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Experiences of Refugee Women in Accessing and Utilizing a Refugee-Focused Pre-natal Clinic in the United States: A Mixed Methods Study

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Abstract

Recently, there has been a significant increase in individuals seeking refuge in many western countries. Upon arrival, refugee women face challenges in accessing and utilizing critical prenatal care. We conducted a mixed-methods study, combining a patient exit survey and focus groups to understand the experiences of multi-ethnic refugee women in accessing and utilizing a specialized prenatal care service in Arizona, United States-Refugee Women's Health Clinic (RWHC). Clearly, refugee women recognized the importance of prenatal care. Self-motivation, support from partners, community members, and trained health advocates, who provide logistic and language support were critical drivers that promoted prenatal care utilization, as these drivers addressed any barriers that limited their capacity to engage. Those who engaged with RWHC had a positive opinion of it, evidenced also by the high satisfaction index scores, irrespective of ethnic background. Our research shows a clear justification to scale-up such specialized prenatal services for refugee women.

Keywords: *Refugee; Immigrant Population; Maternity Care; United States; Patient Experience.*

Backgorund

Since 1975, over three million refugees, including women have been received in the United States (U.S.) [1]. Recently, there has been a significant increase in individuals seeking refuge in western countries like the U.S. mostly due to conflict in parts of the Middle East and the horn of Africa [2, 3]. The current trend shows that one in every 122 persons across the globe is a refugee [3]. This situation has prompted many developed countries to increase their quota commitment of numbers of refugees that will be welcomed annually [4, 5]. It is a crisis that can no longer be ignored [6]. Specifically, within the state of Arizona in the U.S., there are over 82,000 refugees with an average of 4,000 refugees arriving yearly [7]. Approximately half of the resettled refugees are women and girls.

When refugees arrive in their 'new' country, one of their most critical needs is health care and arguably the most vulnerable sub-population of refugees is refugee women. Compared to their male counterparts, refugee women face unique challenges as they adjust to their new life in the host country, mostly due to their lower English language proficiency which has been associated with their relatively lower access to educational opportunities [8]. This limited language proficiency and their lack of familiarity of the new health system make it difficult for many refugee women to negotiate access and navigate the healthcare system of their host country [9, 10]. When refugee women access the healthcare system, evidence suggests that they and babies born to them have an increased risk for poorer outcomes of pregnancy and childbirth, compared to women and babies of the host population [11, 12]. Some of these poor outcomes have been attributed to their unique challenges in integrating with the host country health system, including cultural acceptance, language, finance and health literacy.

To address these disparities and improve outcomes of pregnancy and child birth for refugee women, the Maricopa Integrated Health System (MIHS) (the only safety net public hospital in Arizona) launched the Refugee Women's Health Clinic (RWHC) in 2008. The program aimed to enhance access to comprehensive, culturally-sensitive care for refugee women in the Phoenix metropolitan area of Maricopa County, Arizona. RWHC has two components: two dedicated clinic sites and cultural health navigators (CHNs) who are certified medical interpreters, members of the refugee community, and specifically employed by MIHS to serve as cultural and linguistic liaisons between the refugee community and the health care system [13].

Broadly, research aimed at understanding experiences of refugee women utilizing facilities for pregnancy and delivery are limited. A 2014 systematic review [10] that captured experiences of maternity care of immigrant (including refugee) and non-immigrant women identified only four studies that focused specifically on immigrant women in the U.S. These studies were conducted among women from Somali [14], Hmong [15], Puerto Rican [16] and Hispanic [17] origins. The aim of this research was to assess satisfaction of refugee women from multiple ethnic backgrounds in utilizing the specialized prenatal care provided at the RWHC. This assessment would be important in planning health care provision for refugee women newly resettled in Western host nations.

Methods

This is a mixed-methods study that combines results from a patient exit survey and a qualitative inquiry. We have chosen to use a mixed-methods approach for the purpose of triangulation of our findings, as this helps us to better understand areas of convergence [18, 19].

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Participants and study location

Participants in this study were refugee women from the ethnic communities and languages served in greatest number by RWHC: Somali, Arabic, Burmese, Kirundi and Swahili. The study was conducted at the two RWHC sites: the main MIHS hospital campus, and a satellite Family Health Center in Mary vale located near large residential communities of newly arrived refugees.

Data collection

Quantitative data collection and measures

Due to the sensitive nature of this research, which was focused on a vulnerable population, we employed a convenience sampling technique. For data collection, we used an anonymized 18-question instrument comprising four sub-sections: background characteristics, access to care, experience of utilizing prenatal care and reasons for missed appointments [Appendix 1]. This questionnaire was designed based on insights from a previously validated patient experience survey [20] and a research conducted in the United States on the needs for care during pregnancy and delivery as described by Somali refugee women [14]. We also inquired if the women were willing to recommend RWHC to other women, if they considered RWHC as their regular source of prenatal care and their other health care needs. For assessment of access and utilization, we used simple 'yes' or 'no' responses to each question, incorporating visual emoji to simplify representation of the options, in consideration of the limited literacy of the population of interest.

Qualitative data collection and measures

Following the survey, we asked each woman about their willingness to participate in a focus group discussion (FGD) to discuss in detail their opinion on access and utilization of prenatal care at the RWHC. FGDs were chosen for this research because this method permits interaction between respondents [21, 22]. This interaction was critical in providing the most robust description of opinions of refugee women regarding the dedicated prenatal care.

We purposively sampled women who completed the exit survey to ensure representation of women across the main ethnic groups. All study instruments were translated and back-translated into the five main languages. The CHNs reviewed all documents ensuring cross-cultural equivalence was maintained throughout [23].

One FGD session was conducted for each of the represented language groups. Participants in each FGD ranged from between six and eight. All sessions were moderated by a research team member, while another team member served as note-taker.

The topic guide sought to understand the "why" behind the answers that the women provided in the surveys and their opinions regarding the specialized prenatal service at the RWHC. All FGD sessions, lasting about 45 minutes, were audio-recorded. Data collection continued until thematic saturation was attained.

Data Analysis

For the quantitative data analysis, we grouped women into their respective language groups. We then applied descriptive statistics to report the measures of central tendency of the total satisfaction index scores across the five language groups represented in the survey. Maximum total satisfaction index score was seven and the lowest was zero. Other descriptive statistics reported were transportation option to the facility and missed appointment (for access to care) and cadre of care provider, use of RWHC for maternal health care, use of RWHC for other health care needs (for utilization of care). In addition, we summarized our findings on reasons for missed appointments. All quantitative analyses were performed using STATA™ SE 12.1 (STATACorp, College Station, Texas).

For the qualitative data analysis, we transcribed the audio recordings verbatim. The moderators of the individual FGD sessions then independently reviewed the transcripts for accuracy. Thematic approach, which focuses on detecting and describing both implicit and explicit ideas (themes) within the transcript [24] was used to reduce the data. We followed Braun and Clarke's six-step approach: becoming familiar with the data, generating initial codes, searching for themes, reviewing themes, defining and naming themes and producing the report [25]. The emerging understanding was tested, alternative explanations explored and findings of the analysis described [26]. Qualitative analysis was performed with the aid of NVivo™ 10 (QSR International, London, United Kingdom). We report our study following the consolidated criteria for reporting qualitative research (COREQ) checklist [27].

Results

Survey results

127 women participated in the survey comprising: 39 (31%) Somali-speaking, 33 (26%) Arabic-speaking, 32 (25%) Burmese-speaking, 21(16%) Kirundi-speaking and 2 (2%) Swahili-speaking [Table 1].

Table 1: Distribution of women recruited in the patient exit survey

Language spoken	Frequency (n)	Percentage (%)	Cum. percentage (%)
Kirundi	21	16.54	16.54
Arabic	33	25.98	42.52
Swahili	2	1.57	44.09
Somali	39	30.71	74.80
Burmese	32	25.20	100.00
Total	127	100.00	

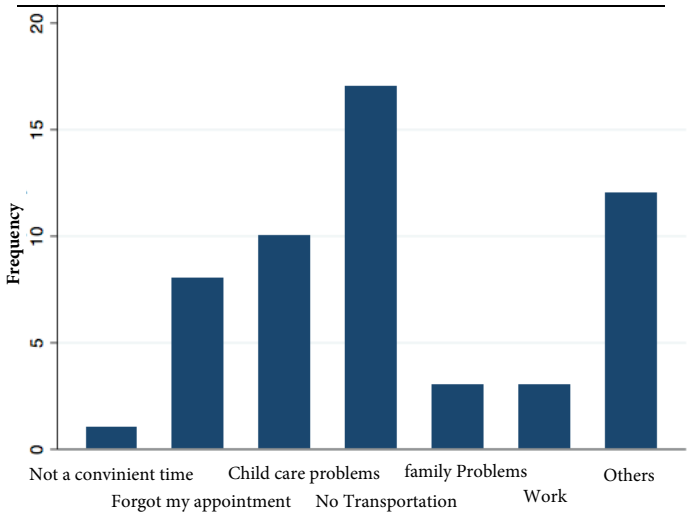
Most refugee women, 91 (77%) used a pre-arranged taxi to reach the facility for prenatal appointments. The remaining 23% had access to a private car to transport them. RWHC was the sole source of maternity care and their other health care needs for 116 (91%) and 115 (91%) refugee women sampled respectively while the remaining women used other facilities in combination with the RWHC. Fifty-four (43%) refugee women reported having missed appointments in the past [Table 2].

Of the 54 refugee women who reported that they had previously missed their prenatal appointments, the commonest reasons given were lack of transportation 15 (28%), child care problems 10 (19%), and forgot appointment 8 (15%). Other less common reasons given were family problems and work (6% each) [Figure 1].

Table 2: Summary of experiences of access and utilization to prenatal care

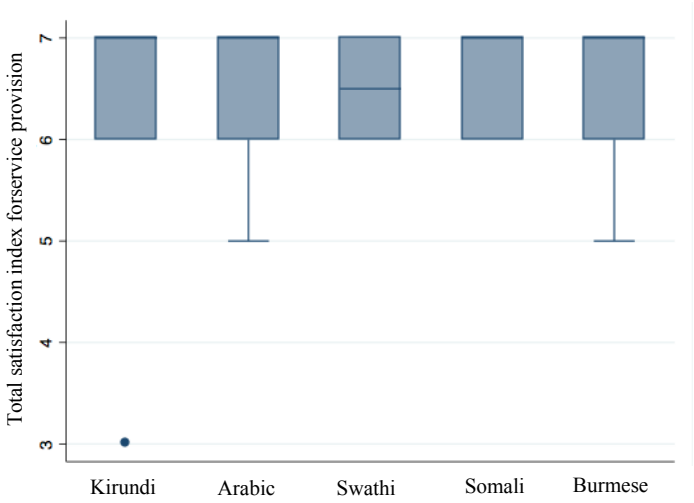
Sample characteristics	Frequency (n)	Percentage (%)	Cum. percentage (%)
Transportation to facility			
Taxi	91	77.12	77.12
Private car	27	22.88	100.00
Care provider			
Nurse/midwife	33	25.98	25.98
Doctor	94	74.02	100.00
RWHC only for maternal health care			
Yes	116	91.34	91.34
No	11	8.66	100.00
RWHC for all health care needs			
Yes	115	90.55	90.55
No	12	9.45	100.00
Missed appointment			
Yes	54	42.52	42.52
No	73	57.48	100.00

Figure 1: Reasons for missed appointment at RWHC



123 (97%) of refugee women said they would recommend RWHC to other women. Median total satisfaction score was high across all five language groups ranging from six to seven [Figure 2]. The inter-quartile range was between five and seven for Arabic-speaking and Burmese-speaking women and between six and seven for Kirundi, Somali and Swahili-speaking women respectively.

Figure 2: Box plot –Total satisfaction score for utilization



Findings of qualitative inquiry

There were four key emerging themes from our study: 1) recognition of the importance of prenatal care, 2) positive drivers for use of prenatal care, 3) barriers to prenatal care use and 4) opinions of specia-lized prenatal care.

Recognition of the importance of prenatal care

Refugee women recognized the importance of prenatal care in ensuring that their babies and themselves can be kept healthy throughout the prenatal period. They also perceived prenatal care as an opportunity to get "encouragement" and "counsel" on what to do and how best to manage themselves during pregnancy. Refugee women who had not used prenatal care in previous pregnancies while in their home countries appear to now recognize the importance of prenatal care also. In addition, women classified as having high-risk pregnancies appeared to understand the need for them to make additional visits for their providers to closely monitor their babies.

- Prenatal care is important for the safety for the baby and the mom. If the baby has some issue, it is possible to know about it earlier with prenatal care. 22-year-old Burmese-speaking woman, Gravida 2, Para 1, first visit.
- During my last pregnancy, I didn't go to the doctor, now I have decided to go because the doctors here told me of the importance of getting care as I have had four babies that died right after they were born.38-year-old Somali-speaking woman, Gravida 13, Para 8, made 6 visits so far, arrived in USA in March 2016.

Refugee women engaged in our study also seemed to recognize the need to start prenatal care within the first trimester of pregna-ncy. The women in our study generally pointed to commencing prenatal care between 8 and 12 weeks gestational age.

- It is good for me and the baby because the early prenatal care can prevent complications during the pregnancy…I think 8 to 12 weeks is a good time to start prenatal care. 33-year-old Swahili-speaking woman from Congo, Gravida 6, Para 6, made 10 visits so far.

Refugee women also viewed prenatal care as a service that helps to prevent cesarean delivery.

- [During prenatal clinic], my doctor can monitor me closely and take action to ensure that I don't have to have a C-section. This is my first baby I do not want C-section. 22-year-old Somali-speaking woman, Gravida 1, Para 0, made six visits so far, came to the USA in 2014.

Positive drivers for motivating prenatal use

Refugee women appeared to be driven to attend prenatal care by themselves and people around them, including their partners and community members who see value in prenatal care. They could make their own choices as to whether to attend prenatal care. In addition, it appears that the health system also refers women to the RWHC when they present in other facilities that do not provide specialized refugee care.

- I was encouraged by one of my friends who received care at the clinic. My husband and I then decision together. 44-year-old Kinyarwanda-speaking woman from DR Congo, Gravida 10, Para 8, made 8 visits so far.
- My neighbor and I talked about her positive experience at the clinic and I felt encouraged by her advice. I made the decision on my own. 21-year-old Kinyarwanda-speaking woman from DR Congo. Gravida 1, Para 0, made 4 visits so far.
- I went to public health and they drew my blood and they told me we are transferring you care to Maricopa refugee women clinic. I wanted to know about my baby's health. 38-year-old Somali-speaking woman, Gravida 13, Para 8, made 6 visits so far, came to USA in March 2016.

Having trained medical interpreters who work as CHNs at the RWHC was a key driver of utilizing the clinic specifically. This was reported by participants across all language groups. It appears that those who live within the community are also aware about the CHNs and push women to use prenatal care provided at RWHC because of this awareness.

- I chose the clinic because there are a lot of Burmese interpreters here, which is why a community member encouraged me to come. 33-year-old Burmese-speaking woman, Gravida 3, Para 2, made 5 visits so far.

The drive that the CHNs provide appears to be predicated on the fact that women view the CHNs as "same". The women opined that because CHNs are women like themselves and belong to the same culture, nationality, and language, they are more open to communicate with them regarding their feelings, their health and their other needs, which makes it easier for them to use prenatal care.

- The CHN is everything to me because the CHN is a woman like us, I can talk openly about my pregnancy and my problems, and that is very good for us because in our culture it is easy for women to talk to women, and not for women to talk to men. The CHN belongs to my culture, is from my country, and speaks my language. I can tell her everything without feeling shy and can make complaints without feeling embarrassed. She can then express it better to the doctor. 38-year-old Arabic-speaking woman, Gravida 5, Para 3, first visit, been in the US for eight years
- Without the CHN, we couldn't do anything. She does everything - appointments, interpretations, transportation. 37-year-old Arabic-speaking woman, Gravida 4, Para 3, second visit, been in the US for ten years.

Barriers to prenatal care use

Inability of communicate effectively with their providers in English language was deemed a barrier to prenatal care use amongst refugee women. This was reported as a barrier to care in health care facilities that do not have sufficient interpreters.

- Language barrier was a problem for me with other clinics, and I felt very frustrated. I could not tell the doctor how I really felt, sometimes my husband had to go with me because he speaks better English, but I really did not like that and he sometimes did not have time. But not with this clinic, since there are so many interpreters here. 25-year-old Burmese-speaking woman, Gravida 2, Para 1, made 3 visits so far.

Refugee women from all language groups also reported transportation issues as a barrier to seeking for care.

- Taxi/transportation is a barrier. We don't have a car, so if there is no taxi there is a problem. 32-year-old Burmese-speaking mother, made multiple visits already.

Opinion of specialized prenatal care

Generally, women had positive opinions about the specialized care that they received at the RWHC. Women felt that they were treated with respect and were involved in the decision-making process. In addition, having CHNs who could help "navigate the complex US health care system"was seen as a very positive opinion of the prenatal care received from the RWHC. However, having to wait for a long time to see the provider was a recurring negative opinion seen across the language groups.

- I feel that I was treated with respect. I was included in decision making with the midwife and doctor. There was a long waiting time. 33-year-old Burmese-speaking woman, Gravida 3, Para 2, made 5 visits so far.
- It is something very important to take care of the pregnant woman and her baby. They take good care of the woman and the baby. 34-year-old Arabic-speaking woman, Gravida 6, Para 5, first visit, been in the US for eight years.
- The cultural health navigator understands all the procedure before they happen and she educated me more about the complex US health care system. The CHN helped me overcome my fears. She explained to me step-by-step. She is my eyes and ears and I don't think I could have handled my pregnancy without her help. 21-year-old Kinyarwanda-speaking woman from DR Congo. Gravida 1, Para 0, made 4 visits so far.
- I have been coming to the clinic for a long time, I have only gained profit from the clinic. I love everything, the taxi, the interpreter and the doctor. I love the interpreter because she helps me understand the language that I don't speak. Then she

talks to the doctor that gives me the medicines that I need and cares for me. 22-year-old Somali-speaking woman, Gravida 1, Para 0, made 4 visits so far, came to the USA in 2014.

Moving forward, women suggested that appointment reminders can be more comprehensive to include referrals and refill for medications. In addition, transportation services can be improved.

- Better transportation services can be used to get more women to use prenatal services earlier in their pregnancies and more often. Reminder of appointments can help also. Not only for appointments, but also labs, referrals, medication refill, and ATC. 27-year-old Burmese-speaking mother, made multiple visits already.

Discussion

Generally, it appeared that refugee women who have moved to the U.S. recognized that prenatal care is an important service needed for monitoring and supporting their babies and themselves throughout pregnancy. This included refugee women who had not been previously convinced on the importance of prenatal care prior to moving to the country. An earlier study conducted among resettled Somali women in the U.S. made the same observation, though the researchers pointed that the refugees had been resettled in the U.S. for five years or longer [28]. Length of time in the U.S. may have influenced the perception of women to prenatal care or it may be that refugee women are already convinced about the importance of the service long before they arrive in the US. However, it is difficult to specifically identify when this understanding was gained by the refugee women. Many refugee women are known to be of low socioeconomic status, education and empowerment levels, which are factors known to limit awareness and utilization of prenatal care [29, 30]. In addition, refugee women often continue to believe and adhere to their traditional health beliefs and practices even after moving to their new countries[31], as such efforts to continue to increase awareness need to be sustained and indeed scaled up.

Women in our study pointed to language and communication as well as transportation challenges as barriers to access and utilization of prenatal care. Other studies have reported similar findings amongst refugees who have resettled in the U.S. [14, 32, 33]. Ability to communicate in the language of the host country is critically important through the entire care process from access to utilization. Refugee women need to either be able to speak the language or have interpreters who can accurately transmit their feelings and concerns to their providers; and the provider's advice and counsel to the women. Women generally found the CHNs as both critical drivers to encouraging them to engage with the care and important partners in their care delivery. It makes sense that CHNs fit this purpose since they have a shared experience with the refugee women and have a deep understanding of the U.S. culture and the healthcare system. They are also able to communicate effectively in their native language as well as in English language. It appears that CHNs, if appropriately deployed, are able to fill the gap in care, access, and utilization [32, 33].

Regarding transportation challenges, our survey showed that it posed the greatest challenge to refugee women regarding access to care (28%). Other reasons given for missing prenatal care appointments were child care problems (19%) and forgetting appointments (15%). Similar reasons were highlighted by refugees in Australia [34]. The CHNs in the RWHC already call women to remind them of appointments and prearrange their transportation. However, the women identified that reminders need to include all their engagements with the healthcare facility including laboratory tests, medication refills and referrals, and not just prenatal care appointments.

In terms of utilization, their self-motivation and encouragement from partners and community members were critical drivers that promoted their use of prenatal care. Refugee women were generally highly satisfied with receiving specialized services for prenatal care, evidenced also by the high satisfaction index scores that cut across the different language groups who sought care. Having the CHNs as bridges between the women and the providers appears to limit barriers to utilization particularly as it relates to language and the complexity of navigating the U.S. healthcare system. While interpreter services have long been utilized as serving this bridge, and have been shown to be effective in improving quality of clinical care for patients with limited English proficiency [35], there remains concerns regarding confidentiality and privacy, especially with women who come from cultures in which private reproductive health issues are treated with high secrecy[36]. Our findings provide evidence to support the acceptability and effectiveness of multilingual health advocates, like CHNs, in facilitating care for refugees. Refugee women want CHNs who are of the appropriate "age, language and gender" [34].

In particular, Somali refugee women in our study pointed that they viewed prenatal service as a care package that prevents them from undergoing cesarean deliveries since it allows providers to identify potential risks early on. Previous studies found that Somali refugee women in particular do not want caesareans "because of fear of death" [14, 37].

Findings from our study need to be interpreted with caution. First, for the survey, we used convenience sampling, which is known to lead to under-representation or over-representation of specific groups within the sample. However, we do not believe that this would have changed our conclusion in any manner, since the satisfaction levels were comparable across the various language groups. In addition, our use of a mixed-methods approach in which we triangulated the results of the survey with findings from the qualitative enquiry allowed us to verify our conclusions.

Going forward, it is critical to design national guidelines that are tailored to the needs of refugee women [38]. While best practices aimed at improving cultural responsiveness of providers to providing care and awareness programs regarding the importance of prenatal service are sustained [39], emerging evidence from our research points to the need for health advocates like CHNs should be implemented to serve as 'bridges'. In combination with a dedicated clinic, our findings demonstrate that this type of care is exactly what refugee women not only deeply want but desperately require. Implementing this kind of specialized prenatal service for refugee women is expedient, as was similarly concluded in another study conducted in Australia [40], especially with the current wave of heightened migration.

The 1951 Refugee Convention states that refugees should enjoy access to health services equivalent to that of the host population [41]. Evidence shows that prenatal service utilization is lower (33%) among refugee women who died due to pregnancy and childbirth related complications compared to the general population (79%) [42]. If we are to provide the same level of care as native-born citizens receive, refugees need to be supported. However, to ensure their equitable

table access to health services, particularly prenatal care, functional and structural barriers that limit this access must be removed.

Abbreviations

CHN: Cultural Health Navigators; COREQ: Consolidated criteria for Reporting Qualitative research; FGD: Focus Group Discussion; MIHS: Maricopa Integrated Health System; RWHC: Refugee Women's Health Clinic, U.S: United States.

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Competing interests

The authors declare that they have no competing interests.

Authors' contributions

ABT, SG and CJA were involved in the conceptualization of the research as well as the design of the research instruments. ABT and SG led the conduct of the survey and focus groups. ABT and SG analyzed the research findings. All authors were involved in the development of the manuscript and approved the final version.

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Ethics approval and informed consent

All procedures performed in studies involving human participants were in accordance with the ethical standards of the institutional review board (IRB) of MIHS and with the 1964 Helsinki declaration and its later amendments or comparable ethical standards. Informed consent was obtained from all individual participants included in the study. This article does not contain any studies with animals perfo-rmed by any of the authors.

References

1. Refugee Processing Center. Admissions and Arrivals [Internet]. Reports. 2016 [cited 2017 Jun 14]. [Crossref]
2. UNHCR. World at war: UNHCR global trends - forced displacement in 2014 [Internet]. Geneva; 2014. [Crossref]
3. UNHCR. Worldwide displacement hits all-time high as war and persecution increase [Internet]. News. 2015 [cited 2017 Jun 14]. [Crossref]
4. BBC. Migrant crisis: Migration to Europe explained in seven charts [Internet]. Europe. 2015 [cited 2017 Jun 14]. [Crossref]
5. Worland J. U.S. to increase number of refugees admitted to 100,000 in 2017. TIME [Internet]. 2015 Sep 2015; [Crossref]
6. Davidson PM and Mbaka-Mouyeme F. The refugee crisis: We cannot ignore this for much longer. Health Care Women Int. 2016; 37:945-945. [Crossref]
7. Arizona Department of Economic Security. Refugee arrivals by nationality and FFY of resettlement [Internet]. Arizona Refugee Resettlement Program. 2017 [cited 2017 Jun 12].p 1-2. [Crossref]
8. Deacon Z and Sullivan C. Responding to the Complex and Gendered Needs of Refugee Women. Affilia. 2009; 24:272-284. [Crossref]
9. Robertson CL, Halcon L, Savik K, Johnson D, Spring M, Butcher J, et al. Somali and Oromo refugee women: trauma and associated factors. J Adv Nurs. 2006; 56:577-587. [Crossref]
10. Small R, Roth C, Raval M, Shafiei T, Korfker D, Heaman M, et al. Immigrant and non-immigrant women's experiences of maternity care: a systematic and comparative review of studies in five countries. BMC Pregnancy Child birth. 2014; 14:152. [Crossref]
11. Small R, Gagnon A, Gissler M, Zeitlin J, Bennis M, Glazier R, et al. Somali women and their pregnancy outcomes postmigration: data from six receiving countries. BJOG. 2008; 115:1630-1640. [Crossref]
12. Essen B, Hanson BS, Östergren P-O, Lindquist PG and Gudmundsson S. Increased perinatal mortality among sub-Saharan immigrants in a city-population in Sweden. Acta Obstet Gynecol Scand. 2000; 79:737-743. [Crossref]
13. RWHC. Refugee Women's Health Clinic [Internet]. About Us. 2015 [cited 2017 Jun 17]. [Crossref]
14. Herrel N, Olevitch L, DuBois DK, Terry P, Thorp D, Kind E, et al. Somali refugee women speak out about their needs for care during pregnancy and delivery. J Midwifery Womens Health. 2004; 49:345-349. [Crossref]
15. Jambunathan J and Stewart S. Hmong Women in Wisconsin: What Are Their Concerns in Pregnancy and Childbirth? Birth. 1995; 22:204–210. [Crossref]
16. Lazarus ES and Philipson EH. A longitudinal Study Comparing the Prenatal Care of Puerto Rican and White Woman. Birth. 1990; 17:6-11. [Crossref]
17. Shaffer CF. Factors Influencing the Access to Prenatal Care by Hispanic Pregnant Women. J Am Acad Nurse Pract. 2002; 14:93-96. [Crossref]
18. Greene JC. Qualitative program evaluation: Practice and promise. In: Denzin NK, Lincoln YS, editors. Handbook of qualitative research. Thousand Oaks, CA: SAGE Publications; 1994; 530-544. [Crossref]
19. Greene JC, Caracelli VJ and Graham WF. Toward a Conceptual Framework for Mixed-Method Evaluation Designs. Educ Eval Policy Anal. 1989; 11:255-274. [Crossref]
20. Raube K, Handler A and Rosenberg D. Measuring Satisfaction Among Low-Income Women: A Prenatal Care Questionnaire. Matern Child Health J [Internet]. 1998 [cited 2017 Sep 13]; 2:25-33. [Crossref]
21. Kitzinger J. Qualitative Research: Introducing focus groups. BMJ. 1995; 311:299-302. [Crossref]
22. Krueger RA and Casey MA. Focus Groups: A Practical Guide for Applied Research. 4th ed. Knight V, Connelly S, Virding A, Suwinsky P, editors. Thousand Oaks, California: SAGE Publications Inc.; 2009. [Crossref]
23. Lee C-C, Li D, Arai S and Puntillo K. Ensuring cross-cultural equivalence in translation of research consents and clinical documents: a systematic process for translating English to Chinese. J Transcult Nurs. 2009; 20:77-82. [Crossref]
24. Ritchie J and Lewis J. Qualitative research practice: a guide for social science students and researchers. London: SAGE Publications; 2003. [Crossref]
25. Braun V and Clarke V. Using thematic analysis in psychology. Qual Res Psychol. 2006; 3:77-101. [Crossref]
26. Marshall C and Rossman GB. Designing qualitative research. Third. Thousand Oaks, California: SAGE Publications; 1999. [Crossref]
27. Tong A, Sainsbury P and Craig J. Consolidated criteria for reporting qualitative research (COREQ): a 32-item checklist for interviews and focus groups. Int J Qual Health Care. 2007; 19: 349-357. [Crossref]
28. Carroll J, Epstein R, Fiscella K, Volpe E, Diaz K, Omar S, et al. Knowledge and Beliefs About Health Promotion and Preventive Health Care Among Somali Women in the United States. Health Care Women Int. 2007; 28: 360-380. [Crossref]
29. Ahmed S, Creanga AA, Gillespie DG and Tsui AO. Economic status, education and empowerment: implications for maternal health service utilization in developing countries. PLoS One. 2010; 5:e11190. [Crossref]
30. Wang W, Soumya A, Wang S and Fort A. Levels and trends in the use of maternal health services in developing countries. Calverton, Maryland, USA. 2011. [Crossref]
31. Essen B, Johnsdotter S, Hovelius B, Gudmundsson S, Sjoberg N-O, Friedman J, et al. Qualitative study of pregnancy and childbirth experiences in Somalian women resident in Sweden. BJOG. 2000; 107:1507-1512. [Crossref]
32. Morris MD, Popper ST, Rodwell TC, Brodine SK and Brouwer KC. Healthcare barriers of refugees post-resettlement. J Community Health. 2009; 34:529-538. [Crossref]
33. Mirza M, Luna R, Mathews B, Hasnain R, Hebert E, Niebauer A, et al. Barriers to healthcare access among refugees with disabilities and chronic health conditions resettled in the US Midwest. J Immigr Minor Heal. 2014; 16:733-742. [Crossref]
34. Department of Health. Improving maternity care for refugee and migrant women in Western Australia. Perth; 2015. [Crossref]
35. Karliner LS, Jacobs EA, Chen AH and Mutha S. Do professional interpreters improve clinical care for patients with limited English proficiency? A systematic review of the literature. Health Serv Res. 2007; 42:727-754. [Crossref]

36. Feldman R. Primary health care for refugees and asylum seekers: A review of the literature and a framework for services. Public Health. 2006; 120:809-816. [Crossref]

37. Brown E, Carroll J, Fogarty C and Holt C. "They get a c-section they gonna die": Somali women's fears of obstetrical interventions in the United States. J Transcult Nurs. 2010; 21:220-227. [Crossref]

38. Higginbottom GMA, Morgan M, Alexandre M, Chiu Y, Forgeron J, Kocay D, et al. Immigrant women's experiences of maternity-care services in Canada: a systematic review using a narrative synthesis. Syst Rev. 2015; 4:13. [Crossref]

39. Correa-Velez I and Ryan J. Developing a best practice model of refugee maternity care. Women and birth. 2012; 25:13-22. [Crossref]

40. Stapleton H, Murphy R, Correa-Velez I, Steel M and Kildea S. Women from refugee backgrounds and their experiences of attending a specialist antenatal Correa-Velez I, Ryan J. Developing a best practice model of refugee maternity care. Women and birth. 2012; 25:13-22. [Crossref]

41. UNHCR. Convention and protocol relating to the status of refugees. Geneva; 2010. [Crossref]

42. Hynes M, Sakani O, Spiegel P and Cornier N. A study of refugee maternal mortality in 10 countries, 2008-2010. Int Perspect Sex Reprod Health. 2012; 38: 205-213. [Crossref]