

Maternal and Reproductive Health Experiences of Francophone Refugee Women Living in Durham, North Carolina

A qualitative case study analysis

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For Laetitia

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Preface

I will never forget the first time I knocked on the door of a tiny apartment in the Oak Creek complex in Durham to meet my partner refugee family. As a student in Dr. Reisinger's service-learning class, my group members and I were on our way to meet a newly arrived refugee family from the Democratic Republic of Congo. Our partner family had only lived in the United States for a little over one month. I was terrified on that first day, not knowing what to expect from the experience. Would my French language skills be strong enough to communicate with the family members? Would I be able to understand the Congolese accent? Would I accidentally do or say something offensive or culturally inappropriate? These fears began to subside the moment that the family opened their door to welcome me and my classmates on our first visit.

My visits with this family throughout the semester included assisting with English language learning, translating important documents and generally aiding the family in assimilating to a new life in America. Most importantly, I came to form a lasting relationship with each member of the family, and I began to see my visits with the family as enjoyable time with friends, rather than two hours toward my service requirement. Through this partnership, I gained a new appreciation for the challenges faced by refugees living in the United States, and I was also able to see that, at its core, a Congolese refugee family is not very different from my own family. I became very close with my partner family, and continued to visit them, even when the semester ended and my service commitment expired. I try to visit my refugee friends at least once a month.

Many of my interactions with the French-speaking refugee population have involved their medical experiences in the United States. As an administrative intern in the Duke

University Hospital Emergency Department, I once encountered a French-speaking refugee woman in a hospital bed struggling to communicate with a physician attempting to prescribe medication. Although I had studied language barriers in healthcare through my global health coursework, I had never personally encountered the challenges faced by many French-speaking refugees in accessing healthcare services. The emergency room physician was unable to communicate effectively with the refugee patient, and because it was after-hours, a French translator was not available to come to the department. Although it is unreasonable to expect every provider in the United States to speak the first language of every patient that arrives at the hospital, this experience was eye-opening as it revealed to me the complexities of accessing quality healthcare as an immigrant in America.

Through conversations with my partner refugee family, I have learned of several common challenges that the French-speaking refugee population faces in navigating the complex American healthcare system. A language barrier and general lack of knowledge of the United States healthcare structures are among the most common frustrations. When considering a research topic for my senior thesis project, I hoped to explore the health-related challenges faced by the refugee population in North Carolina in an effort to better understand the frustrations of my refugee family.

I was inspired to specifically study the maternal and reproductive health of refugee women following my work investigating the sexual and reproductive health knowledge of adolescents in Muhuru Bay, Kenya last summer. Although adolescents in Muhuru Bay had not experienced forced displacement, I recognized similarities in the sacrifices made by both girls in Muhuru and refugee women in search of a better life. Although money is scarce, girls in Muhuru Bay often go to extreme means to pursue education, sometimes risking their sexual and

reproductive wellbeing to go to school. I hypothesized that many Central African refugee women may have also experienced poor reproductive health outcomes due to social and economic inequalities.

My thesis research on the maternal and reproductive health experiences of French-speaking refugee women is a perfect blend of all of my academic passions. This paper contains aspects of writing styles associated with both Global Health and French, and it is a unique blend of my two degrees and areas of study. In some places this paper is quite clinical, focusing on the social determinants of health and other important themes central to the Global Health research style. At times, the paper incorporates a more analytical and literary focus, echoing key aspects of any humanities piece.

The participants' and their stories are central to this work, and these stories serve to guide the reader through the thesis. Throughout the paper, I advocate for a patient-centered model of care in which patients are given the agency to lead medical interactions and advocate for their own healthcare. By the end of this paper, the reader will have had an intimate look at the complex and often troubling maternal and reproductive healthcare experiences of this population. I hope that you will gain a greater understanding of the challenges faced by the often hidden French-speaking refugee population. I am honored to present the voices of each participant through this piece in an unassuming, unbiased manner, focusing instead of the rich experiences and stories told by each woman.

Introduction

Who is a refugee?

While the average American may have an idea of what a “typical” refugee looks like, it is important to understand that there is no one image of a refugee. The recent Syrian refugee crisis has contributed to the stereotypical image of Middle Eastern refugees, as the crisis has been characterized by national media coverage and proliferation of heart-wrenching photos, such as the image of a young Syrian boy found on a beach in Turkey after having drowned in the Mediterranean Sea while trying to reach Europe (Walsh). This crisis narrative is emphasized in the media portrayal of refugee experiences, although the official definition of a refugee encompasses any individual who flees his or her country for fear of persecution. The 1951 Refugee Convention, organized by the United Nations High Commissioner for Refugees (UNHCR), defines a refugee as:

“A person who, owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion, is outside the country of his nationality and is unable or, owing to such fear, is unwilling to avail himself of the protection of that country; or who, not having a nationality and being outside the country of his former habitual residence as a result of such events, is unable or, owing to such fear, is unwilling to return to it.”

The convention also outlines the rights of displaced individuals, as well as the legal obligations of the participatory states to protect these individuals. According to the convention, participatory countries must grant asylum to refugees and cannot force a refugee to return to the country that he or she fled against their will. The convention further establishes basic minimum standards for the treatment of refugees, including access to courts, basic education, and work, as

well as the provision for documentation, including a refugee travel document in passport form. It is important to distinguish the difference between someone who flees persecution and someone who has been granted legal protections as a refugee. Not all migrants who are technically considered refugees according to the 1951 Convention definition will gain legal protections as refugees.

Refugee resettlement process

The process of obtaining refugee status is often long and arduous. Refugees currently living in the United States have endured a difficult process to gain the rare opportunity to gain entry into the country. Many refugees spend a decade or more in a refugee camp or an intermediary country before being scheduled to arrive in the United States. Zita Solange, a refugee from the Central African Republic, recounted her resettlement story to two volunteers from Church World Services, a refugee resettlement agency in Durham, North Carolina. Zita fled persecution in the Central African Republic on foot as part of a group of two hundred people trying to reach the CAR-Chad border. Once she arrived at the border, Zita and her family were met by United Nations staff and transferred to a refugee camp. Zita and her children spent nearly a decade in the camp before receiving confirmation that she would be permitted to relocate in the United States. Zita's initial resettlement date was delayed a year for unspecified reasons, but she eventually arrived in the United States with her children. Her husband, whom she met in Chad, arrived more than one year later.

Although each refugee resettlement story is extremely varied, a typical timeline has been outlined by the Obama Administration White House staff. In order to obtain refugee status, an applicant presents him or herself to the UNHCR operating within the refugee's country of

asylum; for example, a Central African refugee might seek refuge in Chad, where she locates a refugee office. The UNHCR collects identification documents and performs an initial assessment of her status. During this initial stage, the applicant is interviewed multiple times to confirm the need for resettlement, a process that can be traumatic and emotionally challenging for refugees who are often asked to recount stressful experiences. Only applicants who are considered to be “strong candidates” move forward in the process of resettlement in the United States. Less than 1% of the world’s refugee population are considered “strong candidates” and granted the opportunity to move forward in the resettlement process (Pope). The entire refugee screening process, as outlined in the following paragraphs, is conducted in the refugee’s host country. All required screenings occur before the candidate has reached the United States.

Next, the applicant is received by a Resettlement Support Center (RSC) while living in host country abroad. Refugees in consideration for resettlement in the United States are then screened by federal organizations such as the National Counterterrorism Center/Intelligence Community, the Federal Bureau of Investigation (FBI), the Department of Homeland Security and the State Department. Refugees undergo the highest level of security checks of any category of traveler to the United States. After this initial screening, the candidate is then interviewed by the trained officers from the Department of Homeland Security, followed by biometric security checks that analyze the candidate’s fingerprints. Only candidates with no security clearance issues move forward to the final stages of the resettlement process.

Following security clearance, trained doctors conduct medical screenings of the candidate. Some refugees may be denied entry into the United States due to medical reasons, including those suffering from communicable diseases of public health significance, quarantinable disease, and diseases reportable as a public health emergency of international

concern to the World Health Organization, such as active tuberculosis, cholera, and viral hemorrhagic fevers. Prior to 2010, refugees infected with HIV were barred from entering the United States, but this is no longer a medical restriction (Pope). Before arriving in the United States, refugee candidates must also complete cultural orientation classes. The purpose of these cultural orientation classes is “to provide refugees the opportunity to acquire knowledge, skills, and attitudes they need in order to resettle and adjust to a new life in the United States” (Cultural Orientation Resource Center). These classes address 11 essential topics related to processing, travel and resettlement, including pre-departure processing and travel, role of the resettlement agency, housing, health, cultural adjustment, rights and responsibilities, employment, education, learning English, money management, community services and transportation.

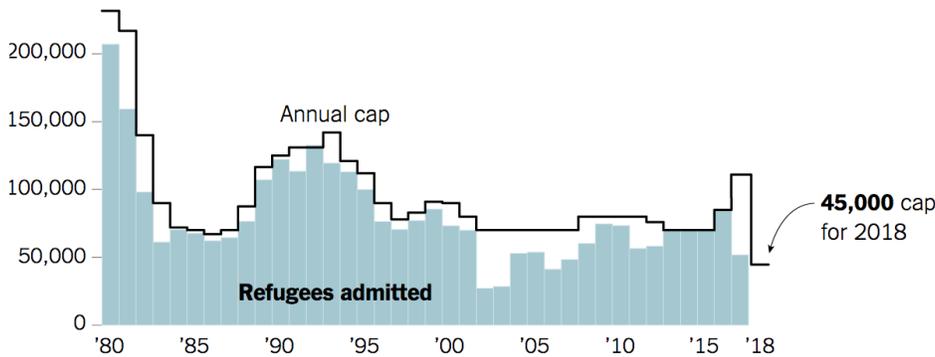
Refugees are then assigned to domestic resettlement locations, where travel to the new host country is arranged by the International Organization for Migration. Although travel to the United States is free for refugees at the time of travel, refugees are expected to repay their travel expenses once they begin working. Refugees who arrive in the United States are required to apply for a green card within one year of resettlement.

The United States offers asylum to a predetermined number of refugees that meet criteria to enter the country. The modern refugee resettlement program officially began with the advent of the Refugee Act of 1980, which included the UN criteria for refugee status and set the legal basis for the Refugee Admissions Program (BRAC). Each fiscal year, the President of the United States defines a cap on the number of refugees who can enter the country. In 1986, Ronald Reagan set the cap for refugees admitted to the United States at 67,000, the lowest cap in American history (Davis & Jordan). This cap changes each year for a myriad of political, economic, and cultural reasons. Most recently, Donald Trump, the current President of the

United States, has established a cap of 45,000 refugees for fiscal year 2018, as outlined in the figure below, reversing a pattern of growth established in the early 2000s (Davis & Jordan).

A Historically Low Cap on Refugees

President Trump will lower the cap on refugees admitted to the United States to 45,000 for the 2018 fiscal year, down from the 110,000 cap set by President Barack Obama before he left office. Mr. Trump had previously ordered that the country admit no more than 50,000 refugees in 2017.



By Alicia Parlapiano | Sources: Migration Policy Institute; State Department

Figure 1: Proposed cap for refugees entering the United States in 2018

There is an unequal distribution of refugee resettlement across the fifty states of the United States. In fiscal year 2016, 54% of all refugees admitted to the United States were resettled in 10 states. Some states did not accept any refugees at all, and others, including Washington, DC, accepted less than 10 refugees in total (Radford & Connor).

North Carolina and refugees:

Between 2011 and 2016, more than 13,000 refugees were resettled in North Carolina. The majority of these refugees were from Burma, the Democratic Republic of the Congo, and Bhutan (Iszler). In fiscal year 2016, North Carolina accepted 3,342 refugees, placing it 7th in the country for refugee resettlement (Radford & Connor).

Durham, North Carolina, a small city of approximately 263,000, accepts, on average, 450 refugees a year (Childress). Due to the relatively large population of refugees in Durham, several

organizations exist to aid refugees in facilitating their transition to an American lifestyle. There are three refugee resettlement agencies in Durham that welcome and support refugees through their first experiences in the United States. These agencies help each family and individual throughout their resettlement in the country. Church World Services (CWS), one of these refugee resettlement agencies, welcomes around 350 refugees to Durham each year (Church World Services Durham). World Relief and Lutheran Family Services in Durham also accept refugees upon arrival in Durham. The number of refugees welcomed by each resettlement agency depends on many compounding factors. One determining factor is the cap established by the President and the national distribution of refugees across the United States, making it challenging for agencies to plan more than 1-2 months in advance.

Duke University, located in Durham, North Carolina, facilitates a number of programs to aid refugees in the area. One such program is an organization called SuWa—Supporting Women’s Action. Supported by the Kenan Institute for Ethics, SuWa is an undergraduate student-led organization that works to empower refugee women through education, small business development and community building. Medical students at the Duke University School of Medicine lead another program called The Refugee Health Initiative (RHI), which provides in-home health education for refugee families in Durham. Volunteer medical students are partnered with refugee families to provide health education on topics such as proper use of medication, exercise, nutrition, reproductive health behavior, mental and dental health. Duke University faculty also offer numerous undergraduate service-learning courses that connect student volunteers with refugee organizations and families in Durham. These are housed in language departments, in English, and in the Duke Global Health Institute (DGHI).

Why study francophone refugees?

In fiscal year 2016, the largest group of refugees to enter the United States was from the Democratic Republic of Congo (Radford & Connor). 16,370 refugees from the Democratic Republic of Congo were accepted into the United States, representing 19% of all refugees to enter the country that year (Radford & Connor). The second largest group of refugees to enter the United States that year was from Syria, with 12,587 total refugees resettled (Radford & Connor). Although French-speaking refugees compose a significant portion of the refugee population in the United States, this group is largely invisible in American society, media and politics. In fact, many Duke students and fellow Durham residents do not know of the Central African refugee population living right next door. The lack of research available on Central African and French-speaking refugees may contribute to the invisibility of this group in the United States. Without research and advocacy for the rights of this group, francophone refugees will continue to be ignored in dialogue on refugee populations in the United States.

The French-speaking refugee women included in this study are originally from the Democratic Republic of Congo and the Central African Republic. In order to better understand the experiences of these refugees, it is important to consider the reasons for the refugee crisis in each country.

Background

Refugee crisis in the Democratic Republic of Congo

Armed conflict and civil unrest have tormented the Democratic Republic of Congo (DRC) since 1996. This complex conflict began with the invasion of Eastern DRC by Rwandan troops, who were searching for the individuals responsible for the Rwandan genocide of 1994 and who were hiding in the eastern part of the DRC and planning to retake political control of Rwanda (Vépière). Many years of conflict followed, including the First Congo War in 1996 and the Second Congo War in 1998. Although a peace accord was signed in 2003, a humanitarian crisis persists in the DRC today (Vépière). The DRC contains more internally displaced persons than any other country in the world, placing the country ahead of nations such as Syria, Iraq, Afghanistan and Nigeria (Schwikowski). The Internal Displacement Monitoring Centre (IDMC) counted 922,000 internally displaced persons in the DRC in 2016, emphasizing the urgency needed to aid this population (Schwikowski).

The prolonged conflict in the DRC has had a significant impact on the physical and psychological wellbeing of the population. It can be assumed that the majority of Congolese refugees have experienced or have witnessed violence throughout their life course (Mantuba-Ngoma, 1). Congolese women have been particularly and uniquely affected by the conflict in the DRC, where rape is often used as a weapon of war. Sexual violence targeting women has increased the spread of HIV/AIDS and other sexually transmitted illnesses. There are reports of young girls being raped in front of their parents as a form of torture and humiliation (Mantuba-Ngoma, 1). Many women have lost their spouses as a result of conflict violence. These widowed women are often left traumatized by their loss and witnessed violence (Mantuba-Ngoma, 1).

Many women also lost their children and other family members during the conflict, adding to the prevalence of psychological problems in women from the DRC (Mantuba-Ngoma, 1).

Judith Bass, an associate professor at the Bloomberg School of Public Health at Johns Hopkins, has conducted mental health interventions targeting sexual violence survivors in the DRC. Her research has shown that survivors of sexual violence have high rates of depression, anxiety and post-traumatic stress disorder (PTSD). In 2013, Dr. Bass and her team conducted a controlled trial of psychotherapy for Congolese survivors of sexual violence. In this trial, the research team randomly assigned 16 villages in the country to provide cognitive processing therapy or individual support to female sexual-violence survivors with high levels of PTSD symptoms and combined depression and anxiety symptoms. The study revealed that group psychotherapy reduced PTSD symptoms and combined depression and anxiety symptoms and improved functioning, suggesting evidence-based practice for the mental health treatment of survivors of sexual violence in the DRC.

Because women have been directly and negatively impacted by the humanitarian crisis in the DRC, they have mobilized as an important group to ending the conflict. Mantuba-Ngoma emphasizes the important role that women in the DRC have played in restoring peace to the country, stating that *“les femmes ont décidé de s’impliquer fortement dans la résolution du conflit, en participant activement aux diverses négociations pour l’instauration de la paix dans le pays/women decided to forcefully involve themselves in conflict resolution efforts by actively participating in many negotiations for the instauration of peace in the country”* (2).

Socioeconomic factors have also had a large impact on the health of women in the DRC during and following the conflict. Consequences of socioeconomic inequalities experienced by women in the DRC include reduced food production, increased food insecurity and malnutrition,

reduced household incomes and inadequate healthcare leading to epidemics of diseases such as cholera, measles and meningitis (Kalonda).

Refugee crisis in the Central African Republic

The Central African Republic (CAR) has been characterized by civil unrest for decades due to an unstable government, but the refugee crisis in the CAR worsened when a coup led by a group of rebels deposed President Ange-Félix Patassé and took control of the government in March 2013. François Bozizé, the leader of this rebel operation, proclaimed himself as President of the CAR. In December 2013, hundreds of thousands of individuals living in the CAR were forced to flee their homes. Militants brutally murdered civilians, ravaged homes and burned villages. Today, more than 500,000 refugees from the CAR seek asylum in countries such as Cameroon, Chad, the Democratic Republic of Congo and the Republic of Congo. 600,000 more individuals are internally displaced within the CAR (UNHCR, CAR situation).

The current situation in the CAR is one of the most poorly funded emergency situations in the world (UNHCR, CAR situation). Many individuals from the CAR lack basic necessities for survival. Food, health, housing, water and public hygiene are all major concerns for refugees living outside official sites (i.e. outside of refugee camps) and for the communities that host these individuals (UNHCR, CAR situation).

Rape is also used in the CAR as a weapon of war (United Nations Security Council). Although widespread, sexual violence remains under-reported in this context. It is believed that many victims of sexual violence do not report the abuse due to fear of stigmatization and embarrassment. In fact, some reports indicate that victims and their families are often threatened by government officials to keep their silence (United Nations Security Council). Under-reporting

has also been aggravated by a lack of confidence in the judicial system of the country. The disintegration of the judicial system has contributed to a lack of protective measures for victims of sexual violence. This failure has hindered access to aid and support for victims. Women's health has also been directly affected by the physical destruction of hospitals and other medical centers (United Nations Security Council).

Refugee women from the DRC and the CAR have been negatively affected by political unrest and violence associated with crisis situations. This study is particularly interested in the maternal and reproductive experiences of refugee women because women from conflict zones are particularly vulnerable to poor outcomes in maternal and reproductive health (Chi et. al).

Maternal health

In order to analyze the stories told by each participant in this study, it is important to understand what constitutes “good” maternal health, as well as what barriers to maternal healthcare exist for refugee women in Central Africa.

The World Health Organization has identified several maternal health indicators that can be used to measure the progress of a country on the goal to better maternal health outcomes. The indicators that are particularly pertinent for women in a humanitarian crisis are: 1) maternal mortality, 2) unmet need for family planning, 3) antenatal care coverage, 4) skilled birth attendant at delivery, and 5) access to emergency obstetric services.

Maternal mortality. The maternal mortality ratio of a country represents the obstetric risk associated with each pregnancy, and is a strong indicator of the quality and accessibility of maternal healthcare services in a country. The average maternal mortality ratio in low- and

middle-income countries in 2015 was 239 per 100,000 live births. Almost all (99%) of maternal deaths occur in low- and middle-income countries (WHO, Maternal mortality). The maternal mortality ratio in the Democratic Republic of Congo in 2015 was 693 per 100,000 live births, and the maternal mortality ratio in the Central African Republic in 2015 was 882 per 100,000 live births (WHO, Maternal mortality 1990-2015). These ratios classify both countries in the top ten countries with the highest maternal mortality. A high maternal mortality ratio in the DRC and the CAR reflects the inequitable access to health services for women living in conflict zones, even as compared to other women living in sub-Saharan Africa, which had an average maternal mortality ratio of 546 in 2015 (Unicef).

Unmet need for family planning. Unmet need for family planning is defined as the percentage of women of reproductive age, either married or in a union, who want to stop or delay childbearing but are not using any form of contraception (United Nations, Department of Economic and Social Affairs, Population Division). The equation below explains this metric in mathematical terms:

$$\text{Unmet need for family planning} = \frac{\text{Women of reproductive age (15-49) who are married or in a union and who have an unmet need for family planning}}{\text{Total number of women of reproductive age (15-49) who are married or in a union}} \times 100$$

Access to family planning can improve maternal health outcomes by reducing the number of high-risk and high-parity births, thereby reducing maternal mortality. Furthermore, family planning can help to prevent unwanted pregnancies, some of which may result in unsafe

abortions—one of the leading causes of maternal deaths globally (Say, et. al.). The most recent Demographic and Health Survey data, conducted in 2013-2014, shows a 30% unmet need for family planning among married individuals in the DRC and a 45% unmet need for family planning among unmarried individuals in the DRC (PRB). The most recent Demographic and Health Survey data for the CAR, conducted in 2011, shows a 27% unmet need for family planning (DHS). It is important to note that individuals displaced by conflict may not be represented in the Demographic and Health Survey and may have an even greater unmet need for family planning.

Antenatal care coverage. Antenatal care is defined as the care provided by skilled healthcare professionals to pregnant women and adolescent girls in order to ensure the best health conditions for both mother and baby during pregnancy (WHO recommendations on antenatal care for a positive pregnancy experience). Antenatal care includes the identification of risks during pregnancy, the prevention and management of pregnancy-related or concurrent diseases, and health education and promotion. The World Health Organization emphasizes the importance of antenatal care for a positive pregnancy. Antenatal care reduces maternal mortality directly, through the identification of obstetric complications, and indirectly, through the management of pregnancy in at-risk populations, such as adolescents and HIV-positive mothers. The WHO recommends at least four antenatal care visits during a pregnancy to ensure the best outcomes for mother and baby. Globally, 86% of pregnant women access antenatal care with a skilled health professional at least once, but only 52% of pregnant women in sub-Saharan African receive at least four antenatal care visits (Unicef, Antenatal care). Expanding access to antenatal care and increasing the number of antenatal care visits for pregnant women can have a significant impact on the maternal health outcomes of pregnant women in conflict zones.

Skilled birth attendant at delivery. The WHO also emphasizes the importance of having a skilled birth attendant present at every delivery in order to ensure better maternal outcomes during birth. A skilled birth attendant is defined as a doctor, nurse or midwife who could prevent or manage obstetric complications if necessary. In sub-Saharan Africa, only around half of all live births were delivered in the presence of a skilled birth attendant in 2016 (WHO, Skilled Birth Attendant).

Emergency obstetric services. There are two levels of emergency obstetric care: basic and comprehensive. According to guidelines outlined by the United Nations Population Fund, in order for a facility to meet criteria of basic emergency obstetric care, the facility must have the capabilities for:

- Administering antibiotics, uterotonic drugs (oxytocin) and anticonvulsants;
- Manual removal of the placenta;
- Removal of retained products following miscarriage or abortion;
- Assisted vaginal delivery, preferably with vacuum extractor;
- Basic neonatal resuscitation care.

To be considered a comprehensive obstetric care facility, a facility must have the capabilities of all of the functions listed above, as well as capabilities for:

- Performing Caesarean sections;
- Safe blood transfusion;
- Provision of care to sick and low-birth weight newborns, including resuscitation.

Globally, at least 25% of pregnancy-related complications result from the absence of family planning or the inability to access safe procedures (WHO). The majority of maternal morbidities and mortalities could be prevented with improved reproductive and obstetric healthcare. There is

no cause of death or disability for men aged 15 to 44—the so-called “reproductive age”—that is close to the magnitude of maternal mortality and morbidity (O’Heir).

Maternal health in a refugee camp setting

The UNHCR asserts that health is a human right and thus prioritizes its protection. One goal of the UNHCR is to assure that all refugees are able to access healthcare that is equivalent to the health services available to the local population surrounding the refugee camp. These services must adhere to minimum humanitarian standards. The UNHCR articulates the potential reproductive healthcare risks in a humanitarian crisis in their “Emergency Handbook”, a “guide to agile, effective and community based humanitarian emergency responses”. Issued in 2015, the 4th edition of the UNHCR’s *Handbook for Emergencies* is primarily used for UNHCR emergency operations and its workforce. In the chapter titled “Health in camps”, the UNHCR highlights that reproductive health problems, and in particular, obstetric and pregnancy related complications, are more likely during complex human emergencies.

Focused attention on reproductive health of refugee women has developed gradually over the last twenty years. In the 1990s, the response of humanitarian agencies to the reproductive health needs of women in crisis was limited (O’Heir). The first time that these needs were mentioned on a global platform was in 1994 at the International Conference on Population and Development in Cairo. In 1999, five years following the Cairo conference, an updated version of the UNFPA’s Field Manual was distributed, including recommendations on addressing the reproductive health needs of refugee populations.

In 2004, O’Heir et al. published a study on the care for pregnant refugee women in low-resource settings following conflict and displacement. The data presented in that study show that

poor pregnancy outcomes are common in many populations affected by war. However, the data also indicates that pregnancy outcomes for refugees are often better than those same outcome measures for women in the refugees' country of origin and for women living in the refugees' host country. In 1998, the UNHCR compiled data from eight refugee camps around the world for a global report. This report indicated that the rates of neonatal deaths and maternal deaths at each refugee site were lower than the estimates in the countries of origin and the host countries.

The most likely reason for this discovery is the availability of health services in refugee camps. The UNHCR often employs a community health workforce to achieve the goal of reaching each refugee in the camp. The widespread availability of humanitarian aid staff in camps may help to ensure that refugee women receive more consistent and higher quality care. While pregnancy-related issues are high among populations in plight, many of these concerns may be improved in a refugee camp where women have access to quality health services. The success of a comprehensive reproductive healthcare system depends on the presence of well-trained staff, the availability of necessary supplies, equipment and medications, access to basic emergency obstetric care, sufficient funds, community participation and coordination among international aid agencies.

While some factors of organized humanitarian assistance may improve maternal care for refugee women living in camps, it is important to note that life for women in refugee camps is not easy. The rate of sexual assault is much higher for women in plight (O'Heir, Vu, et. al.). These women were forced to leave their home countries, their families and their own lives because of fear of persecution. A systematic review of literature on the prevalence of sexual violence among female refugees in complex humanitarian emergencies revealed that approximately one in five refugees or displaced women experienced sexual violence (Vu).

However, the study conducted by O’Heir emphasizes that good maternal and reproductive health is possible for women in exile if a concerted effort is made to ensure this quality of healthcare.

In 2010, the WHO published the “Inter-agency Field Manual on Reproductive Health in Humanitarian Settings.” This manual synthesizes documented best practices in crisis situations globally. The manual highlights the importance of good reproductive health for populations in crisis by presenting the consequences of neglecting reproductive health in humanitarian crisis situations, including maternal and neonatal mortality, sexual violence, unplanned pregnancies, unsafe abortions and the potential spread of HIV.

To help ensure good reproductive health in populations in crisis, the WHO created the Minimum Initial Services Package (MISP), a set of recommendations that is the starting point for quality reproductive health in humanitarian crises. The MISP was updated in 2010 to reflect recommendations outlined in the field manual. The objectives of the MISP are: the prevention of sexual violence and the clinical management of the consequences of rape; priority interventions to reduce HIV transmission; priority interventions to reduce maternal and neonatal morbidity and mortality; and the rapid implementation of comprehensive reproductive health services integrated with primary care. The MISP can serve as a guideline for organizations working to ensure quality healthcare in times of crisis. To meet the needs of pregnant women in crisis, the MISP establishes a referral system to facilitate transportation and communication between the community and the health facility. It is important that pregnant women have access to safe obstetric care. Following the WHO indicators for maternal health, the MISP emphasizes that each health facility should have skilled birth attendants, supplies for normal deliveries and management of obstetric and neonatal complications. The MISP offers the distribution of hygienic delivery kits to visibly pregnant women and birth attendants “to promote hygiene home

deliveries when no access to the health facility is possible.” These kits contain basic supplies including: a plastic sheet, a bar of soap, a pair of gloves, a clean razor blade and three pieces of string (to cut the umbilical cord), two pieces of cotton fabric (one to dry the baby and the other to swaddle the baby), and illustrated explanatory brochures. These kits can be ordered through the UNFPA.

The WHO stresses that “these actions should be supported and expanded with comprehensive reproductive health services throughout crises and recovery” (MISP). The objectives and recommendations presented in the MISP are *minimum* benefits. These benefits and services must be increased and scaled-up to ensure a better state of care for populations in crisis.

Maternal health of refugees in the United States

Upon entry into the United States, all refugees must apply for health insurance coverage. Some refugees qualify for Medicaid, a government-sponsored health insurance plan. Medicaid provides health coverage to millions of Americans, including eligible low-income adults, children, pregnant women, seniors and people with disabilities. If refugees meet eligibility criteria for Medicaid, they enjoy many benefits of the program, including maternal and reproductive health care coverage. Medicaid covers family planning, evaluation and treatment of sexually transmitted infections, prenatal care, obstetric care, and post-natal care up to 60 days after birth. Voluntary abortions are not funded by Medicaid under the Hyde Amendment, which prohibits the use of federal funds for abortion, except in the case of life-saving measures, or if the pregnancy results from incest or rape (Taylor & Ravi).

If refugees are not eligible for Medicaid coverage, they may enroll in the Refugee Medical Assistance Program (Taylor & Ravi). This program is a temporary health coverage plan and lasts only the first eight months following the arrival of the refugee in the United States.

If a refugee's place of employment offers health insurance coverage, she may choose to utilize this coverage plan, often for a monthly fee. If this is not an option, refugees can also seek medical coverage through the Health Insurance Marketplace through the Affordable Care Act (Taylor & Ravi). Refugees receive the same benefits as United States citizens under this law. Preventative health services, including contraceptives, are covered without cost-sharing. Other services covered include annual exams, breast and cervical cancer screenings, services to support survivors of violence, breastfeeding services, and the screening and treatment of sexually transmitted infections. These services are essential to ensure a healthy reproductive life for refugees. The Affordable Care Act also includes maternity coverage similar to the Medicaid program.

Refugees can also seek reproductive health care at non-profit health organizations such as Planned Parenthood, which offers comprehensive reproductive health services for any woman. Still, such reproductive health clinics are at risk of losing funding from the government, which would result in a significant reduction in access to quality reproductive healthcare for low-income families, including refugees.

Study goal

There exists a research gap in refugee women's reproductive health, and particularly for the francophone refugee population. Although refugee reproductive health rights and outcomes have not been studied extensively, even articles that focus on this topic have ignored the Central African French-speaking female population (Gagnon et. al.). The refugee crisis in Central Africa is one of the most serious humanitarian crises globally, and women's health is of particular concern due to the prevalence of sexual violence in this setting. Furthermore, refugee women deserve access to basic maternal and reproductive healthcare, especially in a humanitarian crisis, because effective family planning can help improve outcomes for the entire family (Family Planning 2020).

This thesis explores the maternal and reproductive health experiences of French-speaking refugee women living in North Carolina. The stories gathered from conversations with refugee women are analyzed for their relation to the maternal health indicators and recommendations outlined by the WHO, UNHCR and other organizations as explained in this section. The purpose of this paper is to highlight the importance of efforts focused on the maternal and reproductive health of refugee women, and specifically, the power of refugee women's voices on this subject. A patient-centered research approach whereby refugee women are able to speak of their own maternal and reproductive health experiences is essential in providing optimal care to an already marginalized population of women.

Methods

Study overview

The researcher recruited Francophone refugee women living in Durham, North Carolina to participate in this qualitative case study. Each participant participated in a one-time qualitative interview conducted in French at her home. The purpose of the interview was to assess refugee women's experiences with maternal and reproductive healthcare across the three stages of the life course of resettled refugees: stage 1—conflict zone, stage 2—intermediary country, and stage 3—resettlement in the United States. This life course perspective was selected to be broad enough to encapsulate the varied paths to arriving in the United States, yet specific enough to effectively analyze and compare refugee experiences.

Setting

This study was conducted in Durham, North Carolina. Prior to 2008, Durham County received an average of 40 refugees annually for resettlement. From 2008 to 2010, Durham County experienced a 450% increase in refugee arrivals (Durham County Community Health Assessment). Since then, the three agencies in Durham have resettled a fairly constant number of refugees each year, accepting an average of 450 refugees annually. The majority of refugees arriving in Durham each year are accepted by three main local agencies: World Relief, Church World Services and Lutheran Family Services.

Refugees in Durham interact with various health systems in an uncoordinated manner. Upon arrival in the United States, refugees receive an initial infectious diseases screening from the Durham County Health Department. At the Health Department, each refugee is then scheduled for an appointment to see a physician at the Lincoln Community Health Center,

although the first doctor's visit could be 3-4 months after the initial health screening at Health Department. Dr. Emily Esmaili from the Lincoln Community Health Center explained that refugees are seen every 6-8 weeks for at least the first 8 months of living in the United States. Dr. Esmaili believes that there are systemic barriers preventing refugees from receiving the full benefits of the many health services in Durham, including language barrier and a lack of knowledge of the American health system (Esmaili, interview, 2018).

Although the Lincoln Community Health Center focuses primarily on family medicine, the clinic does work to address maternal and reproductive health questions and concerns. For example, physicians at Lincoln will have conversations about family planning with refugees during newborn visits. According to Esmaili, community health centers such as Lincoln provide sexual health counseling services for adolescent refugees. Providers are able to provide contraception and abortion services to these adolescents because they do not require family or parental consent.

Participants

To be eligible for this study, participants were required to be French-speaking refugee women from Central Africa currently living in the United States who had given birth at some point in their lives. Five women were recruited for participation in the study. This small sample size is reasonable for a qualitative case study, especially given the limitations in eligibility criteria and number of eligible participants in the area.

Participants in this study were initially recruited via flyers (Appendix B) distributed to refugee agencies in Durham, including the main offices of Church World Services and World Relief. Participants were also recruited through convenience sampling, whereby scripted and

IRB-approved text messages (Appendix C) were sent to participants who had a pre-established relationship with the researcher. Subsequent participants were recruited through a snowball sample in which the initial participants suggested eligible women whom she believed may be interested in participating in the study. A snowball sample was especially beneficial to this study because of the nature of this hard-to-reach population.

Procedures

Prior to implementation of the study, the researcher received approval from the Duke University Institutional Review Board. After hearing an initial description of the study procedure via a scripted text message, interested participants were instructed to contact the researcher to organize an interview meeting time. Each interview occurred in the home of the participant and was conducted in French. Participants were required to provide verbal consent before beginning the interview. Each participant separately consented to be audio-recorded for transcription and translation purposes. Each interview lasted an average of 60-70 minutes. Every woman who completed the qualitative interview was compensated with \$25 in cash for her time.

Measures/Materials

Although the interview process was unstructured, an interview guide was used to organize the interviews (Appendix A). The interview guide was organized around four major topics: 1) perception of health system structure and general healthcare experiences, 2) maternal and obstetric healthcare experiences, 3) history of family planning, and 4) hopes for the future. The interview followed the life course of each participant, and the researcher posed questions from each category of the interview guide when eliciting the participant's healthcare experiences

at that life point. For example, a participant may have been asked to explain the general health system of her country of origin, and later asked to explain the health system structure of her intermediary country. Sample questions from each category are outlined in the table below:

Table 1: Sample interview questions from interview guide

Category	Sample Question 1	Sample Question 2	Sample Question 3
<i>Health system structure and general healthcare experiences</i>	When you are sick, where do you seek care?	Tell me about the person who provided you with healthcare services.	Tell me about the last time you visited a health clinic.
<i>Maternal and obstetric healthcare experiences</i>	Tell me about the first time that you were pregnant.	When you thought you might have been pregnant, what did you do?	Tell me about your visits to health clinics during your pregnancy: what kind of pre-natal care did you receive?
<i>History of family planning</i>	Before you began having children, did you think of an ideal number of children to have?	Tell me about any education you have had on ways you could plan your pregnancies to ensure that you only became pregnant when you were ready to be pregnant.	If your daughter or other close female family member was of reproductive age and possibly sexually active, what would you recommend that they do?
<i>Hopes for the future</i>	What kind of support are you looking for in your healthcare experiences in the United States?	Do you hope to have more children in the future?	How can the medical community satisfy your physical and mental health needs in the United States?

Each question was framed to elicit a story from the participant, rather than a yes or no answer. This was important in encouraging the patient narrative central to the methodology of this study. The questions in the health system structure and general healthcare experiences category were intended to identify participants' attitudes in accessing general health services, both in the United States and abroad. The researcher posed the questions in the maternal and

obstetric healthcare experiences category in order to gain an understanding of women's obstetric and pre-natal histories. Questions on each participant's history of family planning were asked to assess contraceptive knowledge, beliefs and use. Questions about the participants' hopes for the future were used to assess each participant's identified areas of improvement in the United States health system. These categories were explored across each distinct life stage.

Data Analysis

Audio recordings of the interviews were transcribed and key sections of each interview were translated into English. The transcribed and translated data were then analyzed using a thematic analysis approach (Nowell et. al.). Each interview transcript was read several times and closely examined for key details and emerging themes. The most important themes of the transcript were identified and recorded to serve as the basis for further analysis and organization. Quotations from each transcript were organized according to each identified theme in order to efficiently analyze similar subject areas that may have been discussed at various points in one interview. Narrative memos based on the organized transcripts were written to summarize the main themes and important life events expressed in each interview. These narrative memos were helpful in distinguishing the various life experiences of the participants and organizing the content of the thesis results section. The narrative memo followed a general structure, starting with a short paragraph outlining and summarizing the life course and maternal health experiences of the participant. Next, the organized transcript notes were attached, allowing for easy comparison of quotations on a general topic.

For example, "general healthcare structure in host country" was a common theme discussed in each interview. This theme would therefore be included in every participant's

narrative memo, allowing for an efficient and easy comparison of the general healthcare structure in each participant's home country. From this cross-transcript analysis, themes and experiences common to a majority of participants were discovered. These common experiences act as a basis for the findings of this study, presented in the "Results" section below.

Results

This section presents five interviews with study participants. The general life course of a refugee will be discussed in terms of three distinct stages. The first stage is the conflict zone, the country of origin of each refugee. In most cases, a woman gained refugee status because of the civil unrest experienced in this conflict zone. The second stage is the intermediary period, a time when a refugee lived in a country with the protection of refugee status, while waiting to be resettled in the United States. In the intermediary period, a refugee may or may not live in a refugee camp. Because the experiences of a refugee in a camp are distinct from a refugee not living in a camp, these two settings will be discussed as sub-groups of the intermediary period. The third stage is resettlement in the United States. For many refugees, the United States is the final destination in a long journey of resettlement. With this structure, the healthcare experiences and beliefs of refugee women can be easily compared across each stage of the life course. The life course stages are outlined in a logic model below:

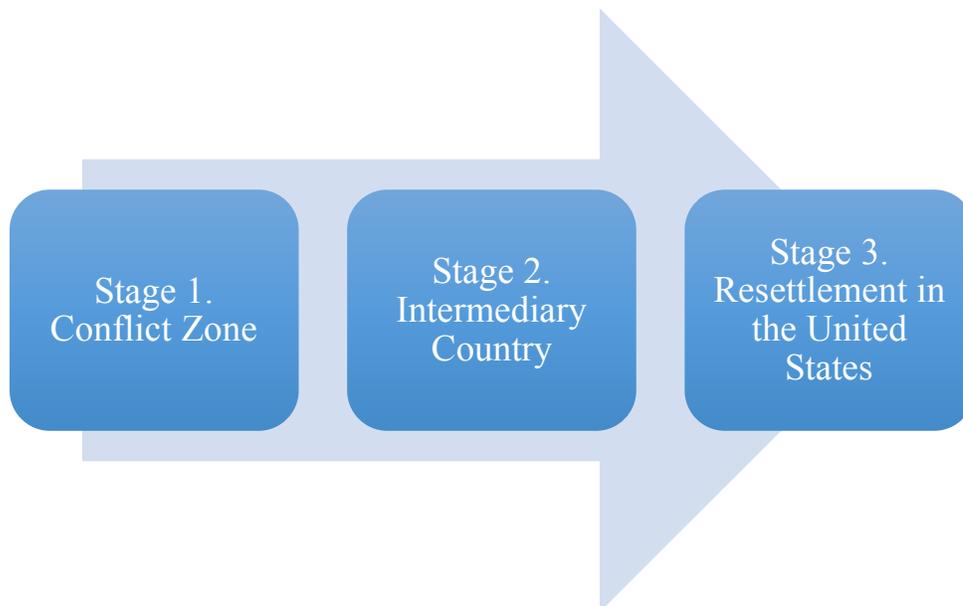


Figure 2: Stages of refugee life course

Reports across categories were uneven, with most participants sharing great detail of their maternal and reproductive health experiences in an intermediary country as compared to in the United States or in a conflict zone. This may be because the majority of maternal health experiences discussed throughout the interviews occurred while living in an intermediary country. Furthermore, the average length of time spent in the intermediary country was 10 years; for some participants, the time spent in an intermediary country accounted for the longest period of their life.

Description of Participants

While every participant in this study was a French-speaking refugee woman currently living in the United States who has given birth, each participant has traversed a unique path to arrive in North Carolina as a refugee.

A total of five women were interviewed for this study. Participants included women from the Central African Republic (n=3), the Democratic Republic of Congo (n=1), and the Republic of Congo (n=1). Each participant has refugee status in the United States, and each was resettled in Durham as her first resettlement site in the United States. Participants spent time in the following countries as refugees: Cameroon (n=1), Chad (n=2), and the Republic of Congo (n=2). Two participants resided in a refugee camp during their time living in an asylum-seeking country. The time spent in the United States was extremely variable among participants. One participant arrived in the United States in 2014, one in 2015, one in 2016, and one in 2017. The fifth participant did not state how long she had lived in the United States.

Each participant has given birth to multiple children. The average number of births was 4.2. Participants have given birth in the following countries: Central African Republic, the

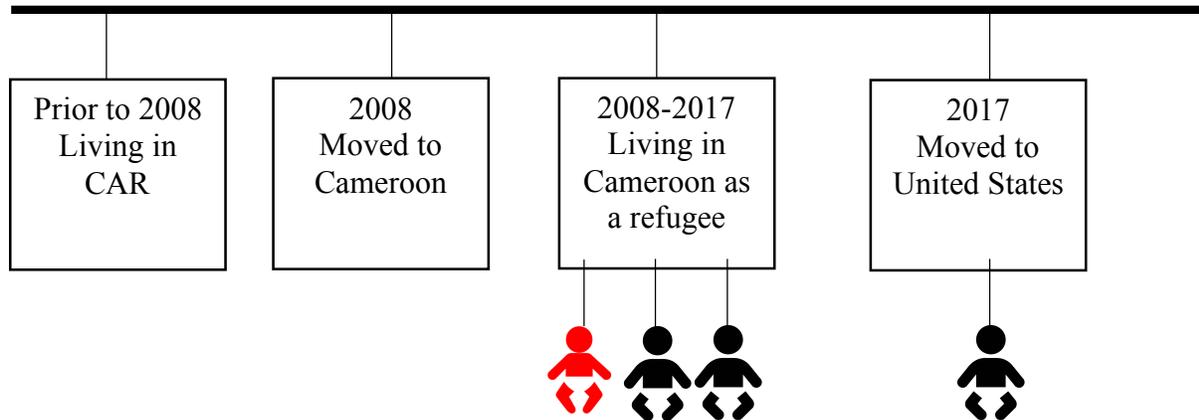
Democratic Republic of Congo, the Republic of Congo, Cameroon, Chad and the United States.

Two participants have given birth to a child in the United States, and one participant was pregnant at the time of the interview. Participants range in age from 21 years old to 55 years old.

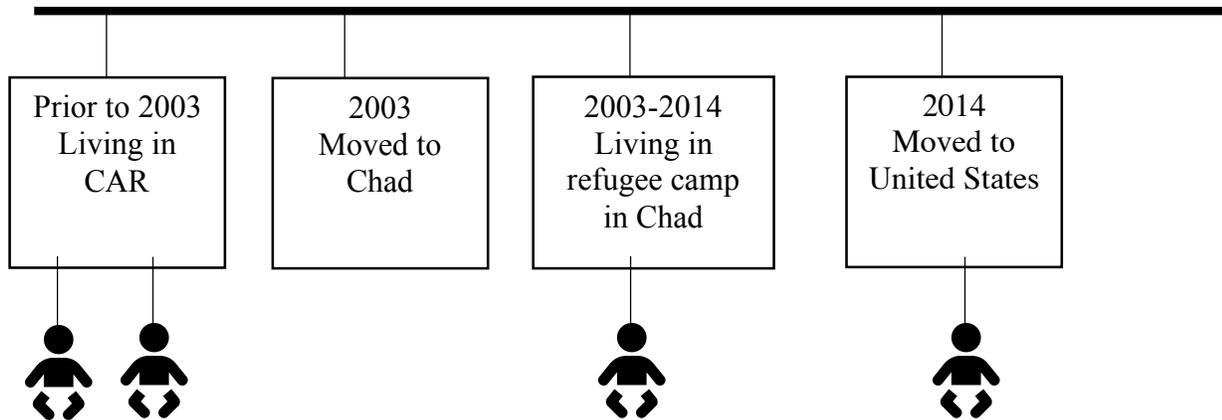
Participant biographies

Each participant will be introduced in this section, using pseudonyms. These pseudonyms will be used throughout the rest of the thesis when discussing the participants. A timeline of each participant's pathway to arrival in the United States is outlined below. Each birth is represented by a baby icon, placed on the timeline at the life stage where the newborn was delivered. A red baby icon represents the death of a child. A pregnant woman icon represents a participant who is currently pregnant.

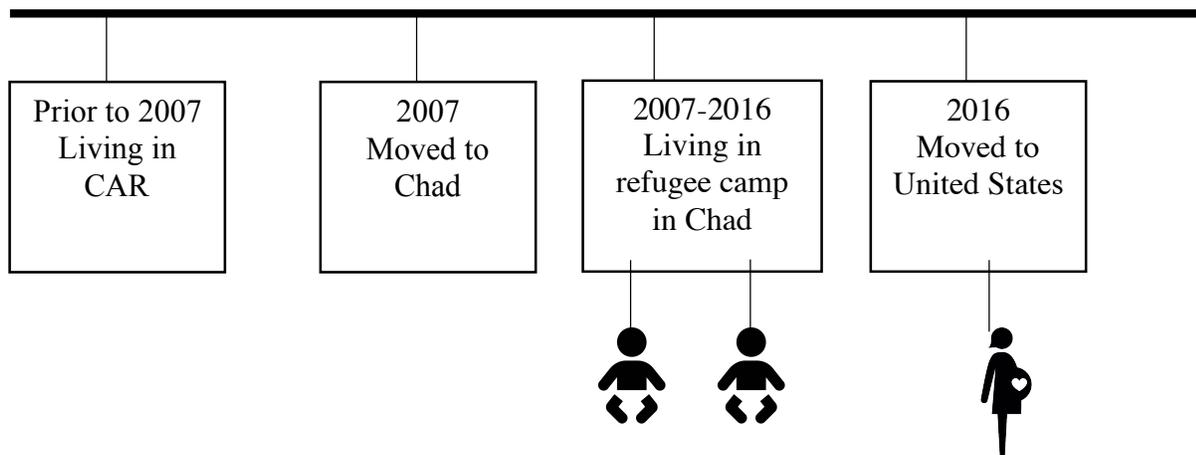
Rose (~25 years old) was born in the Central African Republic and fled to Cameroon as a refugee in 2008. Unlike the traditional course of a refugee, Rose did not reside in a refugee camp during her nine years of residency in Cameroon. Rose gave birth to three children in Cameroon, although her first born child passed away. In 2017, Rose moved to the United States with her husband and two children. Upon arrival to the United States, Rose discovered that she was four months pregnant with her fourth child. Rose delivered at Duke University Hospital in Durham, North Carolina in 2017.



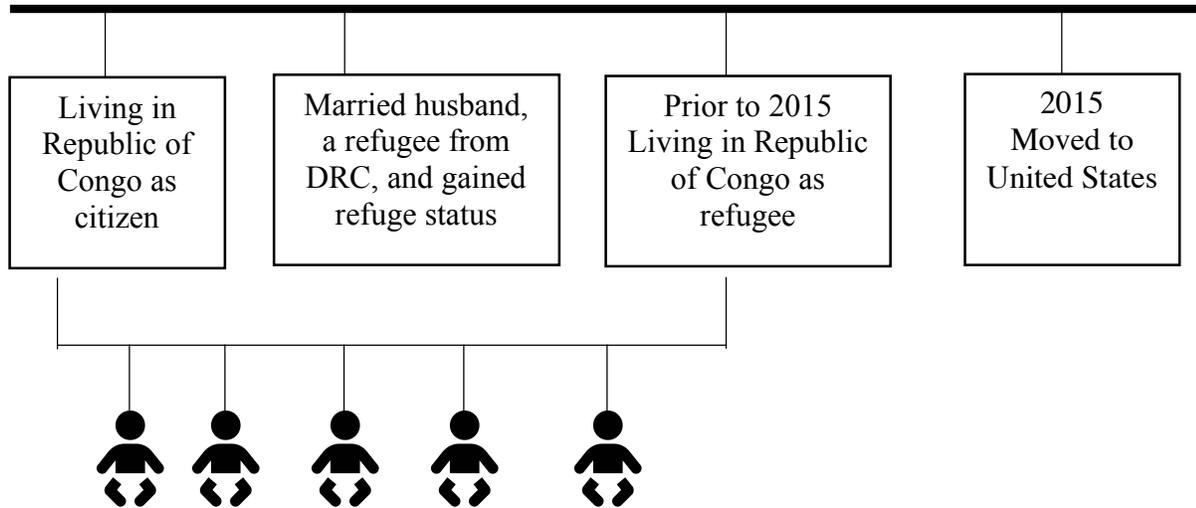
Alizia (~32 years old) was born in the Central African Republic and fled to Chad as a refugee in 2003. She resided in a refugee camp in Chad for 11 years before arriving in the United States in 2014. Alizia gave birth to two children in the CAR, one child in Chad and one child in the United States. Alizia was 8 months pregnant when she arrived in the United States, resulting in a stressful arrival as she rushed to secure Medicaid insurance. Alizia delivered at Duke University Hospital in Durham, North Carolina in 2014.



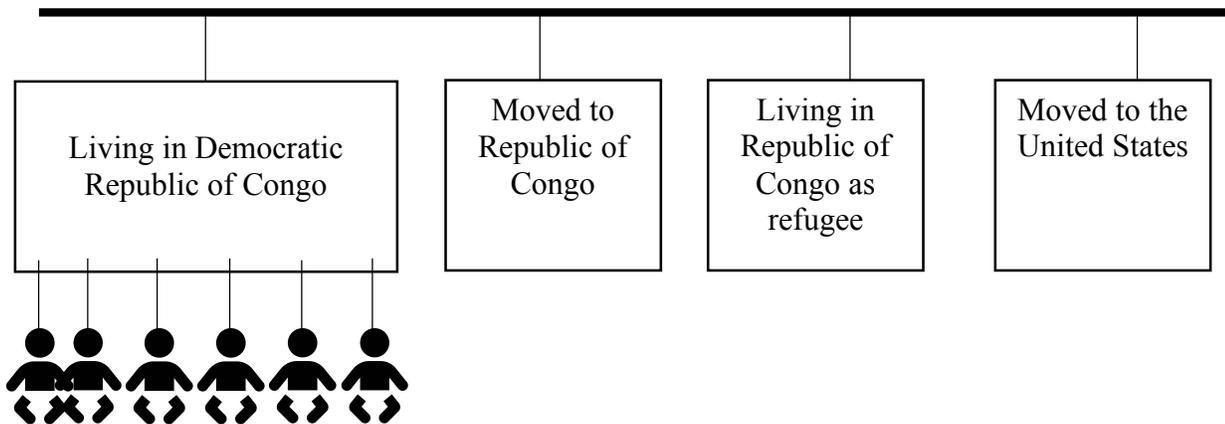
Elodie (~21 years old) was born in the Central African Republic and fled to Chad as a refugee in 2007. She lived in a refugee camp for almost 10 years before arriving in the United States in 2016. Elodie gave birth to two children in Chad and was pregnant with her third child at the time of the interview. Elodie plans to deliver at Duke University Hospital in Durham, North Carolina in 2018.



Victoire (~35 years old) was born in the Republic of Congo, Brazzaville. While living in Congo, she married a man from the Democratic Republic of Congo who was seeking refuge in her country. She gave birth to five children in the Republic of Congo before coming to the United States as a refugee in 2015. Although she reports having experienced political violence in Congo, Victoire and her five children gained refugee status via her husband who lived through unspeakable horrors that forced him to leave the DRC. Victoire experienced mistreatment and medical malpractice during the delivery of her third child, the details of which are outlined later in this study.



Josephine (~55 years old) was born in the Democratic Republic of Congo and fled to the Republic of Congo as a refugee. Josephine did not reside in a refugee camp during her time in the Republic of Congo, but rather moved frequently throughout the country. Josephine gave birth to six children, all of whom were born in the Democratic Republic of Congo prior to fleeing the country. Josephine has been living in the United States for almost 3 years.



A. General healthcare

The first questions asked when discussing each distinct setting in which a participant lived were focused on the general healthcare experiences that the participant had experienced in that location. The questions generally inquired about the structure of the health system for refugees in that setting, the availability and type of healthcare providers in that setting, and the participant's overall impression of the health system. In this section, the general healthcare experiences of the participants will be discussed across the refugee life course: in a conflict zone, in an intermediary country, and in the United States.

Stage 1: Conflict Zone

Although the five participants of this study lived in three different countries of conflict in Central Africa, there were commonalities in the experiences of each participant. One similarity was the general health structure of each country described by the participants. Most participants identified hospitals as the first point of contact in the health system for a sick individual.

Participants reported that tests to identify an illness were performed at the hospital, followed by treatment or referral to a specialist within the hospital or in a private clinic. The participants also stated that medical professionals at these hospitals could prescribe and directly distribute any necessary medications to the sick patient.

There was a discrepancy in reports on the presence of ambulatory services in a country of conflict. Alizia, from the Central African Republic, stated that members of the community operated ambulances to bring sick individuals to the hospital; however, Elodie, also from the CAR, stated that, "*c'est à nous de chercher pour aller à l'hôpital*" it is up to us to go to the hospital", implying that it was the responsibility of the community members themselves to find a

way to the hospital, without a true ambulatory service. Ambulatory services are a strong indicator of a country's capacity to provide quick emergency healthcare and is a direct indicator of the level of care available in the country (Berman).

Alizia, from the CAR, and Victoire, from the Republic of Congo, both mentioned community health centers as another option for sick individuals to seek medical care. Victoire provided a great deal of detail about the tiered health system that existed in the Republic of Congo, a system that she compared to the health system in North Carolina. She indicated that she visited large hospitals "*comme tout le monde*/like everyone" for urgent or specialized care, but that there also existed smaller community health centers for more general health concerns, which she paralleled to the Lincoln Community Health Center of Durham. Victoire explained that a patient at a community health center in the Republic of Congo would pay 2500 francs for a consultation. This up-front payment included the funds for a physician consult and any medications that may be necessary. Victoire stated that a consultation with a specialist at a large hospital would be more expensive, possibly costing 5000 francs. Victoire compared the cost differential between a doctor's visit at a community health center and at a hospital to the difference of visiting a doctor at Duke University Hospital versus at Lincoln Community Health; it is more expensive to be treated at Duke, just like it was more expensive to go to a hospital in the Republic of Congo.

The up-front financial cost of accessing healthcare was a defining characteristic of the healthcare systems in each participant's country of origin. Many participants described being required to purchase various items related to the provision of care, including Alizia who was required to purchase a notebook for the medical staff to record information on her medical condition during her visit. Hospitals required patients to pay for care from the moment that they arrived at the facility. If these funds were not received, the patient would not receive care from

the hospital. Many participants preferred to seek care from private health facilities in Central Africa. Because public health facilities are not free, participants noted that they would rather spend money at a private facility where they perceived an elevated standard of care from private medical professionals.

The financial barriers to accessing healthcare were more than just an annoyance for these participants—they were indicative of the underlying political corruption of each conflict country, as described in this quote:

Mais dans les caisses de l'état, quand tu paies, ça ne vient pas dans sa poche [celle du médecin], ça va dans la poche du gouvernement. Même la consultation que tu paies, ça va dans la caisse du gouvernement. Tu vois, certains médecins n'ont pas cet amour-là de bien s'occuper des patients. Mais par contre, quand tu es dans un cabinet privé, ils vont le faire, parce que là-bas, tu es libre de poursuivre si tu as la possibilité. Donc, dans les cabinets privés, ils prennent bien soin des patients. (Victoire)

But concerning government funds, when you pay, the money doesn't go to his pocket [the doctor's], it goes into the pocket of the government. Even the consultation that you pay goes into the government's pocket. You see, certain doctors do not have a love for taking good care of their patients. But by contrast, when you are in a private clinic, they will do it, because there, you are free to continue if you can. In private clinics, they take good care of their patients. (Victoire)

Victoire continued to emphasize the importance of having money to ensure access to medical care, stating that, “*En Afrique, quand tu n’as pas des moyens, tu peux perdre ta vie*// In Africa, when you don’t have [financial] means, you can lose your life”.

In addition to the financial challenges of accessing healthcare, Alizia, from the CAR, spoke about a lack of medical specialists in hospitals in her country. Even when medical specialists were employed at health facilities, she noted that doctors were not always available to see patients. She described how a patient might have arrived at the hospital and not have had access to a provider that could treat the specific ailment of that patient. Doctors typically worked from 7:00 am to 5:00 pm, so if a patient needed to be seen after-hours, a doctor might not be available to treat her.

Although each participant presented several criticisms of the healthcare system in their country of origin, Elodie, from the CAR, believed that the system was well-organized and functioning properly before the war began. Victoire also noted that the quality of the healthcare itself was not poor, but rather it was the governmental management of the health system that led to so many problems, stating that “*L’Afrique en santé n’est pas mal, mais ce qui tue notre pays africain, c’est son gouvernement*/Health in Africa is not bad, but what kills our African country, is our government”. These comments emphasize the impact of conflict on the health structure and functioning of a country, highlighting the fact that the conflict status of a country must be considered when assessing healthcare capacity of that area.

Stage 2: Intermediary Period

Alizia and Elodie resided in a refugee camp in Chad during their time living in an intermediary country before resettling in the United States. Rose lived in Cameroon during this

intermediary period, although she did not live in a refugee camp. Victoire and Josephine both lived in the Republic of Congo during this period, also not residing in a refugee camp. The general healthcare experiences of participants that lived in a refugee camp during their time in an intermediary country are vastly different from the experiences of those who did not live in a camp. The experiences of these two groups will be discussed separately in this section.

i. In a refugee camp

Healthcare services for refugees in UNHCR-administered refugee camps are free. In the refugee camp in Chad, there were doctors, nurses and midwives available at health centers throughout the camp. There were also surgeons available. Elodie noted that there were two hospitals available to the refugees living in the camp: one hospital in the camp itself and one hospital in a city just outside of the limits of the camp. In the case of an emergency, the refugees were taken to the larger hospital in Maro, Chad.

Si tu tombes malade, mais si ce n'est pas grave, toi-même tu peux aller à l'hôpital. Mais si c'est grave, tu peux appeler ambulance et l'ambulance va venir te chercher et t'amener à l'hôpital. Si c'est grave encore à l'hôpital, on va t'envoyer à Maro. (Elodie)

If you fall ill, but if it is not too serious, you can go to the hospital. But if it is serious, you can call an ambulance and the ambulance will come to take you to the hospital. If it even more serious once you arrive at the hospital, they will take you to Maro. (Elodie)

Elodie remembered the presence of many community health workers in the refugee camp. The community health workers were available at least once a week to speak with refugees about any health concerns that they may have. Elodie emphasized that the community health workers were not doctors, and that they played a different role in the health system structure at the camp. Alizia speaks about the abundance of international aid at the refugee camp, resulting in many volunteers, community health workers, and medications. Due to the abundance of aid for refugees provided by the United Nations, Alizia believed that “*les soins au Tchad sont mieux que là-bas chez nous [en Centrafrique]*/the health services in Chad are better than in the Central African Republic”.

Elodie noted the high turnover of medical doctors in Chad, remembering that often, doctors would arrive to work for six months or one year before leaving again. This rapid turnover of medical professionals is especially pertinent in terms of maternal healthcare, since a woman may not be able to meet with the same health care provider throughout her pregnancy in a refugee camp setting.

ii. In a host country

Rose, Victoire and Josephine each reported that hospitals were the main center for healthcare in Cameroon and the Republic of Congo. These hospitals were not located in refugee camps or even necessarily designated refugee hospitals, but rather incorporated into the host community.

Rose, who arrived in Cameroon in 2009, initially felt that refugees were well-treated during her first three years of residence in the country. She believed that health services for refugees were fair, comprehensive and reasonably priced. In fact, refugees—and all citizens—could pay a fee of 300 francs for a consultation at the hospital and receive a comprehensive set of services including necessary exams and medications. However, Rose noticed a change in the health

structure for refugees living in Cameroon in 2012. She reported that when refugees arrived at hospitals seeking care, they were asked to pay an augmented price of 3,500 francs to receive the same services that once cost only 300 francs. Furthermore, Rose stated that refugees who were ill were told that they were not sick and simply given acetaminophen for relief, without having any tests done to determine what was ailing them.

When asked why she thought there was a change in the treatment of refugees, Rose blamed the Cameroonian government, and suggested corruption. Rose remembered that the United States announced that the number of refugees was large and that there was not enough money to support all refugees in the country; however, she also believed that the Cameroonian government did not use the money that they received for the provision of the refugee population to actually care for the refugees residing in the country. She stated that “*les Camerounais ne veulent pas l'utiliser pour nous, les étrangers/ the Cameroonians do not want to use [the money] for us, the foreigners*”. The inability of the Cameroonian health system to handle the influx of refugees from the CAR led to the suffering and death of many refugees in the area. Rose reflected on the widespread mistreatment of refugees during this time, stating that “*beaucoup de gens meurent à cause de la maladie, beaucoup de réfugiés souffrent au Cameroun/ lots of people die due to illness, lots of refugees suffer in Cameroon*”.

Victoire and Josephine, who both resided in the Republic of Congo as refugees, described a more structured healthcare system for refugees. These reflections do not necessarily mean that seeking refuge in the Republic of Congo ensured better treatment. Additionally, both participants left the Republic of Congo to move to the United States at the peak of the refugee crisis in Cameroon, which may explain some of the differences seen in the health structure for refugee services between the two countries.

Josephine described a hospital specifically tasked with providing care to refugees in the Republic of Congo. She believed that she was cared for very well at this hospital and during her time in the Republic of Congo, stating that “*à chaque moment, quand je suis tombée malade, je pars à l’hôpital, on m’a soignée très bien/* at any moment, when I fell ill, I went to the hospital and was treated very well.” Josephine noted that all care provided at the refugee hospital was free for refugees.

Victoire is originally from the Republic of Congo, but the health services available to her changed once she gained refugee status through her husband. Victoire then received access to non-profit clinics operated through partnerships with the UNHCR, such as one medical center called *Médecins d’Afrique*. When a refugee arrives at the clinic for a consultation, she is seen by a health professional and given necessary medicines and other products on site, free of charge. When the clinic does not have the necessary medications on-site, they are able to make an order and a refugee can return to the pharmacy within a few days to pick up the prescription. If the providers at the clinic are not able to provide a certain service, the patient is transferred to a local hospital in order to see a specialist. Victoire noted that often, if the UNHCR had sufficient funds, the consultation with a specialist would be provided free-of-charge for refugees. Victoire also stated, in the case of a hospitalization, the organization would arrange to find and fund any necessary goods.

Victoire emphasized that refugees were not always so well cared for in every context. As mentioned when discussing the importance of financial capital in accessing healthcare in the Republic of Congo as a citizen, Victoire emphasized this importance, even for refugees. This is especially true in instances of low funding from the UNHCR. Victoire stated that “*on avait beaucoup de réfugiés mourir parce que le HCR dit qu’ils n’ont pas l’argent/* many refugees died

because the UNHCR said that they did not have money”. Even so, Victoire asserted that even refugees without financial capital can benefit from their refugee status, particularly in receiving assistance from agencies such as the UNHCR. “*Mais vous qui n’êtes pas réfugié, quand vous n’avez pas l’argent...vous n’avez rien/* But if you are not a refugee, when you do not have money...you don’t have anything at all”.

Stage 3: Resettlement in the United States

All participants described generally positive health experiences in the United States. This finding was particularly surprising based on the extensive literature and anecdotal accounts of healthcare barriers for refugees post-resettlement in the United States (Morris et. al.). Rose stated that “*le système de santé ici est très bon...il n’y a pas de problèmes ici/the health system here is very good...there are not problems here*”. These quotes and reported experiences should not be interpreted to mean that there are not issues in the American health system’s treatment of refugee patients; however, this point will be elaborated in the discussion.

Rose and Alizia both mentioned that American healthcare providers are punctual and well-organized. They especially note the attention to scheduled appointments. Rose noted that “*ici, si tu as ton rendez-vous, ils t’appellent...il te rappellent que tu as le rendez-vous, déjà une grande différence de ce qu’on a en Afrique/here, when you have an appointment, they call you...they will remind you that you have the appointment, already a big difference than what we have in Africa*”. Alizia also remarked that “*ici, les gens respectent vraiment les rendez-vous/here, people really respect appointments*”. Alizia emphasized the speed at which medical staff work to care for patients in the United States. Furthermore, she stated that unlike in Central Africa, one can

always find necessary medications in the United States, “*donc, ici c’est mieux que là-bas/so, here it is better than over there*”.

One criticism of the American health system is that it is expensive. Alizia expressed her concern about the cost of healthcare in America, stating that, “*je vois que les services aux Etats-Unis sont très bien...sauf que l’hôpital est cher/ I believe that services in the United States are very good...except that the hospital is expensive*”. Alizia also criticized the long wait times to be seen by a provider, even stating that she is discouraged from visiting the hospital because of the wait: “*les infirmières prennent la tension ou la température, on te met dans une salle pour attendre le médecin, tu peux prendre 30 minutes, une heure de temps...c’est ça qui me décourage à aller à l’hôpital aux Etats-Unis/the nurses take your blood pressure or your temperature, they put you in room to wait for the doctor, which can take 30 minutes to an hour...that is what discourages me from going to the hospital in the United States*”.

Victoire is critical of feeling rushed during visits with doctors in the United States. When she made an appointment to visit a doctor about her asthma, the doctor informed her that he only had 15-20 minutes to speak with her. Victoire is the same woman who had a very close and long-lasting relationship with her obstetrician in the Republic of Congo, a beloved physician who delivered her five children. Victoire explained why her American doctor’s rushed disposition angered her by comparing a good doctor to a good teacher:

Un bon enseignant, quand l’enfant dans la classe veut exprimer ce qu’il sent, l’enseignant ne l’arrête jamais. Bien au contraire, l’enseignant écoute cet enfant, un enseignant essaie d’exploiter l’intelligence de cet enfant.

A good teacher, when a child in the class wants to express how he feels, the teacher never stops him. Quite the contrary, the teacher listens to that child, a teacher tries to exploit the intelligence of that child.

There is great variation in the general healthcare structure and experiences described in each stage of the refugee life course. Most participants agree that the health system in their host countries began to deteriorate with the onset of political and civil unrest. Although each participant has a unique experience with the general healthcare systems in her intermediary country, the researcher concluded that refugees living in a refugee camp had more reliable access to health services due to the presence of UNHCR staff. All participants stated that the health system in the United States was better than the general healthcare provided to them in Central Africa, although many participants noted frustration with long waiting periods and not having enough face-to-face time with the provider in medical settings in the United States.

B. Maternal healthcare

The majority of time in the interviews focused on the maternal healthcare experiences of the participants. The researcher posed questions to assess access to prenatal care, including whether a woman attended prenatal visits during her pregnancy, the kind of medical professionals she visited, and the care that was provided during prenatal visits. Questions were also asked to gain insight into the labor and delivery experiences of participants at each stage of her refugee journey. These questions included where a woman delivered her baby, if a skilled birth attendant was present at the birth, and whether the woman was satisfied with the level of care and attention that she received during childbirth. Questions were also asked to determine the

types of services available to refugee women during childbirth, including caesarean section, epidural and oxytocin for labor stimulation.

Stage 1: Conflict Zone

Alizia, Josephine and Victoire each gave birth in their country of origin, during a time of conflict. Each of these women were living in a different country—Alizia in the CAR, Josephine in the DRC, and Victoire in the Republic of Congo. Alizia and Josephine both described the challenges of pregnancy and delivery without support from the health system. Alizia stated that throughout her first pregnancy in the CAR, she did not receive any prenatal care and delivered at home without the presence of a skilled birth attendant. She explained that, “*chez nous, c’est les villages, donc, il y a des femmes qui aident aussi les gens/* in our home, we have villages, so it’s women who help people”. Alizia further explained:

Parfois quand on est enceinte, on ne peut même pas aller à la consultation, comme ici, les soins prénatals. Donc tu peux rester et le jour que tu veux accoucher, toi seule même tu peux rester dans ta maison, tu accouches.

Often when a woman is pregnant, she can’t even go to an appointment, like here [in the United States], prenatal care. So you stay there and the day that you want to deliver, you, by yourself, you stay at your home, you deliver.

Alizia’s home delivery was particularly long and arduous, and potentially risky. She was in labor for two days at her home, in severe pain, without the presence of a skilled birth attendant.

Alizia utilized health facilities during her second pregnancy and delivery in the CAR. She cites embarrassment as one reason for not seeking medical support during her first pregnancy. Alizia was a young student in school during her first pregnancy, which may have contributed to her feeling of embarrassment and stigmatization that prevented her from visiting the hospital during her pregnancy and delivery.

Victoire, from the Republic of Congo, also noted a similar feeling of embarrassment when she informed her parents of her first pregnancy. Victoire was also a young student in school when she became pregnant, and she expressed feelings of disappointment from her parents who had high academic aspirations for her:

Quand j'ai découvert que c'était une grossesse, mes parents étaient un peu fâchés, parce que je partais à l'école, et on avait beaucoup d'espoirs sur moi, et quand ils m'ont vue avec cette grossesse, c'était pour eux...comme je peux dire, une déception. Parce qu'ils ne s'attendaient pas une grossesse avant le mariage pendant que je suis encore étudiante.

(Victoire)

When I discovered that I was pregnant, my parents were a little angry, because I was at school and they had high hopes for me. When they saw that I was pregnant, it was, how can I explain it, like a big disappointment. Because they were not expecting a pregnancy before marriage while I was still a student. *(Victoire)*

Participants were also asked to elaborate on the availability of certain maternal health services. When asked about the availability and safety of cesarean delivery in the DRC,

Josephine stated that there is not necessarily an elevated risk for women delivering via C-section in the DRC.

Non, il n'y a pas beaucoup de risques. C'est normal. Il y a des gens qui peuvent avoir des césariennes mais il y a des autres où l'enfant peut mourir et la maman se sauve ou bien la maman morte et l'enfant sauve, ou bien tous les deux. C'est comme ça. Ça dépend.
(Josephine)

No, there are not many risks. It's normal. Some women can have C-section, but there are others where the baby dies and the mother survives, or the mother dies and the baby lives, or even both [may die]. That is just how it is. It depends. (Josephine)

Josephine's description of the availability of C-section in the DRC demonstrates the uncertainty of maternal healthcare outcomes in the country. While a woman may have access to a C-section, that procedure may not be safe, and a positive outcome for the mother or baby cannot be guaranteed.

Alizia expressed a more critical opinion of the risks of C-section on the African continent, stating that there are many risks and that many women die from complications associated with C-sections. She cites a lack of materials and equipment as one of the major reasons for the differences in risk associated with C-section in Africa and in the United States, stating that “[aux Etats-Unis], les médecins ont beaucoup de matériaux, mais en Afrique on n'a pas beaucoup de matériaux/ in the United States, doctors have lots of materials, but in Africa they do not.” Alizia explained that doctors in Africa must have reliable access to electricity in

order to light the equipment for visibility during the operation. Because access to electricity is not always reliable, doctors may have to stop the operation mid-surgery, which can lead to the death of the mother. It is important to note that these statements represent Alizia's perceptions of the health system in sub-Saharan Africa, and do not necessarily reflect the true availability of surgical equipment throughout the continent.

Stage 2: Intermediary Period

i. In a refugee camp

Alizia and Elodie both reported attending prenatal care visits during their pregnancies in the refugee camp. Prenatal visits begin after two or three months of pregnancy, and the prenatal consultations are held at the refugee camp hospital. At these visits, a doctor would check on the status of the baby using an ultrasound and provide prenatal vitamins, injections and other necessary medications to the mother. Elodie believes that it is important to attend these prenatal visits in order to ensure that the baby is cared for and safe.

Elodie's belief in the importance of prenatal care has changed since her first pregnancy. Elodie's first pregnancy was in a refugee camp in Chad. Elodie did not know that she was pregnant until a few months into the pregnancy, which she credits to the fact that it was her first time being pregnant. When she realized that she was pregnant, she did not want to seek medical care at the hospital. Her husband called the community health workers to come speak with her. As Alizia also explained, all pregnant refugees in the camp must report their pregnancy and seek pregnancy care at the hospital. The community health workers explained to Elodie that she was required to attend prenatal visits or else "*ils vont appeler la police puisque je vais tuer l'enfant/* they will call the police because I will kill the baby". Elodie did not elaborate on her reasons for

not wanting to seek medical care at the hospital. Following this encounter with community health workers in the camp, Elodie began seeing a doctor in the hospital for regular pre-natal checkups.

Alizia and Elodie both spoke of the specific maternal risks associated with malaria during pregnancy in a refugee camp setting. Alizia cited the risk of contracting malaria as one of the main reasons for the community health workers' insistence on pregnant women seeking prenatal care. Malaria is a common killer in refugee camps, and children and pregnant women are especially vulnerable to the disease. Every pregnant refugee woman receives a free mosquito bed net as part of her prenatal care from the hospital. Both participants explained that hospital staff demonstrate how to use the net to protect oneself from malaria by sleeping under the bed net to prevent mosquito bites. When the baby is born, the hospital will also provide a free mosquito bed net for the newborn to protect against malaria. Alizia warned of the danger of neglecting your responsibility to attend prenatal visits.

On te montre comment te protéger, comment garder la grossesse, mais si tu ne pars pas à l'hôpital, tu connais pas, tu peux te négliger, ça peut te tuer ou tu peux avoir l'avortement forcé. (Alizia)

They will show you how to protect yourself, how to keep your pregnancy, but if you do not go to the hospital, you don't understand, you might neglectful yourself, and your actions could kill you or cause you to have an abortion. (Alizia)

The importance of prenatal visits is emphasized in refugee camps, and attendance is enforced by UNHCR staff and local community health workers. This insistence helps to ensure that pregnant refugee women are meeting the maternal health recommendations of the WHO by attending at least 4 prenatal care visits during the course of a pregnancy.

ii. In host country

Victoire and Josephine both described the prenatal care available to pregnant women in the Republic of Congo as an intermediary country. Victoire attended monthly prenatal care visits in a private clinic during each of her five pregnancies. Victoire was often ill and weak during the pregnancy of her second child, prompting her to request an HIV test from her doctor. Her doctor responded to her request, stating that, “*tel que je vois, tu es très sensible, et tu as perdu beaucoup de poids, mais tu portes une grossesse, donc je ne peux pas te faire cet examen maintenant/* as far as I can see, you are very delicate, and you have lost a lot of weight, but you are pregnant, so I cannot give you this test right now”. The reasons for the doctor’s refusal to perform an HIV test are not completely clear, but Victoire believes that he did not want her to know her HIV-status because “*avec cette maladie, tu peux vivre, tu peux avoir des enfants/* with this illness, you can live, you can have children”. In the end, the physician did perform the HIV test without informing Victoire that he was going through with her request. The doctor submitted the test with a pseudonym for anonymity. The results showed that Victoire was seronegative, and her doctor decided to share these results with her.

Like Victoire, Josephine also attended monthly prenatal visits. Josephine explains that pregnant women receive vaccines and other medications at these visits, and also have a chance to see the evolution of the fetus via ultrasounds. Josephine believes that these visits are important in

ensuring the health of your child, stating that “*si tu ne pars pas, ça depend de Dieu/ if you do not go, it is up to God*”.

Rose, who lived in Cameroon during this intermediary period, described in great detail the challenges that she faced in delivering her children in a public hospital in Cameroon. Rose explains that childbirth requires that a substantial upfront cost be paid before care would be provided when giving birth in a public hospital. Pregnant refugees and their families were expected to purchase all necessary equipment for the labor and delivery, including soap and a clean mat for the woman to deliver on. Rose notes that “*il faut arriver a l’hôpital avec tous, ou si u n’as pas, tu donnes l’argent pour ça et eux-même, ils vont acheter/ you must arrive to the hospital with everything, or if you do not have it, you can give the hospital staff money and they will purchase the necessary equipment themselves*”. Rose believes that her husband paid a total of 60,000 francs, or the equivalent of \$100, for the delivery of her first child.

Rose’s third and final birth in Cameroon was delivered at a hospital specifically designated for refugee patients. Because of a previously diagnosed health condition, Rose was required to delivery this child via C-section. She was anemic, and the doctors believed that it was important that they have access to blood during her C-section in case she needed a transfusion during the operation. Rose describes how her husband was required to find blood donors who would be willing to provide blood for the operation. Rose’s husband had difficulty finding blood donors because all of his contacts were fellow refugees who felt that the “*HCR ne prend pas la charge, même à manger, donc s’ils enlevent le sang, ils vont manger quoi pour recouper le sang ?/ the UNHCR does not take care of them, even to eat, so if they give blood, what will they eat after the donation to replenish the blood lost?*” In the end, Rose and her husband found enough

donors to allow her to have a supply of blood during her C-section. They paid each donor 5,000 francs for agreeing to donate his blood, the equivalent of \$8.

Rose's experience delivering at a public hospital in Cameroon can be compared to Victoire's experience delivering at a public hospital in the Republic of Congo. While public healthcare was expensive for Rose in Cameroon, the public hospital in which Victoire delivered her first child was funded by the government and thus much less expensive, demonstrating a key difference in refugee maternal healthcare across settings.

Victoire described in great detail the mistreatment and medical malpractice she experienced during the delivery of her third child as a refugee in the Republic of Congo. When Victoire arrived at the hospital, the hospital staff did not believe that she was in labor, although she reported that her water had already broken at home. Instead of leading her to the labor and delivery ward, she was asked to wait. She was also given drugs to speed up the labor process, although she was already several centimeters dilated. Victoire attempted to refuse these injections, saying that "*je n'aimais pas des injections, vous faites ça pour avoir votre argent, vous faites votre commerce...je suis déjà prête à accoucher*/I do not want injections, you are doing this to make your money...I am already ready to give birth". When the hospital staff members finally checked her cervix, they discovered that Victoire was almost crowning in the waiting room, and rushed her to the delivery room. When the child was delivered, she was not crying. Victoire reported that the baby had swallowed some amniotic fluid during the delivery, causing her to choke. An experienced midwife rushed to the baby and delivered several large taps on the baby's back, unclogging her throat and allowing the baby's cry to escape. Victoire noted that the hospital staff did not provide any special treatment for the baby following this episode. This child experienced substantial development delays through childhood, including a

delay in speech and the ability to walk. Victoire believes that the hospital staff was negligent throughout the duration of her delivery, leading to the developmental delays experienced by her daughter, stating that “*tout a été fait avec un retard à cause du liquid qu’elle avait avalé à l’accouchement/*everything was done with delay due to the liquid that she swallowed during the childbirth”.

Victoire herself experienced trauma during the same delivery. Because she was injected with medication to induce labor while she was already dilated, Victoire’s delivery was very fast and forceful. Victoire reported that the force of the delivery—amplified by the medications that she was given to expedite her delivery—irreversibly damaged her clitoris. Victoire described how the doctors insisted on “gluing” her clitoris in an attempt to fix the damage and prevent any negative side effects; however, Victoire is still living with the lasting effects of the damage. Victoire reports symptoms of incontinence, and believes that “*mon clitoris n’est pas normal comme toutes les autres femmes...le mien, si je ne fais pas attention, les urines vont meme tomber sur moi...j’ai beaucoup souffert/*my clitoris is not normal like other women’s...mine, if I don’t pay attention, urine will drip on me...I suffered greatly”. The association of damage to the clitoris and symptoms of incontinence does not seem to be medically accurate, so it is possible that Victoire is incorrect in the anatomical classification of her trauma.

Although Josephine did not give birth to any children while living in an intermediary country, she was able to share the story of her teenage daughter’s pregnancy and childbirth as a refugee living in the Republic of Congo. Josephine’s 14-year old daughter became pregnant in the Republic of Congo as the result of a rape. As stated earlier, rape is often used as a weapon of war in the country. Josephine’s daughter did not receive any prenatal care during her pregnancy, as the family was in active flight. Josephine’s daughter gave birth to a boy on a boat while the

family was moving internally within the country. The childbirth was not attended by any skilled birth attendant; however, Josephine's mother, who had been present at many births in her village in the DRC, assisted with the delivery of the child. This experience highlights the challenges faced by refugees who do not have the assistance of an aid agency such as the UNHCR for maternal and reproductive healthcare services.

Stage Three: Resettlement in the United States

Rose and Alizia are the only participants to have given birth in the United States. Elodie is currently pregnant and will be delivering in the Duke University Hospital in early summer 2018.

When Rose arrived in the United States in 2017, she discovered she was four months pregnant after a resettlement agency volunteer accompanied her to the Duke University Hospital Emergency Department for vomiting. She delivered her fourth child via C-section at Duke Hospital, an operation that was scheduled since she had received a caesarean section for the delivery of her third child in Cameroon. Rose explained that the team of physicians at Duke informed her of the potential health risks of a future pregnancy due to a large amount of scar tissue in her stomach and uterus, although she did not elaborate on the potential reasons for this medical condition. The Duke doctors encouraged Rose to use a form of birth control to prevent another pregnancy in the near future to avoid a potentially high-risk pregnancy.

Rose and Alizia both opted to receive an epidural during delivery at Duke Hospital. Alizia initially refused an epidural, stating, "*non, moi je suis africaine/ non, I'm African*", suggesting that she did not believe that she needed an epidural since she had given birth without the assistance of medication. After eight hours of painful labor, Alizia eventually agreed to an epidural, and she delivered her child two hours later.

When asked about a potential language barrier during childbirth, Alizia and Rose both indicated the presence of a French translator during the labor and delivery process. Both participants reported a positive translation experience. This experience is not generalizable to all refugees living in the United States, or even in Durham, as there have been many accounts of challenges associated with low availability of quality translation services in the medical system.

C. Family planning

The final piece of the interview focused on the reproductive health experiences of the participants across each life stage. The main aspect of reproductive health that was assessed was access to and use of family planning services. According to the WHO, family planning “allows individuals and couples to anticipate and attain their desired number of children and the spacing and timing of their births” (Inter-Agency Field Manual on Reproductive Health in Humanitarian Settings—2010). One way to achieve family planning is through the use of contraceptive methods, including hormonal birth control (pills, injections, implants), non-hormonal methods (condoms, withdrawal, sterilization), and elective abortions. The reproductive health histories of each participant are presented in this section, including an analysis of contraceptive use across each life stage.

i. Hormonal birth control

Four of the five participants had used a form of hormonal contraception at some point in their lives. Josephine was the only participant who had never used hormonal contraceptive methods. The most common methods of birth control used by the participants in this study were injections, birth control pills and implants.

Rose did not report using any form of contraceptive method while living in the CAR or prior to the birth of her third child in Cameroon. Following the delivery of her third child in Cameroon, Rose began receiving injection birth control, also known as Depo-Provera. Depo-Provera contains the hormone progestin and is administered every 3 months. The progestin works to prevent pregnancy by preventing ovulation. The rate of unmet need for modern contraceptives in Cameroon is high: 63% of women in Cameroon who do not to become pregnant do not use a modern method of contraception (Guttmacher). In Cameroon, injectables are the most prevalent form of hormonal birth control, making up 28% of all modern contraceptives available in the country. The most common modern contraceptive available is the male condom.

Alizia and Victoire were not specific in their descriptions of past contraceptive use. Although Alizia reported using injections, birth control pills and an implant in the past, she did not clarify at which stage of her path as a refugee she used these methods. The most common form of birth control used in the CAR is birth control pills, making up 58.4% of all modern contraceptives available in the country (Family Planning 2020, CAR). According to the most recent Demographic and Health Survey conducted in 2010, injectables (4.5%) and implants (2.2%) are fairly rare in the CAR, so it is reasonable to believe that Alizia may have used these forms of hormonal birth control while in a refugee camp in Chad. Often, refugees have more reliable access to contraceptives in a refugee camp as compared to in a conflict zone. Elodie, who also resided in a refugee camp in Chad, reported receiving Depo-Provera injections every 3 months while living in the camp.

Victoire was also vague in her description of her contraceptive history, stating that she had used “contraception” and then changed “*la marque*/the brand” of contraception. Victoire stopped

using hormonal contraceptives after experiencing negative side effects. The first method made her lose weight, and the second method stopped her period. When a medical provider suggested that she try injectables, although they would stop her period, Victoire's husband intervened to say no. Victoire now relies on non-hormonal methods, including condoms and natural family planning to prevent unwanted pregnancies after her husband's refusal of hormonal birth control.

Rose and Alizia are the only two participants currently using hormonal contraceptives in the United States. Rose is using Nexplanon, a small rod-shaped implant that is inserted under the skin of a woman's upper arm to provide birth control for up to 3 years. Nexplanon contains the hormone etonogestrel, a synthetic form of the naturally occurring female sex hormone, progesterone. The steady release of etonogestrel prevents ovulation and also thickens the natural mucus at the cervix, making it more difficult for sperm to cross from the vagina into the uterus. Although Victoire does not currently use any hormonal contraceptive methods, she noted that several friends have recommended Nexplanon to her. Alizia uses birth control pills on a daily basis. Because she does not have health insurance, she pays \$25 every three months to receive her birth control pills from her primary care physician.

Upon arrival to the United States, Elodie was continuing to receive Depo-Provera injections every 3 months. When her Medicaid expired, she decided to stop receiving these injections for financial reasons. Elodie is currently pregnant, but hopes to receive the Nexplanon hormonal implant following the birth of her third child. Elodie stated that she will attempt to receive the implant as soon as possible so that she can benefit from her Medicaid status.

ii. Non-hormonal methods

Non-hormonal birth control methods are the most common methods of family planning used worldwide. These non-hormonal methods include barriers methods (condoms), female and male

sterilization, the withdrawal method and fertility awareness (also called, the rhythm method).

The withdrawal method is used to prevent pregnancy by keeping semen away from the vagina by pulling the penis out of the vagina before ejaculation. The withdrawal method will only work if it is done correctly every time that a couple engages in sexual intercourse, but can be unreliable.

While the withdrawal method is said to be about 78% effective, in reality, about 1 in 5 women who use this method exclusively will become pregnant each year. Fertility awareness is characterized by the tracking of a woman's menstrual cycle to monitor periods of fertility. The days near ovulation are the most fertile days in the menstrual cycle, so women using the rhythm method should avoid sexual intercourse during these days in order to prevent pregnancy.

Victoire is the only participant who discussed her use of non-hormonal family planning methods to prevent pregnancy. Because her husband does not permit her to use hormonal birth control, Victoire uses a combination of the withdrawal method and fertility awareness to avoid becoming pregnant. Victoire stated that "*quand je suis en période de fécondité, je demande à mon mari d'utiliser des préservatifs/when I am in a fertile period, I ask my husband to use condoms*". Sometimes Victoire's husband follows this request, but other times he does not, stating that "*qu'avec ma femme de la maison, je ne peux pas utiliser des préservatifs/ with my wife, I cannot use condoms*". When Victoire and her husband do not use condoms, she asks her husband to use the withdrawal method to avoid pregnancy.

iii. Abortion

The topic of abortion was not discussed at length during the participant interviews, but one participant—Josephine—spoke of her experiences with abortion in the Democratic Republic of Congo. While Josephine has never used hormonal contraceptives and does not report having used non-hormonal family planning methods to prevent pregnancy, she did disclose having

considered obtaining an abortion when she became pregnant with her fifth child, despite abortion being illegal in the DRC. Josephine became pregnant with her fifth child when her fourth child was only 5-months old. With four children and one newborn at home, Josephine and her husband were worried about their ability to care for another child. Josephine explained that her husband visited a doctor to explain the predicament. The doctors discouraged Josephine from seeking an abortion, stating that the age difference between her fourth and fifth child would not be a problem for the family. Josephine and her husband listened to this advice and did not go forward with the abortion.

Although Josephine did not obtain an abortion, she explained that many women in the DRC did seek illegal abortions in order to terminate an unwanted pregnancy. When a doctor refused to perform the abortion, Josephine explained that “*elle-même vient prendre les médicaments, n’importe quel médicament*/the woman herself would take medications, any medication” to terminate the pregnancy. Josephine stated that there were many risks with this kind of abortion. In some cases, the medications would kill the baby, but the baby would leave the womb, producing a foul smell. When this happened, a woman would visit the doctor to receive a curettage, a surgical scraping of the uterine lining to remove the deceased fetus from the uterus. Some women were left infertile following the consumption of poisonous medications in an attempted abortion. Other women died in their attempt to force an abortion.

Josephine explained that many women in the DRC died from abortions performed by doctors. If a woman died at the doctor’s office during an abortion, the doctor would flee the scene in fear of legal action by the government. Josephine stated that “*quand l’Etat vient pour voir quelqu’un est mort, et c’est un avortement, on t’arrête...tu pars en prison directement*/when

the government arrives to see a deceased patient and it is due to an abortion, they will arrest you...you will go directly to prison”.

Josephine contrasts the poor outcomes of clandestine abortions in the DRC with the legal accessibility to abortion in the United States, emphasizing the freedom in choice granted to women in the United States. Although the United States does allow abortion, with limitations variable among each state, this choice may not always be an option for women living in the country. While Victoire is not sure if she wants to continue having children due to health concerns, Victoire stated that her husband has said that “*si [une grossesse] arrive, je garde la grossesse/* if a pregnancy comes, I will keep it”. It is important to note that Victoire did not indicate her personal intentions about a potential pregnancy, but rather emphasized the decision of her husband on the matter. This comment highlights the nuances that are important in shaping a woman’s decision about abortion and other family planning methods.

iv. Role of God in family planning

Religion is one influence that has an enormous impact on the family planning beliefs and experiences of the participants of this study. Every participant in this study identifies as a Christian. The role of God in family planning beliefs and practices characterizes many participants’ beliefs about how, why and when they become pregnant.

While most refugee women in this study have used birth control, they do not seem to fully equate their use of contraceptives with the act of planning a family. Many of the participants believe that God has the final decision on the number of children that each woman may bear. When asked if she plans to have any children in the future, Rose stated that, “*c’est ma décision mais Dieu aussi a décidé pour lui/* it is my decision but God has also decided for himself”. Rose is currently using Nexplanon as birth control because of health concerns related to challenges

with her uterus. Although Rose has decided to use hormonal birth control to prevent a pregnancy in the short term, she stated that “*si [Dieu] dit que je ne peux plus accoucher parce que j’ai un problème dans l’utérus/ if God says that I can no longer give birth because I have a problem in my uterus*” then she would not have another child. This statement reveals Rose’s implicit belief of the power of God in deciding when and if she will continue to have children.

While Rose regards her decision to have children as a choice made in conjunction with God, some of the women placed all power on God. When asked if she had considered an ideal number of children to have, Elodie responded with a laugh, “*non...ça c’est Dieu qui va me donner ...s’il dit que c’est fini, c’est fini, s’il dit que je continue, je peux continuer/ non...that is up to God...if he says that I am finished, I am finished, if he says that I will continue, I can continue*”.

Josephine spoke of her gratefulness to God in the context of maternal healthcare. Josephine gave birth to four girls, and she was hoping that her fifth pregnancy would be a baby boy. When she delivered the baby, Josephine explained that her aunt, who was present at the birth, exclaimed, “*Gloire à Dieu, un garçon enfin ! Dieu merci/ Glory to God, finally a boy! Thanks be to God*”. Josephine also thanked God for blessing her daughter with a stress-free pregnancy that was the result of a violent rape. Her daughter was very young and still quite thin, but “*grâce à Dieu, il n’y avait pas de difficultés/ thanks to God, there were not any difficulties*”. This thankfulness shows an unwavering commitment to God and the Christian faith, even in moments of crisis and tragedy.

D. Conclusion

Each participant expressed a unique story of maternal and reproductive health experiences, emphasizing the incredibly varied paths lived by refugee women before arriving in

the United States. In general, participants classified maternal and reproductive healthcare experiences in the United States as superior to the care provided in Central African countries. This difference was mostly due to the health system challenges in countries in Central Africa characterized by civil unrest, violence and a growing refugee crisis, as well as an appreciation for the professionalism and transparency of the United States healthcare system. These results indicate the importance of refugee stories on healthcare experiences to inform policy, action and future research.

At the end of each interview, participants were asked to discuss their hopes for the future. After an emotionally intense interview centered on one of the most intimate topics of conversation, this portion of the interview was important to ensure that participants felt comfortable and uplifted at the end of the session. Josephine, the oldest participant, was the only woman who said she was sure that she would not have any more children. All the other participants expressed uncertainty about their future maternal and reproductive health experiences. These young participants are therefore strong candidates for a follow-up study tracking changes in experiences and attitudes of maternal and reproductive health experiences in the United States as the women spend more time in the country.

Discussion

The purpose of this study was to qualitatively examine francophone refugee women's experiences with maternal and reproductive healthcare across their life course. This study showcases the voices of an often ignored population of refugee women in the United States, providing evidence for the importance of a patient narrative research approach to understanding the health challenges of a certain population. The challenges faced by the refugee women in this study across settings are immense, but the participants have shown resiliency, strength and agency in expressing their own personal stories of maternal and reproductive experiences.

The stories shared by participants highlight the importance of focusing attention to reproductive health, sexuality and motherhood in a refugee setting. This is an important topic that should be a priority of refugee aid agencies, government officials and local organizations that work directly with refugee women. The findings from this study confirm that maternal health outcomes for refugee women are poor in conflict zones. Furthermore, the maternal health experiences of refugee women living in an intermediary country as refugees were worse than the maternal health experiences of refugees living in a camp. The findings revealed that the participants believed to have experienced the best maternal healthcare in the United States. Several key themes emerged following the qualitative analysis of each interview.

Themes

Corruption

Political corruption was commonly cited by participants when discussing the health structure and general healthcare experiences in their host country. Victoire highlighted the direct role of government corruption in the health of its citizens, stating that “*ce qui tue notre pays africain, c’est son government/ what kills our African country is our government*”. A study published in 2017 reviewed data from 44 low-income countries to assess the correlation of various factors on maternal mortality ratio of each country, including gender measures, GDP per capita and the Corruption Index. For sub-Saharan African countries, perceived corruption as measured by the Corruption Index was the only significant predictor of maternal mortality ratio. This study highlights the importance of corruption on the maternal health of citizens. The participants’ stories and narratives confirm the suggested correlation between perceived political corruption and maternal health outcomes and experiences.

Participants who lived in an African host country, as opposed to a refugee camp, during the intermediary period were more likely to report poor health experiences directly related to political and governmental corruption. Rose, who lived in Cameroon during her time in an intermediary country, suggested that the Cameroonian government was keeping money that was intended for assisting refugees in the country. A report summarizing the refugee crisis in Cameroon was released in March 2014 by the UNHCR, bringing attention to the emergency situation in the country. The UNHCR stated that \$22.6 million needed from the United States to assist refugees fleeing the CAR and entering Cameroon, but that only \$4.2 million had been received. Furthermore, only 12% of the \$247 million of funding requested by 15 aid organizations in response to the influx of refugees from the CAR had been received (Barbelet).

This report is in line with the testimony provided by Rose regarding the announcement by the United States that there was not enough money to handle the growing number of refugees entering the country. Although there is no evidence to suggest that the Cameroonian government has withheld any money from the refugee population, the challenge of financially supporting refugees in Cameroon is well-documented in the literature and reflected in increased efforts by the UN to motivate donors to provide care for this vulnerable population (Unicef, Cameroon).

The provision of user fees and exorbitant costs of maternal and reproductive healthcare services was frequently reported by study participants as another factor that could have been influenced by political corruption. Rose, who lived in Cameroon as a refugee, reported having to pay large sums of money to deliver at a hospital. Furthermore, she was required to provide certain items for the childbirth, including a blanket to deliver on, cloth to swaddle the baby in, and even a donated blood supply to be used in the case of blood transfusion during her C-section. There have been growing political efforts in sub-Saharan Africa to abolish user fees in order to increase access to maternal and child health services and improve outcomes for citizens. A difference-in-difference evaluation published in 2018 provided evidence that removal of user fees is associated with an increase in the number of facility-based births, and a small but significant reduction in neonatal mortality rate (Ravit, et. al.).

Corruption has been identified as one of the biggest challenges to ensuring quality health service delivery in the African continent. Women are disproportionately affected by corruption at the healthcare level for many reasons. Women are more likely to have more frequent interaction with health care providers, especially during reproductive years. Women also face a culturally reinforced lack of agency to defend themselves in the face of blatant corruption. It is no wonder that women's empowerment and corruption are inextricably linked. A framework in Uganda

titled “Women, Health and Corruption: Redefining Partnerships for Social Change” advocates for women’s engagement and leadership to facilitate and promote accountability and good governance at the health sector level (Gnocato, et. al.).

The impact of corruption on the impression of the quality of a health system is evident by the participants’ overall positive perception of the healthcare setting in the United States. Although participants noted a high cost of healthcare and challenges in acquiring quality insurance to cover health costs, participants also highlighted an appreciation for the professionalism and transparency of the American health system. These factors may have contributed to the participant’s preference for the United States health system, despite experiencing challenges such as language barrier, expensive care and long wait times. A health system that is not perceived as corrupt is thus more highly regarded by the study participants.

Health systems challenges

Presence of skilled birth attendant

Many participants noted health systems challenges as a barrier to accessing quality maternal healthcare. The World Health Organization recommends that women deliver in the presence of a skilled birth attendant so that proper steps can be taken to avoid complications associated with prolonged labor. There is a large urban-rural disparity in the availability and presence of a skilled birth attendant at delivery in the Central African Republic, with 82.9% of births in urban areas attended by a SBA and only 38.1% of births in rural areas attended by a SBA (Unicef, CAR). This data shows the disparities in maternal healthcare that exist within the Central African Republic and other neighboring countries, highlighting that the stories of Central African women must be considered within a country and residence-specific context.

Alizia's first birth in the CAR was a home delivery that lasted for two days without the presence of a skilled birth attendant. Prolonged labor can be dangerous for both the baby and the mother; the baby may experience low oxygen levels, an abnormal heart rhythm, abnormal substances in the amniotic fluid and uterine infection. If enough time passes, the baby may die in the birth canal, resulting in stillbirth. Prolonged labor may also result in obstetric fistula for the mother, a condition characterized by incontinence due to a hole developing between the vagina and the rectum, ureter or bladder. Although prolonged labor and its consequences can occur in the United States, the presence of a skilled birth attendant can help to reduce this likelihood. Alizia's story is valuable in bringing a human narrative to the WHO recommendation for improved maternal health. This example shows the power of a patient narrative to influence and advocate for change in the standard of clinical care in refugee settings.

Access to reliable medical equipment and technology

Participants also described the lack of access to reliable equipment and technology for the provision of maternal healthcare as another health system challenge. The UNHCR, as a United Nations agency, has the power of support from the global community to implement public health interventions at refugee camps around the world. A key mission of the UNHCR is to ensure access to life-saving and essential healthcare for all refugees in a camp. The UNHCR has defined four specific areas of focus in health: HIV prevention, protection and treatment; reproductive health services; food security and nutrition; and water, sanitation and hygiene services. Alizia and Elodie were both given mosquito bed nets by UNHCR volunteers during their pregnancies to protect them from malaria infection. This intervention is commonly implemented in refugee camps by the UNHCR. The provision of mosquito bed nets to pregnant women accomplishes the UNHCR's health goals of ensuring quality reproductive health services as malaria infection

during pregnancy can lead to substantial health risks for the pregnant woman, her fetus, and the newborn child. Malaria infection can cause maternal anemia which can lead to low-birth weight in babies, an important contributor to infant mortality (WHO, High-risk groups).

Alizia, from the CAR, discussed unreliable access to electricity as a barrier to doctors needing to perform a caesarean section. Caesarean sections, when performed necessarily, are life-saving procedures for the mother and baby, and are thus considered important emergency surgical procedures; however, caesarean sections are not always accessible for women in low-income countries. From 2000-2006, including the year that Alizia gave birth in the CAR, the rural C-section rate in the CAR was only 2% (Unicef). A report from Médecins Sans Frontières in 2014 testified that there was no electricity at the Regional University Hospital in Berbérati, in the west of the country (Médecins Sans Frontières). A local doctor reported that patients had to bring their own light in order to be examined (MSF). With such low access to reliable electricity, emergency surgeries such as C-sections cannot safely be performed. Although there is not a global consensus on the ideal rate of C-section for a country, the low rate of C-sections in CAR may negatively impact maternal health, and ultimately reflects the lack of access to maternal healthcare of its citizens.

Refugee women living in a refugee camp benefited from the presence of the UNHCR to govern key health system functions. Alizia and Elodie, who lived in Chad, both discussed their interactions and experiences with community health workers employed by the UNHCR at the camp. They discussed the role of the UNHCR health workers in ensuring refugee women were granted quality maternal healthcare. Elodie felt that she was unable to turn down prenatal care and even attempted to hide her pregnancy from the community health workers to avoid having to visit the hospital. Alizia reported that she was told it was forbidden to give birth at home at the

camp—all women were required to deliver at the hospital. The community health workers' pressure to deliver at the refugee hospital aligns with the health goals of the UNHCR. Access to emergency obstetric care is a key tenant of the UNHCR's commitment to the reproductive healthcare of refugee women. Women who deliver at a hospital have access to emergency obstetric care, which can prevent maternal and infant morbidities and mortalities (Fournier et al.). Encouraging refugee women to deliver at a hospital and seek prenatal care throughout a pregnancy will increase the chances of these women having access to quality obstetric care as needed.

Refugee women who did not live in a refugee camp during their time in an intermediary period before arriving in the United States were less likely to benefit from aid agencies such as the UNHCR, directly impacting the quality of maternal healthcare provided to them. Instead, these refugee women report inequitable access to medical centers as refugees compared to the native residents of the intermediary country. This patient narrative is important as it highlights the complexities of refugee crises in areas not supported by international aid organizations. These results are strong indicators of health research and policy implementation that should be conducted at the governmental level to ensure that refugees living in intermediary countries are supported and receiving quality healthcare.

Recommendations for future interventions and research

The discrepancy in experiences across settings for each refugee highlight the need for different interventions to address a wide variety of maternal and reproductive health needs at each stage. For example, the urgent needs for refugees that must be addressed in the Central African Republic may not be the same needs that should be addressed for refugees living in

Cameroon. When considering the best course of action for refugee populations, it is absolutely necessary that researchers investigate the needs and concerns of refugees living in each distinct setting in order to propose the best intervention at each stage.

a. Recommendations for interventions

The maternal and reproductive healthcare of refugees is often forgotten by researchers in every stage of the refugee life course. Refugees are faced with many health challenges, including the immediate need for basic necessities such as food, housing and general healthcare services. Although these issues should be addressed with immediacy, the maternal and reproductive health of refugees should not be considered a second-string health problem. As described in the background section of this paper, the Interagency Field Manual on Reproductive Health in Humanitarian Settings is a valuable and vital resource for individuals providing healthcare in humanitarian crisis situations. The central tenant of this manual is that “reproductive health is an essential component of humanitarian response” (WHO, Manual de terrain). Individuals in a humanitarian crisis are particularly vulnerable to challenges associated with a lack of access to maternal and reproductive health services. Several participants in this study discussed the challenges of becoming pregnant at a young age while living in a conflict zone. One of these young pregnancies was the result of a rape used as weapon of war. Special attention should be placed on providing quality reproductive healthcare for this vulnerable population to avoid sexual abuse and other factors leading to early pregnancy and the contraction of sexually transmitted infections.

The qualitative nature of this study provides a model for developing future interventions. Speaking with women about their perceived challenges and needs at each setting throughout their journey as refugees is vital to understanding the refugee experience. Strong communication

with refugee women is essential to developing and delivering the most effective interventions to address specific health problems for this population.

Advancing patient-centered, respectful maternal care is critical to improving the maternal and reproductive health of refugee populations. In fact, concerted efforts to improve maternal health outcomes, including increasing the number of facility-based births and decreasing a country's maternal mortality ratio, are unlikely to be possible without improving quality of care and focusing on the healthcare experience of women (Tuncalp et. al.). The WHO's quality of care framework for maternal and newborn health includes three domains specific to a patient's experience of care: effective and responsive communication, care provided with respect and dignity, and emotional support. The widespread mistreatment of women described by several refugee women in this study emphasizes the importance of adopting a patient-centered, respectful maternal care model in every setting. Future interventions should work to ensure that they are meeting these standards of respect by engaging refugee women at every stage of the intervention.

This study aims to highlight the importance of working with host countries to improve the accessibility of healthcare services for refugee women. As indicated by the participant timelines, refugees can spend up to a decade or more living in an intermediary country. Some women may never resettle to another country, thus spending the rest of their lives in this intermediary country. This time is significant and should be treated as such. Regardless of whether living in a refugee camp or living in a host country with refugee status, this population must be supported by the host government to ensure access to quality healthcare services, including maternal and reproductive healthcare. Coordination between host governments and multilateral organizations

such as the United Nations and the World Health Organization will be critical in ensuring this healthcare is available to refugee women around the world.

As mentioned in the introduction, sexual violence is a common characteristic of humanitarian crises and refugee situations. Future interventions should focus on addressing the sexual trauma of refugee women by incorporating quality mental health care services into maternal and reproductive healthcare standards of care in intermediary countries and in the United States.

In the United States, refugee case management should be scaled up and expanded to include long-term assistance in navigating the complexities of the American health system. Health care providers should work to incorporate reproductive healthcare into the standard of care for refugee patients, as this is a vulnerable population that may not have the agency and knowledge of services like contraceptives to aid in family planning efforts. Health care providers and case workers should also be aware of the financial burden of reproductive healthcare for refugee patients and work to find solutions for refugee women wishing to initiate or maintain reproductive health services. Elodie's discontinuation of hormonal birth control injections due to a lack of health insurance coverage led to an unintended pregnancy. Stories like these are striking and should serve as a strong case for improved attention to refugee reproductive health barriers.

b. Recommendations for future research

There is a considerable gap in the literature on maternal and reproductive health experiences and outcomes of the French-speaking refugee population in all settings. While organizations such as the WHO and the UNHCR have announced the importance of ensuring quality maternal and reproductive healthcare in humanitarian crisis settings, there has not been much research done on existing and on-going interventions in Central Africa to address these challenges in the

French-speaking refugee community. By including quotes from participants in their native or heritage language, this researcher tried to demonstrate a respect for individuals within the French-speaking refugee community. The researcher's knowledge of the French language was important in allowing participants to feel comfortable expressing their experiences and narrative in a familiar language. Participants who had a prior relationship with the researcher were more open and candid about their experiences. This suggests that a personal approach to research, focusing on storytelling and intimate relationships, may be beneficial to understanding the maternal and reproductive health needs and experiences of French-speaking refugees.

This distinction is critical in understanding the importance of patient-centered care and patient narrative-based research when working the French-speaking refugee community. Patient-centered research yields increased insight into the personal challenges faced by francophone refugee women in accessing quality maternal and reproductive health services. This research methodology has the potential to be incredibly influential in this population that relies heavily on storytelling and narrative-based conversation to express health challenges.

Limitations

One major limitation of this study is the lack of generalizability due to the small sample size. With only five participants, no definite conclusions can be drawn from this research, and the results cannot be generalized to the entire French-speaking refugee population. Therefore, this study should serve as an in-depth case study analysis of five individual women that may suggest some common challenges for Francophone refugee women in accessing maternal and reproductive healthcare services across settings in their life course. The study should serve as a

testimony to the wide variety of unique experiences lived by refugee women and highlight the fact that no refugee has the same life path.

One reason for the small sample size of this study was the relatively strict eligibility criteria for participation in the study. While there is a fairly large population of refugees from majority French-speaking countries living in North Carolina, not all of these refugees actually speak French at a conversational level. Furthermore, not all refugee women living in North Carolina who speak French have given birth, thus they were unqualified to participate in the study. This is because many refugee women from French-speaking countries were not educated in schools, or left their home countries at an early age. Many from the Democratic Republic of Congo speak Swahili, and have more limited proficiency in French.

While I had originally intended to travel to other refugee resettlement cities in North Carolina, including Raleigh and Greensboro, I was unable to identify a strong community partner in these cities that could facilitate new partnerships with refugee families in the area. Although I established communication with the Center for New North Carolinians in Greensboro, I was advised to refrain from conducting interviews with the French-speaking population on the subject of maternal healthcare, as a prominent member of the refugee community had lost a newborn child within days of my request. A continuation of this study should include interviews with French-speaking refugee women throughout the state of North Carolina in order to increase the sample size of the participants and understand the experiences of refugees in North Carolina who have given birth in health systems other than Duke.

Another potential limitation to consider is social desirability bias. As an undergraduate student at Duke University, participants who had received healthcare services from Duke University Hospital may have felt a need to present their experiences at the institution in a

positive light. Furthermore, as an American citizen, participants may have felt the need to describe the American health system in a positive light.

It is important to consider the potential biases associated with the group of French-speaking refugee women identified for participation in this study. It is possible that this group of five women are not representative of the larger population of French-speaking refugees due to a number of factors. Because these women are living in Durham, North Carolina, where resources for refugees are abundant, if not always utilized, this group of refugee women may be more engaged with the American healthcare system and better linked to services. These potential confounding factors were not considered when conducting this research, as the nature of the qualitative case-study analysis was not to be generalizable to the entire population; however, future research studies should consider environmental factors that may increase the agency of refugee women in a certain location.

Although a comprehensive interview guide was prepared to help direct each conversation, not every participant was asked the same questions. In some cases, the interviewer unintentionally skipped questions intended to be asked. At other times, the interviewer failed to probe deeper into a topic, although more information would have been useful when analyzing the interview transcripts. On some occasion, this was because the participant did not answer or elaborate on a topic, and the researcher did not want to make the interviewee uncomfortable. These limitations impact the level of analysis that is possible with the qualitative interview data, and thus impact the quality and scope of the findings. A follow-up study should be conducted to further analyze the maternal and reproductive health experiences of each participant. There are certainly more stories to be told on this topic, and a follow-up study may be able to yield

additional testimonies to aid in presenting a more comprehensive case-study analysis of this population of study participants.

A major limitation of any qualitative study is the inevitable fact that research quality is heavily dependent on the analysis of the researcher. This type of subjective research can be easily and unconsciously influenced by the researcher's personal biases. Although every effort was taken to stay true to the data presented in the participants' recorded stories, this limitation of any qualitative study should be considered when analyzing the results of this study.

Conclusion

Throughout the process of researching and writing my thesis, I have come to appreciate the importance of the patient narrative in influencing medical care. Patient-centeredness is now considered an essential component of clinical and health services research. The Patient-Centered Outcomes Research Institute (PCORI) is an independent nonprofit, nongovernmental organization in Washington, DC that was authorized by Congress in 2010 to close the gap between patients, their families and clinicians. PCORI believes in the power of patient stories to influence clinical and healthcare research and improve health outcomes. This thesis serves to support the transition to patient-centered care and research focused on the patient narrative to drive clinical change. The findings from my thesis research have confirmed the importance of patient narrative in informing health outcomes. When women are given the opportunity to share their stories, they can highlight important maternal and reproductive health experiences that may not have been previously considered in previous research studies. As the recipients and focus of healthcare services, patients should be able to use their voices to reflect their desired health outcomes (PCORI).

I was especially struck by the incredible resiliency of the participants interviewed in this study. Each woman has experienced unspeakable tragedy, forced from her home country in fear of persecution, and has shown incredible bravery as a mother living in these challenging settings. The maternal and reproductive health experiences of refugee women are powerful stories of perseverance and the strength of the human spirit. These stories have shown me the importance of understanding a patient's concerns and experiences through language and personal interaction. When given the agency to inform decisions and recommendations on their own healthcare, refugee women have the power to demand change in the treatment of refugee patients around the

world. This thesis serves as a call to action for patient-centered research as the standard of research and policy recommendations. I hope that any reader of this paper walks away with a deep appreciation for the importance of language and patient narratives to inform future action.

Bibliography

Barbelet, V. (2017). Supporting Central African refugees in Cameroon: Policy and practice in response to protracted displacement. *Humanitarian Policy Group*.

Bass JK, Annan J, Murray SM, Kaysen D, Griffiths S, Cetinoglu T, Wachter K, Murray LK, Bolton PA. (2013) . Controlled trial of psychotherapy for sexual violence survivors in DR Congo. *New England Journal of Medicine*. 368:2182-91.

BBC. News (2017). Central African Republic profile-timeline. Retrieved from <http://www.bbc.com/news/world-africa-13150044>

Berman, P. (2000). Organization of ambulatory care provision: a critical determinant of health system performance in developing countries. *Bulletin of the World Health Organization*, 78(6).

Brasier (2015). Le droit à la santé des femmes immigrantes au Canada et au Québec en relation avec les engagements internationaux du Canada : analyse de la législation et du programme fédéral de santé intérimaire. *Université du Québec à Montréal*.

Bridging Refugee Youth & Children's Services. (2018). "Refugee 101". Retrieved from <http://www.brycs.org/aboutRefugees/refugee101.cfm>

Bureau of Population, Refugees and Migration (2017, October). Refugee Arrivals by State.

Center for Health and Gender Equity. (2017). Global Gag Rule. Retrieved from

http://www.genderhealth.org/the_issues/us_foreign_policy/global_gag_rule/

Chi, P. C., Bulage, P., Urdal, H., & Sundby, J. (2015). Perceptions of the effects of armed conflict on maternal and reproductive health services and outcomes in Burundi and Northern Uganda: a qualitative study. *BMC International Health and Human Rights*, 15, 7.

<http://doi.org/10.1186/s12914-015-0045-z>.

Childress, G. (2017). Durham celebrates ‘Refugee Day’ in a show of solidarity. *The News and Observer*. Retrieved from <http://www.newsobserver.com/news/local/counties/durham-county/article149071764.html>

Church World Services Durham. *Frequently Asked Questions*. <http://cwsrdu.org/f-a-q/>

Cultural Orientation Resource Center. (2018). “About Cultural & Community Orientation / Providing Refugee Orientation and Training”. Retrieved from <http://www.culturalorientation.net/providing-orientation/about>

Davis, J. & Jordan, M. (2017). *Trump Plans 45,000 Limit on Refugees Admitted to U.S.*

Retrieved from <https://www.nytimes.com/2017/09/26/us/politics/trump-plans-45000-limit-on-refugees-admitted-to-us.html>

Demographic and Health Survey Program. (2011). Central African Republic.

Durham County Community Health Assessment. (2011). Community Profile. *Durham County and refugees*. Retrieved from <http://www.dconc.gov/home/showdocument?id=1352>

Esmaili, E. (2017, Nov. 14). Personal interview.

Family Planning 2020. (2018). Central African Republic. *Data*. Retrieved from <http://www.familyplanning2020.org/entities/103>

Fourier, P. et. al. (2008). Improved access to comprehensive emergency obstetric care and its effect on institutional <http://www.who.int/bulletin/volumes/87/1/07-047076/en/>.

Gnocato, K. et. al. (2014). Women, Health and Corruption: Redefining Partnerships for Social Change. *The Graduate Institute of Geneva*.

Granger, E. (2007). La santé de la femme nouvellement arrivée. *Le Médecin du Québec*.

Guttmacher Institute. (2014). News Release. *In Cameroon, 63% of Women Who Want to Avoid Pregnancy Do Not Use a Modern Method of Contraception*. Retrieved from <https://www.guttmacher.org/news-release/2014/cameroon-63-women-who-want-avoid-pregnancy-do-not-use-modern-method-contraception>

Igielnik, R. & Krogstad, J. (2017, February). *Where refugees to the U.S. come from*. Retrieved from <http://www.pewresearch.org/fact-tank/2017/02/03/where-refugees-to-the-u-s-come-from/>

Iszler, M. (2016, December). Triangle groups offer ways to help refugees. *The News and Observer*.

J. Gagnon, Anita & Merry, Lisa & Robinson, Cathlyn. (2002). A Systematic Review of Refugee Women's Reproductive Health. *Refuge*. 21.

Kalonda, O. (2011). Socioeconomic impact of armed conflict on the health of women and children in the Democratic Republic of the Congo. *PubMed*.
<https://www.ncbi.nlm.nih.gov/pubmed/21695885>

Mantuba-Ngoma, M. Les femmes et la reconstruction post-conflit en République démocratique du Congo. *UNESCO*.
<http://www.unesco.org/fileadmin/MULTIMEDIA/HQ/SHS/pdf/Femmes-RDC.pdf>

Mechakra-Tahiri, S, Zunzunegui, M. & Séguin, L. (2007). Self-Rated Health and Postnatal Depressive Symptoms Among Immigrant Mothers in Quebec. *Women & Health*, 1.

Médecins Sans Frontières. (2014). Health chaos in Central African Republic. Retrieved from <http://www.msf.org/en/article/health-chaos-central-african-republic>

- Morris, M. D., Popper, S. T., Rodwell, T. C., Brodine, S. K., & Brouwer, K. C. (2009). Healthcare Barriers of Refugees Post-resettlement. *Journal of Community Health, 34*(6), 529–538.
- Nowell, L. et. al. (2017). Thematic Analysis: Striving to Meet the Trustworthiness Criteria. *International Journal of Qualitative Methods*.
- O’Heir, J. (2004). Pregnancy and childbirth care following conflict and displacement : care for refugee women in low-resource settings. *Journal of Midwifery & Women’s Health, 49* (4), p. 14-18.
- Organisation mondiale de la santé. (2010). *Manuel de terrain interorganisations sur la santé reproductive en situations de crise humanitaire*.
http://www.who.int/reproductivehealth/publications/emergencies/field_manual/fr/
- Patient-Centered Outcomes Research Institute. *Our Mission*. Retrieved from
<https://www.pcori.org/about-us>
- Pope, Amy. (2015). *Infographic : The Screening Process for Refugee Entry into the United States*. <https://obamawhitehouse.archives.gov/blog/2015/11/20/infographic-screening-process-refugee-entry-united-states>

PRB. (2015). Democratic Republic of the Congo. *Youth Reproductive Health: Satisfying Unmet Need for Family Planning*. Retrieved from <https://assets.prb.org/pdf15/unmetneed-factsheet-DRC.pdf>

Radford, J. & Connor, P. (2016, December). *Just 10 states resettled more than half of recent refugees to U.S.* <http://www.pewresearch.org/fact-tank/2016/12/06/just-10-states-resettled-more-than-half-of-recent-refugees-to-u-s/>

Ravit M, Audibert M, Ridde V, *et al.* (2018). Removing user fees to improve access to caesarean delivery: a quasi-experimental evaluation in western Africa. *BMJ Global Health*.

Say, L. *et. al.* (2014). Global causes of maternal death: a WHO systematic analysis. *The Lancet*, 2(6).

Schwikowski, M. (2017). *DRC's homemade refugee crisis*. <http://www.dw.com/en/drcs-homemade-refugee-crisis/a-39064215>

Shaw, D. (2006). Women's right to health and the Millenium Development Goals : Promoting partnerships to improve access. *International Journal of Gynecology and Obstetrics*, 94. P. 211.

Taylor, J & Ravi, A. (2017, June). Access to Reproductive Health Care for U.S.-Based Refugees.

<https://www.americanprogress.org/issues/women/reports/2017/06/20/434714/access-reproductive-health-care-u-s-based-refugees/>

Tuncalp, et al. 2015. Quality of care for pregnant women and newborns—the WHO vision.

BJOG. Vol 122(8); pp 1045–1049.

UNHCR. (1951). *Convention et protocole relatifs au statut des réfugiés*.

<http://www.unhcr.org/fr/4b14f4a62.html>

UNHCR. CAR situation. <http://www.unhcr.org/en-us/car-emergency.html>

UNHCR. Health in camps. *Emergency Handbook*.

<https://emergency.unhcr.org/entry/%2054566/health-in-camps>

UNICEF. (2016). Maternal and Newborn Health Disparities: Central African Republic.

Retrieved from: [https://data.unicef.org/wp-](https://data.unicef.org/wp-content/uploads/country_profiles/Central%20African%20Republic/country%20profile_CAF.pdf)

[content/uploads/country_profiles/Central%20African%20Republic/country%20profile_CAF.pdf](https://data.unicef.org/wp-content/uploads/country_profiles/Central%20African%20Republic/country%20profile_CAF.pdf)

UNICEF. (2018). Humanitarian Action for Children. *Cameroon*. Retrieved from

<https://www.unicef.org/appeals/cameroon.html>

Unicef. (2018). *Statistics by Topic: Maternal Mortality*. Retrieved from

<https://data.unicef.org/topic/maternal-health/maternal-mortality/>

Unicef. (2018). UNICEF Data: Monitoring the Situation of Children and Women. *Maternal*

Health: Antenatal Care. Retrieved from <https://data.unicef.org/topic/maternal-health/antenatal-care/>

United Nations Population Fund. (2014). Setting standards for emergency obstetric and newborn

care. <http://www.unfpa.org/resources/setting-standards-emergency-obstetric-and-newborn-care>

United Nations Security Council. (2016). Report of the Secretary-General on children and armed conflict in the Central African Republic.

<https://reliefweb.int/sites/reliefweb.int/files/resources/N1603746.pdf>

United Nations, Department of Economic and Social Affairs, Population Division (2014). World Contraceptive Use 2014 (POP/DB/CP/Rev2014).

Vépière, A. (2016). *L'Est de la RD-Congo déchiré par 22 ans de guerre*. Retrieved from

<https://www.la-croix.com/Monde/Afrique/LEst-RD-Congo-dechire-22-guerre-2016-08-15-1200782377>

Vu, A., Adam, A., Wirtz, A., Pham, K., Rubenstein, L., Glass, N., ... Singh, S. (2014). The Prevalence of Sexual Violence among Female Refugees in Complex Humanitarian Emergencies: a Systematic Review and Meta-analysis. *PLoS Currents*, 6.

Walsh, B. (2015). Alan Kurdi's Story: Behind the Most Heartbreaking Photo of 2015. *Time*. Retrieved from <http://time.com/4162306/alan-kurdi-syria-drowned-boy-refugee-crisis/>

World Health Organization. (2012). Recommendation 2 : Health indicators. *Accountability for Women's and Children's Health*.
http://www.who.int/woman_child_accountability/progress_information/recommendation2/en/

World Health Organization. (2016). Global Health Observatory (GHO) data. *Skilled attendants at birth*. Retrieved from
[http://www.who.int/gho/maternal_health/skilled_care/skilled_birth_attendance_text/en/ \)](http://www.who.int/gho/maternal_health/skilled_care/skilled_birth_attendance_text/en/)

World Health Organization. (2016). Maternal mortality in 1990-2015. *Democratic Republic of the Congo*. Retrieved from http://www.who.int/gho/maternal_health/countries/cod.pdf

World Health Organization. (2016). Maternal mortality in 1990-2015. *Central African Republic*. Retrieved from http://www.who.int/gho/maternal_health/countries/caf.pdf

World Health Organization. (2016). Maternal mortality. Retrieved from

<http://www.who.int/mediacentre/factsheets/fs348/en/>

World Health Organization. (2018). Malaria: High-risk groups. Retrieved from

http://www.who.int/malaria/areas/high_risk_groups/en/

Appendices

Appendix A: Interview Guide

INTERVIEW GUIDE

These are the kinds of questions that I may ask the participants during semi-structured interviews. The questions asked during the interview may be guided by the conversation, so I will have flexibility in what questions I ask. The questions will follow this general format and focus on these topics.

Health care experiences in general:

- In which country were you born?
- In which countries have you spent an extended period of time?
 - Tell me about what it was like living at each of these places.
- Tell me about the healthcare services available to you in each of these locations?
 - What health services were available to you?
 - What was the quality of care of these services?
- When you were sick, where did you seek care?
 - In a hospital? A clinic? Home visit?
- Tell me about the person who provided you with healthcare services.
 - A physician? A nurse? A community health worker?
 - Was this person from the host country, or were they from a foreign aid organization?
- Tell me a story about a healthcare experience that you had abroad.
- Tell me about any barriers to accessing healthcare that you faced. Was it ever hard to get treatment if you needed it?

- How long have you been living in the United States?
- Have you received healthcare services in the United States?
- When you or a loved one are sick in the United States, where do you seek care?
 - In a hospital? A clinic? Home visit?
 - Does where you seek care depend on what is ailing you?
- Where was the first health clinic that you visited in the United States?
 - Do you still go there for care?
- Do you have a primary care doctor?
- When was the last time you went to healthcare clinic/hospital/etc.? Tell me about that experience.
- Tell me a story about a healthcare experience that you have had in the United States.
- Do you find it easy to access healthcare services in the United States?
- Compare the health system in the United States to the health systems you encountered abroad. Describe the differences and similarities to me using your own experiences and perceptions.

History of obstetric care:

- Tell me about the first time that you got pregnant
 - What was your experience like?
 - Was that abroad or in the United States?
 - Did you meet with any doctors or health workers during that first pregnancy?
 - If so, what advice did they give you during the pregnancy?
 - In your opinion, what are you supposed to do and not supposed to do when you are pregnant.
 - If you could go back to that first pregnancy, what do you wish you would have done differently?
 - Was this pregnancy planned or unplanned?
 - Did you want to become pregnant?
 - Tell me about your family's support of you during this pregnancy.
- When you thought you might have been pregnant, what did you do?
- Tell me about any other pregnancies that you have had. How many times have you been pregnant?
 - Of these pregnancies, how many were conceived abroad?
 - How many pregnancies were conceived in the United States?
 - What was different about each pregnancy?
- How many times have you given birth?
 - Of these live births, how many were delivered abroad?
 - How many live births were delivered in the United States?
 - Tell me about your first time giving birth.
 - Where did you deliver your first birth? Who was in the room?
- How many living children do you have?
- Did you feel supported by members of the health systems where you gave birth? (both abroad and in the United States)
- Tell me about your visits to health clinics during your pregnancy: what kind of pre-natal care did you receive?

History of family planning:

- Tell me about your decision to have children.
- Why did you want to have children?
- What feelings did you experience when deciding to have children?
- Did you feel ready to have a child when you had your first pregnancy?
- Before you began having children, did you think of an ideal number of children to have?
- When you were living abroad, did you ever think about ways to avoid or plan your pregnancies?
 - If yes:
 - What were some of the methods you used to accomplish this?
- Have you ever received education about ways that you could plan your pregnancies to ensure that you only became pregnant when you were ready to be pregnant?
 - If yes: Where/in what country did you receive this education?
 - Tell me about this education. What things were you taught?
- Have you ever used any form of long-acting modern contraception? (examples include: injectable, birth control pills, implant, IUD)

- If yes: What methods have you used in the past?
- If yes: Are you currently using any form of long-acting modern contraception?
 - If yes: Which method are you currently using?
- Tell me about your experience taking contraceptives.
- Tell me about the process you went through to get this contraceptive method.
- What were you feeling when you received this contraceptive?
- Why did you decide to use this contraceptive method?
- If you have switched methods, why did you decide to switch?
- If you have never used a long-acting contraceptive:
 - Why did you decide not to use this form of contraception?
 - Did you ever think about using a method of contraception?
- How readily available were these long-acting modern contraceptives in healthcare settings abroad?
 - Were there any barriers to accessing these modern contraceptives?
 - Tell me about the experience of a woman seeking a modern contraceptive measure in your home country.
- How readily available are these long-acting modern contraceptives in a healthcare setting in the United States?
 - Have you ever received education about these forms of contraception since you have been living in the United States?
 - If yes: Who provided you with this education?
- Have you ever used a short-term modern contraceptive measure? (examples: male or female condoms, diaphragm)
- How readily available were these short-term modern contraceptives in healthcare settings abroad?
- How readily available do you find these short-term modern contraceptives to be in a healthcare setting in the United States?
- In your opinion, what is the ideal age for first sexual intercourse?
- If your daughter or other close female family member was of reproductive age and possibly sexually active, what would you recommend that they do?
 - Would you recommend that they use any form of contraception?
- What did your mother recommend for you when you reached reproductive age?
- What were the popular beliefs around contraceptive methods and family planning in your home environment?

History of reproductive healthcare:

- Have you ever visited a gynecologist?
 - If yes: tell me about your first visit with a gynecologist. How did you feel before, during and after the appointment?
 - If yes: Where/in what country did you visit the gynecologist?
 - Was the visit in a hospital? A clinic? Home visit?
 - If yes: What was your reason for organizing this visit? Did you have a specific concern? Or were you recommended to visit this doctor for a check-up?

- If no: Would you ever visit a gynecologist? If yes, in what context can you imagine yourself visiting a gynecologist?

Hopes for the future:

- Do you hope to have more children in the future?
 - In what ways do you hope to ameliorate or maintain your healthcare experiences in the United States?
 - What kind of support are you looking for in your healthcare experiences in the United States?
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Version français :

Expériences de santé en générale, à l'étranger :

- Dans quel pays êtes-vous née ?
- Dans quels pays avez-vous passé une longue période de temps (au moins 6 mois) ?
 - Dans quel genre de logement viviez-vous dans chacun de ces endroits ? Qui était avec vous ? Racontez-moi votre expérience vivant dans chacun de ces endroits.
- Racontez-moi une de vos expériences avec les services de santé à l'étranger (pas aux Etats-Unis).
- Racontez-moi les services de santé accessibles à vous à chacun de ses endroits à l'étranger.
 - Quels ont été les services de santé accessibles à vous ?
 - Comment jugez-vous la qualité de ces services ?
- Si vous avez été malade, où est-ce que vous avez cherché des soins ?
 - Dans un hôpital ? Une clinique ? Visite à domicile ?
- Parlez-moi de la personne qui vous a fourni des services de santé.
 - Est-ce que c'était un médecin ? Une infirmière ? Un travailleur de santé communautaire ?
 - Cette personne venait-elle du pays ou provenait-elle d'une organisation d'aide étrangère ?
- Parlez-moi de tout obstacle à l'accès aux services de santé auquel vous avez été confronté. Avez-vous déjà eu du mal à obtenir un traitement dont vous aviez besoin ?

Expériences de santé en général, aux Etats-Unis :

- Depuis quand vivez-vous aux Etats-Unis ?
- Avez-vous reçu des services de santé aux Etats-Unis ? (obligatoire – veux-tu qu'elles en dressent une liste ?)
- Racontez-moi l'histoire d'une expérience de soins de santé que vous avez eue aux Etats-Unis.
- Lorsque vous ou un membre de votre famille êtes malade aux Etats-Unis, où cherchez-vous des soins de santé ?
 - Dans un hôpital ? Une clinique ? Visite à domicile ?
 - Est-ce que l'endroit où vous cherchez des soins dépend de votre souffrance ?

- Où a été le premier centre médical que vous avez visité aux Etats-Unis ?
 - Allez-vous toujours à ce centre médical pour recevoir des soins ?
- Avez-vous un médecin généraliste ?
 - Si oui, racontez-moi de vos expériences avec ce médecin généraliste.
- Quand a été la dernière fois que vous êtes allée à un centre médical, à l'hôpital, ou un autre endroit pour recevoir des soins médicaux ?
 - Parlez-moi de cette expérience.
- Trouvez-vous qu'il est facile d'accéder aux services de santé aux Etats-Unis ?
- Comparez le système de santé des Etats-Unis aux systèmes de santé que vous avez rencontrés à l'étranger. Décrivez-moi les différences et similarités en utilisant vos propres expériences.

Votre histoire médicale obstétricale :

- Racontez-moi votre première grossesse.
 - Est-ce que cette grossesse était à l'étranger ou aux Etats-Unis ?
 - Avez-vous rencontré des médecins ou des agents de santé pendant cette première grossesse ?
 - Si oui, quels conseils est-ce qu'ils t'ont donnés pendant la grossesse ?
 - Si non, est-ce que votre famille et vos amis vous ont donné des conseils pendant votre grossesse ?
 - À votre avis, que faut-il faire quand vous êtes enceinte ?
 - Qu'est-ce qu'il ne faut pas faire ?
 - Parlez-moi de vos visites dans les cliniques de santé pendant votre grossesse.
 - Quel type de soins prénataux avez-vous reçu ?
 - Si vous pouviez revenir à cette première grossesse, qu'aimeriez-vous faire différemment ? Voudriez-vous modifier un aspect de votre grossesse ?
 - Cette grossesse était-elle planifiée ou non planifiée ?
 - Est-ce que vous avez voulu devenir enceinte ?
 - Parlez-moi du soutien de votre famille pendant cette grossesse.
- Quand vous avez appris que vous étiez enceinte, qu'avez-vous fait ? Comment vous sentiez-vous ?
- Racontez-moi vos autres grossesses (le cas échéant). Combien de fois avez-vous été enceinte ?
 - De ces grossesses, combien ont été conçues à l'étranger ?
 - Combien ont été conçues aux Etats-Unis ?
- Racontez-moi les différences entre chacune de ces grossesses.
- Combien de fois avez-vous accouché ?
 - De ces naissances vivantes, combien ont eu lieu à l'étranger ?
 - Combien de ces naissances vivantes ont eu lieu aux Etats-Unis ?
 - Racontez-moi votre premier accouchement.
 - Où est-ce que vous avez accouché la première fois ? Qui a été dans la salle ?
- Combien d'enfants vivantes avez-vous ?
 - Est-ce que tous vos enfants habitent aux Etats-Unis ?

- Vous êtes-vous senti soutenu par les membres des systèmes de sante où vous avez accouché ? (à l'étranger et aux Etats-Unis)
- À votre avis, qui sont les personnes les plus influentes pendant une grossesse ? Pendant l'accouchement ? Pendant les premiers mois de la vie d'un enfant ?

Note : Si la mère a vécu une urgence obstétricale, qu'est-ce qui s'est passé ? A-t-elle été transférée à l'établissement appropriée pour gérer cette situation d'urgence ? Est-ce qu'elle a reçu une césarienne ?

Votre histoire du planning familial :

- Racontez-moi de votre décision d'avoir des enfants.
 - Pourquoi voudriez-vous avoir des enfants ?
 - Quels sentiments avez-vous éprouvés en prenant la décision d'avoir des enfants ?
- Etiez-vous prête à avoir un enfant lorsque vous avez eu votre première grossesse ?
 - À votre avis, qu'est-ce que cela signifie « être prête » à avoir un enfant ?
- Avant de commencer à avoir des enfants, avez-vous pensé à un nombre idéal d'enfants pour votre famille ?
- Lorsque vous étiez à l'étranger, avez-vous réfléchi à des façons d'éviter ou de planifier vos grossesses ?
 - Si oui : quelles sont les méthodes que vous avez utilisées pour accomplir ce but ?
- Avez-vous été éduquée sur les façons de planifier vos grossesses pour assurer que vous devenez enceinte seulement lorsque vous êtes prête à être enceinte ?
 - Si oui : ou/dans quel pays avez-vous reçu cette éducation ?
 - Parlez-moi de cette éducation. Quelles choses avez-vous apprises ?
- Avez-vous utilisé une forme de contraception moderne à action prolongée ? (Exemples : injectable, la pilule, l'implant, dispositif intra-utérin)
 - APPORTER DES PHOTOS DE CHAQUE TYPE DE CONTRACEPTION (bonne idée !)
 - Si oui : quelles méthodes avez-vous utilisées dans le passé ?
 - Si oui : utilisez-vous actuellement une forme de contraception moderne à action prolongée ?
 - Si oui : quelle méthode utilisez-vous actuellement ?
 - Parlez-moi de votre expérience en utilisant une forme de contraception.
 - Parlez-moi du processus que vous avez suivi pour obtenir cette méthode de contraception. Racontez-moi l'histoire de la première fois que vous avez cherché des contraceptifs.
 - Que ressentiez-vous lorsque vous avez reçu ce contraceptif ?
 - Pourquoi avez-vous décidé d'utiliser cette méthode contraceptive ?
 - Si vous avez change de méthode, pourquoi avez-vous décidé de changer ?
 - Si vous n'avez jamais utilisé un contraceptif à action prolongée :
 - Pourquoi avez-vous décidé de ne pas utiliser cette forme de contraception ?
 - Avez-vous déjà pensé à utiliser une méthode de contraception ?

- Ces contraceptifs modernes à action prolongée étaient-ils facilement disponibles dans les établissements de soins de santé à l'étranger ?
 - Y avait-il des obstacles à l'accès à ces contraceptifs ?
 - Parlez-moi de l'expérience d'une femme qui cherche une contraception moderne dans votre pays d'origine.
- Ces contraceptifs modernes à action prolongée sont-ils facilement disponibles dans un contexte de soins de santé aux Etats-Unis, à votre avis ?
 - Avez-vous déjà reçu une éducation sur ces formes de contraception depuis que vous vivez aux Etats-Unis ?
 - Si oui : qui vous a fourni cette information?
- Avez-vous utilisé un contraceptif moderne à court terme ? (Exemples : préservatifs masculins ou féminins, diaphragme)
 - Trouvez-vous que ces types de contraceptifs sont facilement disponibles dans les établissements de soins de santé à l'étranger ?
 - Trouvez-vous que ces types de contraceptives sont facilement disponibles dans un contexte de soins de santé aux Etats-Unis ?
- Selon vous, quel est l'âge idéal pour un premier rapport sexuel ?
- Si votre fille ou un autre membre de votre famille était en âge de procréer et était peut-être sexuellement active, que recommanderiez-vous qu'elle fasse ?
 - Recommanderiez-vous qu'elle utilise une forme de contraception ? Si oui, qu'elle forme de contraception ?
- Qu'est-ce que votre mère vous a recommandé lorsque vous avez atteint l'âge de procréation ? Racontez-moi votre expérience en parlant de votre sexualité avec votre mère ou d'autre membre de votre famille.
- Quelles étaient les croyances populaires autour des méthodes contraceptives et du planning familial dans votre pays d'origine et dans votre famille ?

Espoirs pour l'avenir :

- Espérez-vous avoir plus d'enfants dans le futur ?
- Dans quelle(s) façon(s) espérez-vous améliorer ou maintenir vos expériences de soins de santé aux Etats-Unis ?
- Quel type de soutien cherchez-vous dans vos expériences de soins de santé aux Etats-Unis ?
- Racontez-moi votre expérience médicale idéale.

Appendix B: Recruitment flyer

**BESOIN DE PARTICIPANTES
pour une étude de recherche**

Nous cherchons des **refugiées francophones** pour participer dans une étude sur les **perceptions de l'accès aux soins de santé maternelle et reproductive.**

En tant que participante dans cette étude, vous serez invitée à parler de vos expériences liées aux soins de santé maternelle. L'entretien sera dirigé en français et durera environ 60 minutes

Pour vous remercier pour votre temps, vous recevrez \$25.

Pour être qualifiée à participer à cette étude, vous devez être une réfugiée francophone ayant accouché.

Pour plus d'informations sur cette étude ou pour vous porter volontaire pour cette étude, merci de contacter :

Madeline Thornton
Étudiante à Duke University
919-632-5216
Email : mjt41@duke.edu

Les procédures d'étude de cette recherche ont été examinées et approuvées par l'Institution Review Board, Duke University.



Appendix C : SMS script for recruitment

Bonjour [nom]. Je m'appelle Madeline Thornton, et je mène une enquête sur les expériences des femmes réfugiées francophones à propos des services de santé maternelle et reproductive aux Etats-Unis et en Afrique. Je vais demander aux femmes de discuter de leurs expériences avec moi dans un entretien informel. Les participantes doivent être des femmes réfugiées qui parlent français et qui ont accouché. En reconnaissance de votre temps, vous recevrez \$25. Si vous vous intéressez à participer dans cette enquête, contactez-moi par téléphone ou texto (919-632-5216) ou par email (mjt41@duke.edu).

Hello [insert name here]. I am conducting a research study on francophone refugee women's thoughts and experiences with maternal and reproductive healthcare services in the United States and in their home country. I am going to be asking women to sit down with me and discuss their experiences in an interview. Interviewees need to be French-speaking female refugees who have given birth. In appreciation for your time, you will receive \$25. If you are interested in participating in this study, please contact me by phone 919-632-5216 or by email (mjt41@duke.edu).