Attitudes Towards Family Planning among Bhutanese, Burmese, and Iraqi Refugee Women: A Qualitative Study

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Abstract

The number of foreign-born people living in the United States continues to increase yearly. Foreign-born women in the United States, a group that includes both refugees and immigrants, continue to have higher birth rates when compared to their US-born counterparts. This study examines the cultural and socioeconomic factors influencing family planning choices of resettled refugee women living in the United States. Thirty-two Bhutanese, Burmese, and Iraqi women living in Philadelphia participated in interviews and focus groups. A grounded theory approach was used for analysis. Three overarching themes were identified: knowledge acquisition and experiential learning with trans-border migration and resettlement, changes in gender roles and family relations, and provider relationships and provision of care. Findings from the study show that a stable environment results in increased opportunities and personal freedoms, a sense of empowerment, and the desire for family planning. Women want to discuss options, but healthcare providers must begin the conversation. As health care providers in Hawai'i, a state with about 18% of residents being foreign-born, what can be learned from the Philadelphia refugee experience and family planning?

Keywords

Refugee, immigrant, foreign-born, contraception, family planning, resettlement, United States, providers, physicians, empowerment

Introduction

Approximately 50,000 to 80,000 refugees resettle in the United States annually, about half of whom are women and children.[1] Refugee women face many challenges as they resettle in a new country, including obtaining sexual and reproductive health services that meet their needs. Barriers to these services include limited knowledge of sexual and reproductive health, culturally influenced gender roles (eg, male dominance in decisions making), socioeconomic demands, provider attitudes and practices, and poor healthcare access.[2-6]

Although overall birth rates are declining in the United States, foreign-born women (those that are not citizens at birth and include both immigrants and refugees) continue to have higher birth rates when compared to their United States counterparts.[7] The 2010 birth rate for foreign-born women was nearly 50% higher than the rate for US-born women.[7]

The World Health Organization defines family planning as allowing people to attain their desired number of children and determine the spacing and timing of their births.[8] Family planning services play a critical role in a woman's sexual and reproductive health, including access to modern contraceptive methods. However, as indicated by higher birth rates in foreign-born women, the availability of these services alone may be inadequate for meeting family planning needs. Little is known about what factors influence family planning choices for resettled refugees, including the role of health care providers in providing family planning counseling and services. From 2012 to 2017, the Bhutanese, Burmese, and Iraqi people have been among the largest resettled refugee populations in the United States.[1] However, very few qualitative studies from the United States have focused on family planning choices of these populations. Two studies done in the United States with Bhutanese refugees demonstrated that poor sexual and reproductive health knowledge, socio-cultural norms, and stigma around sexual health dictated decisions regarding family planning.[2,9]

In light of limited literature about family planning for Bhutanese, Burmese, and Iraqi refugee women in the United States, the objective of this study was to learn about the family planning practices of resettled refugees and the factors that promote and/or hinder contraceptive use. As health care providers, there is an opportunity to learn about the patient-provider relationship and the counseling practices that are considered effective from the patient's perspective. With this information, the goal was to understand how to effectively counsel and provide culturally sensitive family planning care to resettled refugee women.

Methods

Ethical approval to conduct the research was obtained from the Thomas Jefferson University Internal Review Board. Women 18 years and older of Bhutanese/Nepalese, Burmese, and Iraqi nationalities were recruited for in-depth interviews (IDIs) and focus group discussions (FGDs) from an urban Family Medicine Clinic in Philadelphia and the surrounding community. Women of these specific nationalities were purposefully selected, as they were the predominant refugee groups resettling in Philadelphia at the time of this study. Additionally, women 18 or older were included along with those who were not of reproductive age, as they could offer insight on family planning practices specific to their country and ethnicity. Recruitment was through convenience sampling by community navigators who were proficient

in the woman's language and by the co-investigators of this study with the aid of trained bilingual translators. Further recruitment was conducted through snowball sampling.

Interviews and focus group discussions were conducted over an 11-month period from May 2013 to April 2014. Verbal consent from participants was obtained by trained female bilingual translators. Female co-investigators led the IDIs and FGDs with the assistance of the translators. All sessions were semi-structured, and a discussion guide was followed for both the IDIs and FGDs (Table 1). Focus groups and in-depth interviews were arranged according to ethnicity. IDIs and FGDs were audio-recorded and transcribed. Broken English spoken by the translators and participants was transcribed word for word in the transcription. Since most discussions were through a translator, translations often alternated between the first and third person. For standardization and ease of reading, third person translations have been converted to the first person in this paper.

IDIs and FGDs were conducted until theoretical saturation was reached. Two investigators independently coded the transcripts using the Charmaz grounded theory approach.[10] With this approach, theories were constructed based on the data itself. Analysis of the data began by each of the two investigators manually coding the interviews line-by-line. These codes were entered into Microsoft Excel to form a code list. The two investigators discussed the code lists and grouped codes into concepts. Major themes were developed from these concepts. Discrepancies between the two investigators were resolved through discussion.

Table 1. Discussion Guide
1. Demographics: Can you tell me your age, how long you have lived in the United States, and how many children you have?
2. Can you tell me about your experience with resettling, as in what country you are from, where you resettled through, and if you lived in a camp(s)?
3. How do you decide about how big your family is going to be? (Probe for cultural norms around family size and whether this is changing now that they are in the US.)
4. When do you have this discussion? Who is involved in the discussion?
5. How are these decisions made?
6. How soon after you are married do most people have their first child?
7. Does it matter whether you have a boy or girl? To you? Family? Culture?
8. Now let's talk about planning for your second child? How long do most people wait before having a second child? How successful were you with your plan? What kinds of things do you do not to get pregnant too soon? (Probe for no prevention, rhythm, condoms, etc., herbal/non-traditional meds). Has this changed in any way since coming to the US? If so, how? (probe for if they know about contraception methods)
9. In school or camps were there sessions on sexual education that you attended or knew about? What did they talk about?
10. So, you mentioned that you used _____ methods to try to not get pregnant too soon. Why did you choose this method? How do you feel about it? What do you like or dislike about it? Did they work for you? If so how, or if not why not? How long have you been using it? (Probe for prior to arriving in US or since coming to the US).
11. What other things do people do that can help them plan when to have another child? (Probe for medicines, herbal, non-traditional, other methods, etc.) a. How did you learn/hear about these methods? What do you know about them? How do they work? (probe about whether it was explained by doctor or learned through the community) b. How do you feel about these methods? Would you use them? Why or why not?
12. Some of you mentioned that you have heard about medicines that can help you to plan when you want to get pregnant. What kind of medicines have you heard about? (Probe for different types –pills, injections, patches, medicines that can be inserted in your skin or inside your body that stay there for a few years, TL, vasectomy). a. How do you feel about using a medicine to plan when you have your next child? (Probe about cultural beliefs, discussions with friends?). Would you use a medicine? Why or why not? b. Have you used any of these medicines? How did you decide which medicine to use? – (probe for discussion with friends/family, discussions with doctor or other health care provider, read about it in an article or on the internet, etc. Was decision/choice made with family, partner, or by themselves?) c. What were these discussions like? What did you talk about? (Probe for how contraception works, etc.) What kinds of questions did you have? How easy was it to discuss this with the doctor/nurse? What would have helped to make this discussion better? d. How easy or difficult was it to get the medicine once you made a choice? (Probe about whether access is easy or difficult and why – cost, embarrassment, availability, etc. Probe for access issues prior to and after coming to the US.)
13. What if you become pregnant and don't want the child? What do you do then? Who is involved in the decision (probe about thoughts on abortion)
14. Some women want to get pregnant but can't… what do you think about that? What do your families think about that? (probe about infertility)
15. So now that you are in the United States, have your thoughts on family planning changed since resettlement or are they the same as when in your native country? (Probe about methods, more active planning.)
16. Do you have discussions with your children about their health – especially in regard to sexual health, menstrual cycle?
17. Now let's talk about your visits with a doctor. How is it to discuss your health including planning for a family with your doctor in the United States? Do you feel comfortable bringing up the discussion with your doctor? How is it compared to discussions prior to resettlement? (probe about difficulties, ease of use of translator, sex of physician, access to methods and physician, cost)
18. Is there anything else you want your doctors to know regarding your healthcare or the relationship with the doctor? Is there anything you would want your doctors to do differently? (probe about culture, religion, language, access)

Results

Thirty-two women from Bhutan/Nepal, Burma, and Iraq, with an average age of 40.7, participated in the study (Table 2). Bhutanese and Nepalese women often identified themselves as either nationality because of their displacement to camps in Nepal. Therefore, these women are referred to collectively as Bhutanese in this paper.

Participants reported limited knowledge of family planning methods prior to arrival in the United States, but they described an evolution of their beliefs regarding family planning through the resettlement process. Several overarching themes emerged regarding attitudes towards family planning. These included: (1) knowledge acquisition and experiential learning with trans-border migration and resettlement; (2) changes in gender roles and family relations throughout the resettlement process; and (3) provider relationships and provision of care.

I. Knowledge acquisition and experiential learning with trans-border migration and resettlement

Knowledge about sexual and reproductive health and specifically family planning evolved through the resettlement process. Resettlement involved migrating as a refugee from a country of origin to an initial country of displacement such as Nepal, Thailand, Malaysia, and Jordan, and finally to the United States. Participants' knowledge was based on both formal and informal education modalities, such as workshops in camps to conversations with friends and family. Many women reported that during the resettlement process their access to information increased and influenced their decisions about both contraceptive use and preferences.

Country of Origin

Participants indicated that they received inadequate education about family planning prior to initial displacement. Barriers included geographic isolation and conflict, which often led to limited access to resources. One Burmese woman expressed frustration with the education in her home country:

> 'No choice [in Burma]. I have no choice because nobody educate us to have the first baby, second baby. How long do you have to take time? No one educates [in Burma], so that is a problem for me.' (Burmese, 43 years old)

Societal norms and culture also influenced the depth of education regarding family planning. Iraqi participants, who came from a higher socioeconomic status compared to other participants in the study, had access to advanced education prior to resettlement where they had learned about human anatomy. This school curriculum did not, however, include education on sexuality and contraception, so they acquired this knowledge from friends and family members. One Iraqi woman stated:

> 'No [in school], they teach only about the human body, not about having sex…a neighbor, I think, she tried to teach me these things.' (Iraqi, 45)

Displaced Settings

Refugee camps were reported to be many participants' first introduction to family planning, particularly those from Bhutan and Burma. Educational interventions in the camps included group workshops, clinic services, and home visits by community health workers. These programs were often implemented by international non-governmental organizations, such as the United Nations High Commissioner for Refugees, but also included host governments. Respondents explained how they learned about family planning:

> 'In Mae la or Mae La Oo [camps], every week there was formal teaching on birth control methods…before giving us prenatal vitamins or food, they tell us about birth control. Even if we don't want to hear about it, they still do.' (Burmese, 41)

> 'In the camp - [they had] workshops and meetings. Family planning was all free because the population was growing and Nepal [government] wanted to stop that. Health workers…went to people's homes especially for those having kids.' (Bhutanese, 30)

> 'After we went to Jordan, I attended a lot of workshops on family planning through the UN…they told us about how we should raise the child at different stages of life…I wish that I only had one child to really give all my attention to, so I decided no more, so I started using more protection.' (Iraqi, 40)

Table 2. Demographics of Participants Involved in the In-depth Interviews (IDIs) and Focus Group Discussions (FGDs)

	Nepali/ Bhutanese	Burmese	Iraqi	Mean
# of IDIs	0	1	3	2
# of FGDs	2	3	3	2.67
# of IDI and FGD Participants	10	12	10	10.67
Age Range	19 - 53	24 - 65	19 - 73	
Average Age	39	42	41	40.67
Range of Time in the US	2 months - 2 years	1 month - 6 years	3 months - 6 years	
Average Time in the US	11 months	2 years 2 months	3 years	2 years
% with Children	100	92	70	87.33%

Resettlement in the United States

Following arrival in the United States, participants received counseling about contraception from medical providers and friends. Women indicated collective efforts to inform each other about contraceptives and suggested additional interventions to enhance education, such as monthly community meetings. The shifting cultural landscape of life in the United States influenced attitudes regarding sexual health, including a desire to discuss these issues with physicians, family, and community members.

> 'In our country, the older people don't talk about sex. We learned more about the reproductive cycle and sex here in this country.' (Burmese, 43)

Women indicated a divergence from traditional cultural norms now that they were in the United States. This was considered a positive change because it reduced barriers to family planning that were previously encountered either in their home countries or in refugee camps.

> 'It is harder in the camps. It is frustrating asking for even condoms. I think it's cultural, because they don't talk about sex. We're shy to ask and talk about it there. It is easier here.' (Burmese, 37)

II: Turning the Tide: Changes in gender roles and family relations throughout the resettlement process

With resettlement, women felt empowered to take control of their lives. They rejected oppressive customs from their past and acknowledged an increase in women's rights. Many participants mentioned the institution of early marriage in their countries of origin. Young age and lack of education contributed to limited contraceptive use and unwanted pregnancy.

> 'When I first got married I was very young. I was 15. I had 2 miscarriages…and couldn't really handle it. I didn't know about any protection methods at all…and was just too young to comprehend even what pregnancy means.' (Iraqi, 40)

> 'I didn't really want to have a kid when I was 16, I was really young. But after I got married there was no choice, and I was already pregnant, so I was forced to have the kid.' (Bhutanese, 40)

Participants suggested that limiting family size became increasingly appealing during displacement. As they traveled to larger camps, they became exposed to increased economic opportunities, expanded education programs, and greater cultural diversity. Participants suggested that contraception was a method they employed to regain control over financial and social instability, which occurred during migration and conflict.

> 'In Mae La…a little bit open our eyes. Mae La was the biggest camp, that's a lot of culture there. Some [women] are going to work in Bangkok…they know if you have kids, you can't do business…so they not interested in getting too many babies.' (Burmese, 42)

> '[In Iraq] you don't decide to have a child, it just happens…but when we left Iraq, we saw that people had a different lifestyle and different expectations…I wished I would have waited and didn't have as many kids, just spaced it out.' (Iraqi, 43)

Limiting family size often continued upon resettlement in the United States, although some women indicated an eagerness to have a child in America that reflected a belief in enhanced opportunities in the United States.

> 'They want to have children here. Some women, some family, they want their kids to be president or something like that. They have very high visions.' (Burmese, 43)

With resettlement, many participants portrayed a change of individual thought regarding contraception in particular and women's rights in general. When asked if it was empowering to make family planning decisions, one participant replied:

> 'When we come here, he want another baby and I say no…I say women's rights in here.' (Burmese, 43)

An Iraqi woman was poignant about women's rights, reflecting on differences between Iraq and the United States:

> 'I'm just so fascinated by how much power women have here and I really like it…I wish I had come here at a younger age so I could have advantage of that too…I always rejected the idea of women being so powerless and men having all the power and I always thought it was backwards. But I couldn't do anything about it [in Iraq].' (Iraqi, 41)

III: Provider relationships and provision of care

Participants described the process of assimilation that occurred along with their resettlement in the United States, noting that differences in culture and language were barriers in their relationships with medical providers, and in receiving care. Women expressed embarrassment in discussing their sexual and reproductive health with their physicians, especially through an interpreter. They also continued to struggle with the language barrier, despite interpretation services.

> 'More comfortable in camp talking to doctor, because he was a Karen [speaking Burmese] doctor. Here [in the US] I am shy because we have to go through interpreter phone. Still shy to talk about.' (Burmese, 42)

> 'When [we] talk face to face with the doctor about the family planning measures its easier. But if we have to talk to someone else (translator) – a person in between [the physician], it gets a little embarrassed and we don't feel comfortable talking about it.' (Bhutanese, 31)

Some participants became more comfortable voicing their concerns to their providers over time.

> 'The environment here when we go to the doctor, it's comfortable to speak up, because now we learned that people talk and it's comfortable, and it's ok to talk.' (Bhutanese, 30)

However, a majority of women expressed that they preferred the provider to initiate the conversation regarding their family planning needs, as they felt uncomfortable approaching the subject on their own.

> 'It's easier and comfortable if doctor directly asks the question rather than answering to [the doctor's question] why are you here.' (Bhutanese, 31)

> 'It's very embarrassing to talk about it with doctors, to actually bring it up even though it's very important.' (Bhutanese, 30)

Most women did not have a preference for either a male or female physician for their general medical care but felt that concerns about reproductive health were best articulated to female physicians. Iraqi women often preferred a female provider, but this was not a universal requirement. Burmese and Bhutanese women did not state a preference.

> 'I prefer a female doctor. [For] a general doctor, a male is fine, but if woman issues, prefer female. I just can't let go of all my cultural beliefs.' (Iraqi, 40)

> 'We feel good talking about this with doctors here in the US. It is harder in the camps…It is easier here because the American doctors ask us. And it is usually a woman doctor.' (Burmese, 37)

> 'For me, a male doctor is not a problem.' (Burmese, 41)

Participants were asked about specific cultural attitudes and sensitivities that physicians should consider when providing reproductive health care. Some shared negative experiences about encounters in the United States, reporting that cultural differences and norms could often be misinterpreted by the provider.

A 21-year-old woman spoke about her first visit with an American Ob/Gyn. She commented that the visit could have been different if culturally competent, humbled, and appropriate care had been provided.

> 'When I first turned 21, my family doctor referred me to a GYN physician. I had the worst experience…I had never been to an Ob/Gyn before, and I did not know what to expect. I saw the nurse for about 15 minutes, during which she explained that I will be getting a pap smear…With no further explanations, the physician came in and started the procedure. I told her multiple times that I was uncomfortable and asked her to stop, but the doctor continued against my wishes. I got out of the office confused and in tears. I did not get another pap smear until last year when I found my current doctor and was able to talk to her about my terrible experience with the test. Unmarried girls/women in Iraq do not get pap smears…Needless to say, my first Ob/Gyn here in the US was completely insensitive to my cultural background.' (Iraqi, 26)

Another woman spoke about cultural norms and how they differ between generations. She spoke about how her mother's relationship with her physician was affected by these norms. As a result, she wanted physicians to be aware of cultural norms that may be misinterpreted, thus affecting the care of the patient.

> 'People who are older…it's hard for them to have conversation, to even have eye contact…if it's someone like a doctor, or a figure of authority. In Nepal or in Bhutan, if you have eye contact with people who are older than you or someone who needs to be respected, it's a bad thing…But here, if you don't have eye contact, then there's something wrong. It's a culture difference.' (Bhutanese, 30)

Discussion

Primary Objective

The primary objective of this study was to learn about family planning practices of the resettled refugee populations in the United States and the influences that promote or hinder contraceptive use. Similar to previous studies, this study demonstrated that refugee women have limited knowledge of sexual and reproductive health compared to women of the host population.[2-5] However, women in this study did report increased education on family planning through the migration and resettlement process, which influenced their family planning decisions. With improved knowledge of family planning and reproductive health, increased socioeconomic opportunities, and financial stability, women felt empowered to take control of their lives. This included pursuing educational and economic opportunities, choosing to be on contraception, limiting family size, and rejecting past norms of early marriage.

The impact of resettlement on empowerment and gendered roles is an important finding of this study. Very few studies have previously addressed the notion of empowerment in resettled refugee women and how it influences their family planning decisions. It is acknowledged that gendered roles in numerous cultures prohibit pre-marital sex and make sex and motherhood obligatory within a marriage, thus creating a barrier to education, access, and contraceptive use.[11] Studies have also noted that partner control can influence the contraception choices of refugee women.[4,12]

Our findings are consistent with Kabeer's definition of empowerment as "the process by which those who have been denied the ability to make strategic life choices acquire such an ability."[13] Additionally, the findings of this study align with the description of Upadhyay, et al, of the two most commonly cited measures of women's empowerment related to fertility: participation in household decision-making and mobility level (ability to travel outside the home).[14] Our study indicates that the evolution of

empowerment in resettled refugee women is multifactorial. It is likely a culmination of increased stability and thus mobility, changes in socio-cultural norms due to living in the United States, enhanced awareness of women's rights and changes in gendered roles, and improved educational and economic opportunities. It is important for providers to be aware of this and support women through the process of decision-making whether individually or with their partner. Since attitudes about partners did not emerge as a clear theme in this study, further studies are needed with partners in this population to help elucidate attitudes and barriers towards family planning.

Secondary Objective

The second objective of our study was to learn about the patient-provider relationship and counseling practices that are considered effective from the patient's perspective. Participants reported multiple barriers arising during office visits with health care providers. These included speaking English as a second language, the need for an interpreter, and cultural norms. Due to these barriers, women felt embarrassed discussing their family planning needs with medical providers, although this improved with the length of time of having been resettled in the United States. Nevertheless, many noted the importance of the topic but needed the provider to initiate the conversation. Additionally, women felt it important that the provider learn about their culture and religion, as these factors strongly influenced their family planning decisions.

Several studies have reported similar barriers to obtaining sexual and reproductive health services.[4,5,12] A systematic review found that language and "inappropriate sex or culture matching between the woman and health care provider" led to inadequate healthcare.[15] Studies evaluating the perspectives of the health care providers delivering care to refugee women have mentioned that providers often assume that women have adequate knowledge and expect them to be able to navigate their own sexual and reproductive health needs.[4,12] In this study, refugee women specifically stated that they wanted providers to start a conversation regarding family planning. This important finding has not been reported elsewhere in the literature. However, refugees have made similar statements in studies on barriers to mental health care.[16,17] In these studies, refugees stated that they wanted the provider to initiate the conversation and ask direct questions regarding their mental health.[16,17] This desire was often secondary to cultural norms requiring deference to a doctor's authority.[16] It was inferred that similar norms are present when health care providers discuss a woman's reproductive health.

Current screening guidelines for resettled refugees developed by the Centers for Disease Control and Prevention recommend screening for pregnancy but do not provide guidance on screening for unmet contraceptive or family planning options specific to newly arrived refugee women. Often, family planning is not addressed until the woman is scheduled for a well woman exam and Pap smear collection, which may be months after arrival to the United States. Authors of evidence-based guidelines published in 2011 by the Canadian Collaboration for Immigrant and Refugee Health reported that they found no guidelines for immigrant screening related to contraception.[18] As a result, based on studies on sexually active women, they recommended screening immigrant women soon after their arrival for unmet contraceptive needs.[18] Our findings support this recommendation that refugee women should be screened for unmet contraceptive needs at their initial health-screening exam and at subsequent primary care encounters, and be provided education on family planning options. One simple way to address family planning at any visit is to ask the One Key Question: "Would you like to become pregnant in the next year?".[19] This one question can open up the conversation for patients to discuss their family planning needs, whether contraception or pre-conception care, in a patient-centered way.

Strengths and Limitations

This qualitative study adds to the limited literature on refugees who are currently resettling in the United States. New findings on the evolution of empowerment and provider-initiated care will assist in providing better care to refugee women. In addition, whereas most studies focus on one refugee population, this study examined three different nationalities. As a result, the main themes presented in this paper are likely to resonate with other resettled refugee women of differing nationalities.

As a qualitative study, we recognize that the specific social context that produced these findings has shaped the results, specifically what women were willing to say and how they said it. Inevitably, there were differences between the FGDs and IDIs since the focus groups produced discussion between the participants, while the in-depth interviews did not. However, we did not notice meaningful differences between the responses received in FGDs and IDIs and so do not discuss any in this paper. Additionally, the number of FGDs and IDIs were not equivalent among participants of the three nationalities. Further studies can be done utilizing either FGDs or IDIs to eliminate possible differences. The study was also conducted with the aid of translators, and thus translation error or misinterpretation could have occurred during the interviews.

Implications for Practice and/or Policy

This study was executed in three populations of refugee women from Bhutan, Iraq, and Burma who resettled in Philadelphia. The three groups are distinct from a standpoint of ethnicity and national origin. Similarities were identified in these populations of women regarding the association of environmental safety to empowerment and the use of family planning and contraception. What can be learned from this study that may be helpful for medical practitioners in Hawai'i as they work with the family planning needs of immigrant and migrant populations?

The percentage of foreign-born individuals living in Hawai‘i has continued to rise over the last decade, with people immigrating from Asia, the Compact nations, Samoa, and other countries in the Pacific.[20] Similar to the refugee patients in this study, foreign-born women in Hawai‘i face many of the same barriers and challenges to family planning care. Language, education, culture, and socioeconomic factors influence their attitudes towards health services[21-24] and family planning.[25,26] Similar to these interviewees, the Pacific Islanders' young age and lack of education contribute to limited contraceptive use and unwanted pregnancy. Teen births are more common in Pacific Islanders compared to the United States.[27-29] In the Federated States of Micronesia and the Republic of the Marshall Islands, a high percentage of teenage pregnancies are linked to low family planning knowledge and lack of access to reproductive health services.[26,30] For Marshallese women, a lack of knowledge surrounding contraception use and Marshallese customs of not discussing sex or family planning options lead to women expressing embarrassment in discussing their sexual and reproductive health.[23,26] Chuukese women are modest and culturally their spouses usually have primary roles on health care seeking behaviors.[31,32] With such similarities across cultures and ethnicities, the findings presented in this paper will likely resonate with foreign-born women in Hawai‘i who have also moved in search of enhanced opportunities in health care, education, and employment.

Foreign-born women who resettle in a safer environment with increased opportunities are empowered to take control of their lives. This includes making informed decisions regarding family planning. Health care providers have a unique opportunity to connect with refugees and all foreign-born women in the clinical context. Participants overwhelmingly stated that they want their provider to initiate the conversation regarding family planning and contraceptive use. Thus, it is important for providers to feel comfortable, create an environment that is conducive to this sensitive discussion, and most importantly, initiate the conversation with their patients.

An important step is to incorporate cultural sensitivity training in the medical curriculum and in the workplace with practicing physicians. Such training can increase provider knowledge and enhance communication styles, resulting in improved care and quality support for refugee and immigrant women. Identifying unmet family planning needs will lead to informed healthcare decisions and planned healthy pregnancies.

Conflict of Interest

None of the authors identify any conflict of interest.

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