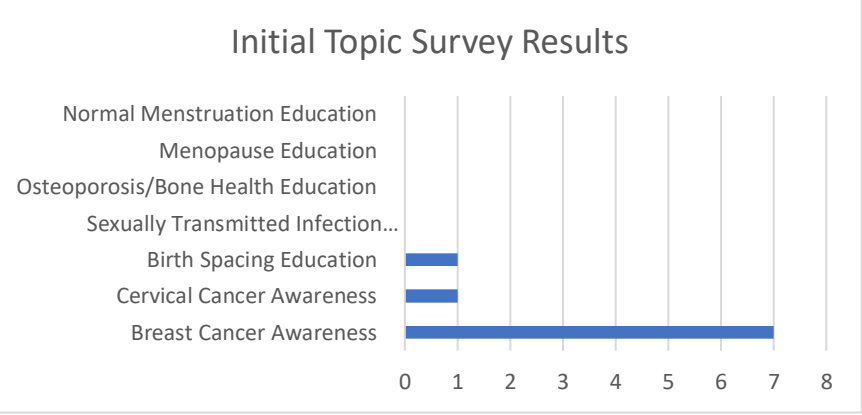
☐ Not at all comfortable | ☐ Somewhat comfortable | ☐ Comfortable

Breast Cancer Awareness	☐ Yes | ☐ No
Cervical Cancer Awareness	☐ Yes | ☐ No
Birth Spacing Education	☐ Yes | ☐ No
Sexually Transmitted Infection Awareness	☐ Yes | ☐ No
Osteoporosis / Bone Health Education	☐ Yes | ☐ No
Menopause Education Session	☐ Yes | ☐ No
Normal Menstruation Education	☐ Yes | ☐ No

What other women's health topics are you interested in learning about:

_____

This information will guide the development of a Women's Health focused education session which will be completed by a Family Nurse Practitioner, Doctor of Nursing Practice student in partnership with Oregon Health & Science University and Multnomah County Health Department.



Appendix G

Project Timeline

	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec-Mar
Finalize project design and approach (703A)			X					
Complete IRB determination or approval (703A)			X	X				
Phase 1 (703B) - Meet with CBOs to determine RH topic of focus and education session development					X			
Phase 2 (703B) -Participant recruitment						X		
Phase 3 (703B) -Education Session Implementation at CBO - Participants complete Pre- and Post-Surveys						X		
Phase 4 (703B) - Participants complete long-term survey -Review survey results -Share survey findings and education materials with MCHC providers								X
Write sections 13-17 of final paper (703B)							X	X
Prepare for project presentation and further information dissemination (703B)								X

Appendix H

Letter of Support from Clinical Agency

Date: *06/04/2022*

Dear *Kaylee Hopkins,*

This letter confirms that I, Charlene Maxwell, allow *Kaylee Hopkins* (OHSU Doctor of Nursing Practice Student) access to complete his/her DNP Final Project at our clinical site. The project will take place from approximately *June 2022* to *March 2023.*

This letter summarizes the core elements of the project proposal, already reviewed by the DNP Project Preceptor and clinical liaison (if applicable):

- **Project Site(s)**:
  - Mid-County Health Center
  - 12710 SE Division St, Portland OR 97236
- **Project Plan: Use the following guidance to describe your project in a <u>brief</u> paragraph.**

Gaps in reproductive healthcare increase the risk for adverse sexual and reproductive health outcomes. Combined with factors related to relocation, displaced persons (DPs) are an inherently vulnerable population at high risk of receiving inadequate reproductive health services (RHS); this is demonstrated by the fact that DPs consistently underutilize available RHS. Unmet reproductive health needs particularly endanger displaced women. These unmet needs increase the risk of unwanted pregnancies, preterm births, sexually transmitted infections, and sexual violence. This project will partner with community-based organizations (CBOs) to assess RHS understanding and utilization gaps among Somali DPs. An education session will be developed based on the most critical reproductive health education need among Somali DPs. The education session will provide patient-centered and culturally sensitive reproductive health education to promote health equity, increase knowledge of reproductive health services, and ultimately increase access to care for this population.

This project will be done in partnership with Mid-County Health Center, a Multnomah County Health Department clinic, and is part of fulfilling requirements for the Program Element 46 (PE46) titled *Community Partnerships and Assurance of Access to Reproductive Health Services.* PE46 provides funding for RHS throughout Oregon state, focusing on enhancing access to reproductive care, specifically for marginalized communities. Providing culturally congruent reproductive health education for Somali DPs will promote equitable healthcare and increase RHS utilization, aligning with the goals of the PE46 program.

The primary intervention is an education session based on reproductive health needs. Multiple studies show that focused education sessions specific to an aspect of reproductive health are an effective format for improving knowledge of available resources. The project will consist of 4 phases, including:

- Phase 1:
  An initial small group needs-assessment to determine topic of focus
  Education session development, development of the education session will be completed in partnership with Somali CBOs to ensure a culturally sensitive intervention
- Phase 2:

Session promotion will include flyers around CBOs and partnered clinics, and word-of-mouth promotion

- Phase 3:
  Implementation of the education session accompanied with a 3-point Likert scale pre-and post-survey to assess session effectiveness and measure improvement. Survey data collected will be handled appropriately with confidentially and will be de-identified. The education session will occur at the African Center for Health and Education.
- Phase 4:
  Analysis and dissemination of survey findings

During the project implementation and evaluation, *Kaylee Hopkins* will provide regular updates and communicate any necessary changes to the DNP Project Preceptor.

Our organization looks forward to working with this student to complete their DNP project. If we have any concerns related to this project, we will contact *Kaylee Hopkins* and *Rebecca Martinez* (student's DNP Project Chairperson).

Regards,

Charlene Maxwell, DNP Medical Director, focus on Child, Adolescent, and Reproductive Health
Multnomah County Community Health Centers
Charlene.maxwell@multco.us
971-337-6563
DNP Project Preceptor (Name, Job Title, Email, Phone)

_____Charlene Maxwell /s/_____ _____6/6/22_____
Signature Date Signed

Appendix I

Cause and Effect Diagram

Team: Mid-County Health Center, MCHD **Project**: Improving Access to RHS Among Somali Refugees

1) Input the effect you'd like to influence.
2) Input categories of causes for the effect (or keep the classic five).
3) Input causes within each category.