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Community Assessment of African Maternal Health in the Portland Region: Drivers for Community, Health Services and Institutional Change

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in the Portland Region:
Drivers for Community, Health Services and Institutional Change**

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IMMIGRANT & REFUGEE
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Table of Contents

Executive Summary	4
Research Methodology.....	5
Findings from African Leadership Council Forum.....	5
Findings from Focus Groups with African Mothers	11
Concerns.....	11
a. “They don’t care”	11
b. Pushing C-sections.....	12
c. Disrespect and Discrimination.....	13
d. Not enough information about child immunizations.....	14
e. Doctors unfamiliar with childhood conditions in the immigrant community.....	15
Systemic Barriers to Services	15
a. Language Accessibility	15
b. Physical Access to Health Services	15
c. Information on Health Services	16
Future Hopes and Dreams: Culturally Specific Health Services.....	16
Recommendations	18
References	20

Executive Summary

Disparities faced by Africans are formidable.¹ The stress of acculturation, trauma and tragedy, and isolation from formal support systems are pronounced for many African families. The health experiences of Africans is beginning to be documented in the literature, and issues identified more broadly are also being felt in the Portland region. Locally, we know that child poverty affects $\frac{2}{3}$ of African children, unemployment is at levels almost double that of Whites, and despite high levels of education, few are able to access management or professional roles, often due to the tightly curtailed access to recognizing foreign credentials. English language access is also tight – with more than $\frac{1}{3}$ of the community speaking limited English. Housing access is a challenge, and the constraints that landlords and regulators place on occupancy makes this more difficult, limiting the ability of families to replicate their living arrangements in Africa and reducing their ability to sustain stable housing. Notable is the increasing evidence that employment, working conditions and health is well-established, as weak economic conditions deteriorates health.² There is also emerging recognition that simply being a newcomer serves also as a risk to health, and we understand that immigration and the extensive time it takes to acculturate and gain social and economic footing has a harmful effect on one's health.³

Challenging maternal health and early childhood experiences place mothers and children at risk. In addition to the larger disparities in wellbeing (as signaled above), gender-related struggles in African families have a negative impact on mothers and children accessing health care. Experiences of disrespect and unequal treatment are abundant in the African community when seeking health care in Oregon. More than one-in-three African women had concerns about their treatment at the hospitals where they gave birth. This is similar to a level of concern about disrespectful medical treatment, where many studies, beginning with the Surgeon General's report that most health services are ripe with mistrust, stigma, too high costs, and clinician bias when they serve communities of color, and further evidenced in studies in the African community.^{4 5 6}

Particularly desired is the creation of a culturally specific health service for the African community, with specialty in providing maternal and child health services, as well as refugee supports for mental health. These findings, alongside local and national research reports as well as community input such as IRCO's Community Needs Assessment 2014 reiterate that there is a need for culturally specific maternal and children's health services.

This community needs assessment surfaces a range of health priorities faced by the African community. While the scope of the study is limited by time and resources, and strategically focused on maternal health, there are a wider set of upstream and downstream health challenges that impede the community's wellbeing. We encourage policy makers to remember these whenever health policies, and in fact all manner of policies and programs tied to the social determinants of health, are being considered.

African community members from the African Leadership Council gathered for a forum in early March 2015 to reflect on community priorities tied to the health and wellbeing of the larger African community prior to focusing on the issues related to maternal and child health. The priorities in this forum include a balance of the need for internal community services (such as health promotion and education and health access information), and improving the cultural responsiveness of service providers. The main body of this report contains the insights of the 56 African women who participated in six focus groups. Their voices guide us towards a robust agenda for improving maternal health, and, as was seen in the Leadership Council, a balance of health promotion activities, health information, and improved cultural responsiveness among service providers. They dream, as well, for culturally specific health services, aiming to build providers who hold African women's health and wellbeing as their top priority.

Research Methodology

A community assessment was conducted through two information gathering processes. First, a forum was held with the African Leadership Council, gathering eight community leaders to discuss the long-term health needs and strengths, alongside priorities for reform. Second, six gatherings of African women were conducted, via focus groups with the aid of trusted interpreters to bridge cultural or linguistic barriers. The goal of the focus groups were to define potential indicators with a culturally specific focus on maternal and child health highlighting concerns of African mothers. We also gathered priorities for the African Immigrant community for assessing and improving maternal health.

With the help of the Leadership Council, 56 African women were recruited to participate in six focus groups. Participants represented a diverse range of originating countries and cultures including Liberia, Democratic Republic of the Congo, Somalia, and Togo. We gathered in various locations to accommodate the participants such as private homes, churches, Africa House, and the Togo Core Center. Each focus group lasted from ninety minutes to slightly over two hours and in keeping with tradition, was generously complemented by a meal provided by the host.

Protocols and focus groups questions were developed by the researcher and reviewed by members of the Leadership Council. Revisions based on the recommendations of the reviewers were then integrated into the questions.

Transcripts were reviewed and summarized and then coded using qualitative analysis software (using Atlas.ti). We employed a thematic analysis using both an inductive and deductive approach. We first inductively analyzed interviews while paying attention to important themes related to maternal health care experiences of the focus group participants. We then used a deductive approach to look specifically at participant responses to focus group questions.

Findings from African Leadership Council Forum

The host for the study was the African Leadership Council and they were involved in establishing a set of community-wide priorities. Summarized below, we find that the community has strengths that are tied to their shared identity and bonds of culture and experience. Informal networks link many together, and information can flow readily across these networks. Organizations such as Africa House and the African Women's Coalition add structure and opportunities to these connections. While most often these networks serve as assets for the organization, they can also serve to limit access to services: *"a community member was not given enough pain killers at dentist office so person endured terrible pain; person did not return to complete treatment and many in the community now won't seek out dental care."* While most often these networks positively serve and protect the community, they can transit experiences which lead to decisions to not seek care.

The pattern of health needs are tied to three significant factors: (1) refugee and newcomer needs, (2) health information and health promotion activities, and (3) unwelcoming and disaffirming health service providers, who are sorely in need of cultural understanding and culturally responsive service adaptations. Examples include significant concern over the quality of services received and the absence of culturally

responsive health providers. Stories abound about errors and omissions that readily permeate the community, and serve as a disincentive for seeking care:

[Lots of people talk about getting] inappropriate prescriptions and missing the early stages of diseases when treatable so by the time the patient ends up in hospital, the disease is in late and more serious stages.

Some of the community has non-prescribed use of ampicillin because there is a belief that the doctors don't want you to get better, so you need to treat oneself.

U.S. doctors have been trained to work on Americans. They have no training on voodoo and traditional healing, and they just don't understand us.

We also heard stories of appreciation for culturally responsive practitioners:

One parent told a western provider that it was important to take their child back home to a river to heal their frustration and depression. The doctor respectfully asked for some time to try western treatments. Eventually the child responded positively to treatments [without needing to head home].

The community also identifies issues such as acclimatization to western diets, activities and general life experiences. Unmet mental health needs are significant and the stigma associated with it prevents the seeking of support. When the content of the chart that follows is reviewed, it becomes clear that change is needed both within the community (in terms of health education and promotion) and the services available for community members (in terms of cultural responsiveness).

The priorities in the following chart detail their insights, and it is important to notice both the overlap with what are recognized as best practices for refugee settlement, as well as the divergence. Consolidation of these priorities appears in the work of the United Nations High Commission for Refugees, but extends them considerably into the policy environment in the areas of economic, social, cultural and political needs. Loosely framed as a human rights approach that should be available to all residents and citizens, the United Nations High Commission on Refugees (UNHCR) highlights the conditions that lead to integration in all arenas of life, and identified as the following:

1. "Restore security, control and social and economic independence by meeting basic needs, facilitating communication and fostering the understanding of the receiving society;
2. Promote the capacity to rebuild a positive future in the receiving society;
3. Promote family reunification and restore supportive relationships within families;
4. Promote connections with volunteers and professionals able to provide support;
5. Restore confidence in political systems and institutions and to reinforce the concept of human rights and the rule of law;
6. Promote cultural and religious integrity and to restore attachments to, and promote participation in, community, social, cultural and economic systems by valuing diversity;
7. Counter racism, discrimination and xenophobia and build welcoming and hospitable communities;
8. Support the development of strong, cohesive refugee communities and credible refugee leadership;

9. Foster conditions that support the integration potential of all resettled refugees taking into account the impact of age, gender, family status and past experience.”⁷

Overlapping items center on #6, 7, and 8, and to a lesser extent in items #1 and 2. The degree to which mainstream society welcomes Africans, and the degree to which it demonstrates both capacity for and willingness to adapt to practice inclusively is contested. If #9 (on fostering successful integration) were to be given political and institutional priority in the region, there would be considerable willingness to become open to learning how to be culturally responsive and inclusive.

Divergence occurs when the UNHCR identifies the importance of social and economic independence, but the community stops short of saying that these issues are to be addressed by mainstream society. It takes considerable self-confidence and an appropriate level of entitlement (requiring one consider themselves and their community as deserving of society’s resources) to hold such expectations.

The community’s strengths, as shown below, are those that prepare them for resourcing each other to share information, to extend themselves to support each other with pragmatic needs such as child rearing, information about navigating the systems, and encouragement when things are tough. The community also steps in and supports those who cannot afford housing, and prevents homelessness. The community culture is strong and resilient. The children raised in these environments may face risks in both their traumatic histories as well as their poverty and low income, but they have considerable assets in terms of academic effort, being respectful and becoming bicultural and bilingual. These are assets that should be tapped into to enhance education and human services, as resources that could strengthen the network of services available to the community. The message is that mainstream society needs to consider African children and families as assets to the region, with insights on how to support marginalized communities, how to survive and even thrive in the midst of severe distress, how to practice with inclusion and how to support everyone to participate in a range of systems and institutions.

African Leadership Council Assessment	
African Women/Family Health	
Needs	Strengths
<ul style="list-style-type: none"> • Help with domestic violence • Language accessibility • Adapt to US culture • Lack of vitamin D and don't know it • Overweight - less activity and manual work than in home country • Wait too long to get disease diagnosed resulting in serious conditions • High prevalence of diabetes, high blood pressure, liver cancer, breast cancer⁸ • Trauma and rape in refugee camps • Oral health - fear of dentists; sometimes use potions instead • Local cultural healing potions for diabetes and high blood pressure (sometimes useful if they believe in it) 	<ul style="list-style-type: none"> • Culture of respect and responsibility for each other, for raising kids, supporting each other • Multigenerational families • Extended family that share child raising • Bonds together are strong e.g. obligation to each other • Not lost ... have hope in the face of USA stressors • More natural because need each other in the U.S. • Resilience - faced horrible trauma for 15-20 years in refugee camps • Patience
African Child Health	
<ul style="list-style-type: none"> • Trauma in refugee camps discourage the; witness trauma and death; may witness mother being raped • After move to US - child health comprised by poor living conditions (including mold, toxic environments (chemical), and poor diets. • Children here are suffering but parents don't go to hospital enough to get diagnosis • Oral health - prevalence of tooth decay is high; need education about hygiene • After some time in U.S. (as depressed and frustration grows) children display less respect for family and teachers (seen as Emotional illness by community). 	<ul style="list-style-type: none"> • Kids are active • Work & study very hard • Want to get As - parents push them to succeed • Strong immune systems - rarely get flu or go to hospital (if born outside of U.S.) • Low levels of asthma • Natural food diets contribute to strong immune systems • Children are respectful (80% estimate) • Being bicultural and bilingual
Mental and Emotional Health	
<ul style="list-style-type: none"> • High levels of depression • Nightmares (parents and children) • Undiagnosed mental/emotional issues, as result of depression and anxiety of growing up in refugee camps • Non-acceptance of illness, don't want to go to provider; mental illness considered as "I'm crazy" • Frustration • Talk to themselves • Other psychoses (e.g. schizophrenia) • Single new arrivals ... lots of alcohol and drug use ... may lead to homelessness • Stress on family and community care givers if the person they are caring for is depressed • Denial of illness 	<ul style="list-style-type: none"> • Resilience • Belief they can deal with problems themselves • Prevalence of mental/emotional health is low for community members

Mental health issues did not surface in the maternal focus groups. Such issues are, however, pronounced across all refugee communities and while we often focus on the internal disincentives for seeking care (such as stigma and lack of identification of needs related to trauma), there is new research identifying that the provision of care may be just as much of a barrier:

Newcomers [of color] face discrimination based on their skin color, language proficiency, culture, and immigration status. [Canadian data] show that newcomers [of color] are more than twice as likely as White immigrants to perceive discrimination (after controlling for gender, education and fluency in English or French).⁹

In another study, the failings of mental health providers are pronounced among people of color, in general, with service providers demonstrating that racial bias is pronounced, and service users of color “feel misunderstood, alienated and stigmatized when accessing mental health services, and feel that their experiences of race-based discrimination are often dismissed and discounted.”¹⁰ This study reminds us of the report of the U.S. Surgeon General’s ground-breaking report on health disparities in the U.S.A. that launched the issue of racial disparities across the health care system into the national spotlight back in 1999.

In a compelling conclusion in a 2009 study of immigrant youth, the author asserts (and in doing so, reinforces the prior work of the authors in determining protocols for the development of culturally specific organizations):¹¹

Mainstream service providers need to embark upon thoughtful, coherent and system-wide efforts to integrate cultural diversity into all organizational aspects, including governance, policies, resource allocation, communication plans, effective intercultural community relations, personnel practices, service delivery and evaluation.¹²

The types of needs that we expect African children and youth to face would include the following:

... unique mental health, social and emotional challenges... relate to pre-migration experiences and to the experience of settling... including adjusting to school, intergenerational pressures and increased family responsibilities.¹³

Underuse of mental health services is documented in the research. Newcomers who have been in the country for less than 15 years are much less likely to use mental health services than longer term immigrants and native-born residents, and that this pattern is particularly true for women.¹⁴ Addressing stigma on a community wide basis, in addition to addressing the bias and lack of cultural competence held by service providers is recommended.

When we invited the African Leadership Council to discuss their perspectives of the types of services they receive, they specifically noted the challenge with their own knowledge (health terminology, and popular beliefs that might be based on one bad community experience), but the main set of perceptions are that the community is not well served by health providers, or by police. Their insights are detailed in the following chart.

Health Services Provided	
Needs	Strengths
<ul style="list-style-type: none"> • Education about correct terminology • Police pickup homeless; spend few days in jail; released and cycle begins again • One bad experience with provider of a community member and the entire community is deterred from getting services • Doctor's don't pay enough attention or treat community members well • Preventative health education and treatment • Choice of doctor is limited; want doctors who have experience with African health issues • Better pain management & options • Not enough advocates within medical system • Culturally-specific services • Bilingual/bicultural staff • Language accessibility • Health system doesn't recognize African issues - seen same as African Americans • No respect for people's cultural & healing beliefs 	<ul style="list-style-type: none"> • Advocates • Advanced medical procedures • Technology & Infrastructure • Open to cooperate (when advocates show up) • Lots of money within the health system

We also asked the community to identify what they perceived as the upstream causes of their distress. Obviously, poverty and low incomes impede all health outcomes, and parents struggle with, as one community member said, *“Health care is considered a lower priority when measured against living expenses like rent and food.”* Below are their responses:

Upstream Causes of Health Distress
• U.S. culture changes family dynamics
• Food/Diet - forced to buy cheapest options
• Lived through civil war
• Homeless or inadequate housing
• Families split up both in Africa and also to adjust to occupancy limits on housing
• Bring home issues here (such as experiences in refugee camps, civil war, tribal conflicts, and long term unemployment)
• Barrier to accessing resources
• Joblessness
• Low income - if can't pay rent & food, health needs slide
• No health insurance
• Settlement of bills - don't know they can pay with credit cards

From our perspective, Portland needs to take these broader policy recommendations to heart, beginning with a clear articulation from our leaders that newcomers are assets to the region, and that we cannot assert our regional advantages until we improve racial equity and inclusion for all. Look for a report from the New Portlanders Policy Commission in the coming months that will highlight the concrete goals we hope will be embraced by the City and County to generate a more robust welcome to newcomer communities.

Findings from Focus Groups with African Mothers

Concerns

African women gathered to discuss concerns in hopes that the process would elevate and carry their concerns to the right places and result in improvements for health care of all African community members.

So we need someone to talk about it (health care concerns) and to talk on our behalf.

We need your help. We came here thinking that we will be helped as refugees.

Some participants also brought specific questions to the focus group in hopes of finding answers, for instance asking how to deal with breast-feeding problems or where to learn about available resources for the cultural needs of their male children such as circumcision (not covered by insurance). The following themes in this section were discussed as a response to a question asking participants about their greatest concerns with regards to maternal health care in the U.S.

a. “They don’t care”

Focus group participants talked about their interactions with medical professionals in the U.S. as impersonal and unsatisfactory often saying, “They don’t care.” Coming from various African countries, women talked about having experiences with medical professionals in other countries (in Africa and Europe) who treated them with love and compassion. The women described a much more relational experience with doctors in their sending countries than they had found in the U.S., saying:

In Africa, you feel that the medicine and the doctors they care about you and the baby and taking care of you, caring for you, but here it feels that they care more about the system and they leave you.

Here I don’t feel there is no initiative to build some relationship with your patient - they are not involved in my health. They are always in a hurry to get out. At home in Africa they build a relationship. They know you so well...they know exactly where things stopped the last time.

Even if the place is not equipped well they prefer being there (in Africa) because they see some love, concern and care... the medicine you give to people is (also) your conversation... “Hello, how are you? Have a seat.”

One woman expressed wishes that doctors were not “cold” but instead could be more comforting and reassuring even when they couldn’t do anything for pain during pregnancy rather than being told to “just sit it out.” Some participants linked the lack of relationships with their doctors with a lack of trust and respect for the patient that led to redundancy in questions, “... the doctors don’t trust her – ask(ing) the same question repeatedly.”

Other women cited examples of being left alone while in labor for hours even though they might arrive at the hospital without any supporting family members or with only their husband (who would have to leave

during delivery for cultural reasons). An inexperienced young woman who accompanied her sister to the hospital described her anxiety and dismay about being left alone here:

When they brought us to the so called delivery room they did the exams and they said no, she is not ready yet, then they put us in another room and they forgot us over there. No one came to see us anytime. She was in pain but I was calling them, they were just coming and look (from) far (and leaving again)

Being left alone when in labor (or in the emergency room), lack of compassion from health providers, and lack of trust were voiced as reasons for beliefs that health care professionals were uncaring, uninformed and unprepared to provide the best medical care for African women.

I didn't have contact with my husband and they doubted me with regards to my pregnancy dates ... They don't trust. Went through some labor but the child had died so ended up having a C-section.

African women in our focus groups clearly placed a high value on the relationship between doctor and patient and had many experiences before arriving in the U.S. (and for a minority in the U.S.) that reinforced the link between caring and compassionate doctors and good health care.

The experience of distant, emotionally-devoid health providers is demonstrated in the literature. A study of 34 Somali women ties this to a combination of disrespect on behalf of the health providers, and palpable senses of prejudice and bias.¹⁵ Wearing traditional dress and hijabs, as well as sharing details of Muslim religion exacerbated negative treatment.¹⁶

b. Pushing C-sections

Across focus groups we heard many stories about health care providers “pushing” procedures during labor and delivery that were both unexpected (i.e. had not been previously discussed) and seemed unnecessary such as the use of epidurals for pain and C-sections. Early termination of pregnancies, inducement of labor, counseling about being too old to become pregnant, and recommendations about using formula over breast-feeding were also received as inappropriate and clear signals that the U.S. medical professionals had little experience with maternal experiences and practices within African countries. In circumstances where female extended family members were not available to accompany the expectant mother and no advocate was present, women were left to fend off the persistent and often threatening recommendations (about endangering their newborn) from attending medical professionals during the arduous labor process.

Focus group participants felt that doctors were motivated to induce labor, perform C-sections and shorten pregnancies by the higher cost of such procedures.

They wanted to induce the baby which is Un-African. (The mother) wanted to wait until the right time even if is past the due date. They wanted her to have epidural. She was given liability papers to sign “if the baby dies it’s my fault” because she wanted to wait beyond her due date as she believed the baby was not ready to be born. She eventually had a C-section.

I like the way they do things (they have tools and knowledge) but the system is just pushing C-section. She suspects that the greater income from a C-section rather than vaginal delivery is driving

decisions to perform C-sections.

Seems like in the US the emphasis is on giving pills and medication rather than considering natural healing options.

African women preferred following the natural rhythms of pregnancy and labor (without C-sections) whether children took a longer or shorter time to be born than predicted by due dates and especially when they had experienced multiple childbirths previously.

When looking at what the literature says about the frequency of African women having C-sections, we find that this prevalence is confirmed in the literature: “The rate of C-section among Somalis [are] twice as high as that of American-born counterparts.”¹⁷ Additional sources also document this disparity¹⁸ and flag that these high levels are also associated with negative outcomes such as fetal distress and higher stillbirth levels.¹⁹ Qualitative research studies also emphasize the fears this brings for African women, and the culture of pronounced discontent that occurs between the community and hospital delivery care.²⁰

In the literature we also find an interesting and complex set of explanations:

- One interesting factor in the discord that African women often find with health providers has some rooting in what may be longer terms for pregnancy, with one study saying that: “Somali women have a nine-fold risk of giving birth past 42 weeks of gestation as compared with their American-born counterparts.”²¹ It is believed that this can catalyze impatience among health providers to deliver. Literature also reveals that deliveries take longer with African women.
- The high levels of “female genital cutting” (or “female circumcision”) is slowly gaining commentary in culturally sensitive literature. Narratives from African women give voice to the discomfort that obstetric staff have with their genitalia and are rushing into C-sections as opposed to exploring episiotomies and waiting for natural births to occur.²² This has been confirmed in at least two studies in the UK, Norway and Sweden where health providers state that lack of experience and preparation for working with circumcised women is causing doctors to do C-sections.²³
- There has been a de-skilling of neo-natal health providers over the years, and heavy reliance on fetal monitors which actually limits women’s mobility in the delivery room, and narrows the likelihood they will be sufficiently active to bring on birthing.²⁴
- The political economy of hospitals results in billings that are higher for C-sections than natural deliveries, and this can be responsible for pressure for the use of C-sections.²⁵

c. Disrespect and Discrimination

Although a minority of focus group participants (6/56) related positive experiences with their doctors who were culturally competent (e.g. respecting their headscarves), many others shared stories of disrespect and discrimination in their interactions with the U.S. health care system.

Some discriminate because of your weight, your race, and your gender... if the doctor is a male or a female it affect for connection wise.

Just the way you look is making people judge you.

When I go to the hospital they look my chart, they know what's in my chart and they don't judge me. But if I go to the emergency room and the moment the doctor pulls out my chart their whole face is changed. Based on your medical condition... Even if they have no idea about you, they face change based on what they see in the computer. So is just messed up everywhere.

I see all the time with others when I translate, example, I translated for older couple who were not treated well. It makes me want to cry. Tone of voice was mean and condescending.

African women talked of feeling as though whatever they were going through just “didn’t matter” to the doctor who seemed to rush through the visit or the medical professional that talked down to them.

There are several discourses that have surfaced in the literature about the reason for inequitable and insensitive treatment. These include heightened racism towards Muslims in the post-9/11 USA, as well as health traditions that include the use of potions, self-healing, indigenous spiritual healing practices carried over from Africa²⁶ (and sometimes necessitating a return to Africa), and the pervasive “foreigner” discourse that positions newcomers as “alien” and “not American” as opposed to a valued community member with a wealth of diverse experiences. The core recommendation is obviously for service providers to “unlearn” their racial, linguistic, and cultural bias, and for the institutions that house these services and service providers to embark on serious efforts to become culturally responsive.

Anti-Muslim beliefs in the USA are a post-9/11 phenomenon and the work of hate groups have been advancing an environment of hostility over the last decade. In the work of the Southern Poverty Law Center, the portrayal of the community is “irrational, intolerant and violent.”²⁷ With the focus of the Republican candidates in the 2016 presidential campaign advancing anti-Muslim beliefs, it is likely the type of prejudice and bias against many in the community will intensify in the coming years. Locally, we hope for leaders to stand opposed to such hatred and follow the call for affirmation of all newcomers, and ask for elected leaders:

...to proactively affirm that all newcomers are essential to the fabric that is Portland and Oregon. Speaking out is needed to support the community. When indignities are loaded onto the community, the injustice needs to be voiced. When wars and turmoil besiege newcomer families in their home country – they need warm encouragement and active enlisting of support. When community members are spoken of in derogatory ways, newcomers need defending. In short, newcomers want to rely on the support of political leaders to assert the moral authority of inclusion; we need a strong public discourse that values all Portlanders.²⁸

d. Not enough information about child immunizations

African mothers expressed frustration over the lack of information and education about immunizations for their children, being told only that immunizations were “required by the state.” Coming from countries where immunizations were given on different schedules they had lots of questions that went unanswered by the medical professionals. They were unsatisfied with the written information that they received to take home and wanted time to discuss their questions with the doctor.

Back home it is much more emphasized than here. There they teach you and make sure you take your kids. Here they assume that you know but sometimes you don't know.

e. Doctors unfamiliar with childhood conditions in the immigrant community

One mother shared an experience with a U.S. doctor that left her with worries about the health care of her child. She expressed doubt in the current doctor's ability to treat a condition that had been diagnosed in Kenya before her arrival in the U.S.:

Other issue is my daughter, she has a big belly and in Kenya they said there was something wrong with her digestion ... we came here and they sometimes prescribe something but it hasn't helped much.

Systemic Barriers to Services

Newcomers' inexperience with a health care system in the U.S. that is very different than in their countries of origin, creates confusion about what is covered under the new health care plans, and a lack of knowledge about available resources combined to create a multitude of barriers for the African mothers.

a. Language Accessibility

Language accessibility continues to be a formidable barrier for many African women especially new arrivals who are unaware of interpretation services (and how to access services) provided by health care and county resources. Participants preferred interpretation in person rather than over the phone as some described having to use visual cues at times. Some women described problems finding interpreters who spoke the same dialect. On the other hand, African women who spoke English (and had private insurance plans) were most likely to find providers who were culturally competent and encouraged their patients to speak out when they were uncomfortable with any recommendations or had preferences for maternal health care.

b. Physical Access to Health Services

Making appointments were seen as problematic as they resulted in long waiting times to be seen and most difficult for those who had limited access to transportation. Mothers with other young children would also have to make arrangements for childcare and transporting children in addition to finding transportation for themselves with the additional financial burden of associated costs. Participants would prefer walk-in clinics where they would have more flexibility in planning travel and childcare arrangements.

Back home when you feel sick you go directly to your clinic or your hospital, but here when you feel really sick and need a doctor you go to the clinic and they ask you to book an appointment.

Transportation was a considerable obstacle both in terms of cost and access. Even when transportation resources could be arranged childcare could become a secondary obstacle as with one mother who talked about having to take a second sick child with her for another child's appointment when she could not afford childcare, saying:

It was a desperate situation for me because I'm by myself with all these kids ...Transportation is really a problem too because one day they sent a driver to pick up the kid who is sick but I couldn't leave the other one who is sick too and they could only take one boy and his mother. How can I leave this one by himself? And they didn't take me.

A large number of newly arrived African mothers had expectations that visits to the doctor's office, clinic or the hospital would not only result in a diagnosis but also medication to treat the diagnosed illness. But they

were disappointed to learn they would have to arrange to travel elsewhere for medicines. “Whenever you go to the hospital and get attention they just perform tests and tests, they don’t give you any medicine”. Being directed to pharmacies for their prescriptions created anxieties and challenges due to additional costs for medicines and transportation.

c. Information on Health Services

A great deal of frustration and confusion was expressed over what was covered under the new Oregon health care plan. Several women were disappointed that they could no longer choose which clinics or doctors to visit. Others talked about not understanding why they had received bills for medical care, which they thought, should have been covered by OHP. A priority issue for many of the mothers was not having circumcision for their male children covered by OHP and the stress they were suffering as they tried to find the money to pay out of pocket for a surgery considered important to their respective cultures.

Finally knowing how and where to find out about available resources (in their own languages) that could potentially address many health care associated needs (like childcare and transportation) was daunting and seemed to fuel the feelings of hopelessness with a system that didn’t seem to care.

Future Hopes and Dreams: Culturally Specific Health Services

Following up from the recommendations from both the Leadership Council as well as earlier recommendations in the “Unsettling Profile” report, the concept of culturally specific health services have remained a dream of the community. Further developing this theme was a question brought to the focus groups: “If you had an African Maternal Health Center, what would it look like and how would it operate?”

African women expressed real joy when talking about hopes and dreams for how the center would look, feel, and provide for their community. First the center would employ community members who spoke the many languages of the African community. The center would be decorated with the flags of their home countries and have traditional African music playing at all times.

It will have pictures, food, languages, it will give the image of Africa ... would like to see a banner that says “welcome Africa,” in her language.

Health professionals could be from any country as long as they had significant experience working in African countries and understood and respected African cultures (speaking the language of the patients would be paramount). Female doctors would be available for those who requested them. Walk-in clinic services would provide for patients who could arrive at any time for services. Education opportunities for mothers and families around child nutrition and immunizations would be offered regularly. Relational principles and respect for cultural wisdom would guide every interaction between doctor and patient.

I like it when they make you feel like you're somebody and your life matter. And when they say well what do you think? What would you like to do? What would you like me to do for you? I like that.

Doctors need to listen to the patients. There are some things that we know and some things we do not know. We come from Africa. Africans back there do a lot of things without hospitals, take care

of kids without hospital, went to hospital when is necessary. We don't have insurance back home to go to hospital. We don't like hospitals, We go to hospital when is necessary. We take care of our kids, we know how to take care of our kids, we know what to do, and there are times we don't know so we go to the doctor. But if the doctor is patient enough to listen and see what they can do, it would help a lot. In a good hospital doctors are understanding so they can be able to treat you.

Participants added the following wish list of what they wanted from an African Maternal Health Center, organized into key themes they want addressed.

Caring relationships with providers

- “They treat you like a human being and don't make you feel like it is all about the money. It makes you feel good if they call you by your name”
- Doctors need to be able to listen
- Love and compassion to be palpable throughout the center

Understanding of African health concerns and community history

- Doctors understand their patients and put themselves in their shoes
- Time, effort and positivity. A “positive mind set can help for the transformation” in the culture shift from Africa to the U.S.A.

Expansion of resource availability:

- Resources to help situations that insurance do not cover
- Resource center with supplies like contraceptives

Responsive services provided:

- Counselors for depression or someone to talk about (personal) situations
- Pre-doula and post-doula service: “Most people come from Africa and they don't have family here, they have kids, they have to be at the hospital by themselves. She has no experience and a doula can help.”
- Low cost or free doula services provided
- Immunization education
- Education classes around prevention for women and young children
- Free training from people in the community sharing experiences

Shared identity with service providers:

- Having people who represent the community, that know the people and their problems and develop confidence in order to talk
- Female doctors for women who request them. The importance of having female doctors is extended for most women who identify as Muslim, and seek for all health providers to be female, was affirmed in a research study which stated:

Muslim women want the option of receiving care from an exclusively female staff. Muslim and Hindu women bemoan gowns that fail to cover them appropriately, and ask for head covers in the operating room.²⁹

Recommendations

Improvements to services form the central set of recommendations for this project, and surfaced in three ways: explicitly in the African Leadership Council forum, directly by the women in the focus groups, and implicitly as frequently contained in the narratives told in the focus groups. We also, at the close of this report, identify recommendations for a change agenda that could be led by the African community. These recommendations are supported by the fullness of this report, including the literatures that were reviewed for the study.

To begin, we identify the tri-level change recommendations that were raised by the Leadership Council. Of note, there is an elegance and a powerful imperative voiced in these ideas to provide services directly for the community, and those to improve both policies and services. This theme will again be voiced at the close of this report. While the specifics of these recommendations are less about maternal health, the scope of the approach is similar to the issues raised by African mothers, as will be seen in the next set of recommendations.

Intervention Options		
Help our community directly	Improve Policies	Improve Services
<ul style="list-style-type: none"> • Health prevention training • Education to build awareness on chronic illness • Conflict resolution training • Education about oral health prevention • Training on how to choose a doctor or to know that we have options although few • Advocacy supports in health care system • Definition of mental health is confusing for community who has referred to this as emotional health in country of origin. • Know our rights especially for African women 	<ul style="list-style-type: none"> • Disaggregate data - separate African data from African American data • Use community advisors to settle issues before resorting to judicial system • Dedicate financial resources to culturally responsive expansion • CCOs - create policies to "put teeth" behind equity requirements (new policies that focus on accountability for adherence) within public institutions. Need different levers for private institutions. • Additional upstream policy changes that have been addressed in previous reports. 	<ul style="list-style-type: none"> • Screening with follow-up care about results and treatment • African doctors and dentists needed • Hire bilingual African health providers • Get professional schools to learn more about African issues and how to best treat • Train service providers by sending overseas to work in African clinics • Bring African doctors to the USA to train doctors here

Service improvements prioritized by African mothers who participate in the focus groups are identified in the following set of priorities:

- Centralized information, both online and at service locations that provides health information that is relevant for African newcomers. This should be developed under the leadership of African newcomers who know their questions and information needs.
- Cultural competency training for health care professionals who work with the African community, stretching just beyond individual practice improvements and into the culture and climate of the service itself, who it hires, and how it identifies priorities for improvements.
- Create a culturally specific health service for Africans with specialty services for African mothers

- Expanded opportunities to engage and train African women as community health workers
- Education classes for nutrition and immunization
- Data disaggregation of indicators for maternal health of African women
- To address transportation difficulties, two recommendations exist:
 - Expanded home visits program for African women to educate about health care related resources (including transportation and childcare)
 - Subsidize transportation costs to reduce access barriers
- Resources for training and providing culturally competent doulas to support maternal health care needs of African women

An emerging theme in this community health assessment is that African advocates are being directed, through the information gathered, to embark on a tri-level change process:

1. Directing efforts to promoting the health system literacy among community members as well as learning more about health promotion and disease prevention;
2. Identifying key health institutions that are willing to enter a deep partnership with African advocates to: (a) learn about the African community and health provider needs, (b) identify culturally responsive service improvements, and (c) remain in partnership with the community so that there can be a continuous learning cycle adopted by the health institution. Tracking this process and relevant service improvements could serve as a valued resource for replication of this effort in other health institutions.
3. Advocating for policy improvements that are relevant for African women. One example would be for Coordinated Care Organizations to be held accountable for their adoption of culturally responsive service protocols.

Such a tri-level change effort would achieve several benefits:

- Communicate to local African women that there is nothing deficient about their bodies or the scope of their needs because the health advocates would be pressing not only for community enhancements but also for broader institutional and policy change. This would effectively identify that change needs to happen for both service providers as well as community members.
- A partnership approach to institutional change, alongside raised health literacy and health promotion practices, would likely satisfy health providers that the partnership is real, and not just identifying deficiencies in the health providers.
- Gain knowledge about how to improve services in ways that could, in subsequent efforts, address health needs in other non-dominant communities.

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