REPRODUCTIVE HEALTH IN REFUGEE WOMEN

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ReproNet
California's Refugee Reproductive Health Network
1. Identify statistics of refugee arrivals to the US
2. Compare Canadian and US refugee screening guidelines for contraceptive use
3. List impact of refugee status on maternal morbidity
4. Describe the Refugee Reproductive Health Network (ReproNet)
The US does not receive any refugees at this moment.

In 2018, Canada received more refugees than the U.S.

10% of refugees to the US arrive in California.

More than half of refugees to the US arrive in ten states.

The counties with the largest percentages of refugees in California are:

A. San Diego, Los Angeles, San Francisco
B. San Diego, Los Angeles, Sacramento
C. San Diego, Los Angeles, San Jose
PATHWAYS TO SAFETY FOR VICTIMS OF PERSECUTION OR ORGANIZED VIOLENCE
ASSISTANCE TO REFUGEES AFTER ARRIVAL
WHAT RESOURCES ARE AVAILABLE TO REFUGEES UPON ARRIVAL?

- Standardized health exam at entry to US
- Support from resettlement agencies to integrate, including “cultural orientation” and Medicaid enrollment assistance (90 days)
- Eligible for Medicaid for at least eight months
SEPTEMBER 17, 2018

TRUMP TO CAP REFUGEES ALLOWED INTO U.S. AT 30,000, A RECORD LOW

Syrian refugees preparing to leave Beirut, Lebanon, this month to return to their homes in Syria. Photo Credit: Anwar Amro/Agence France-Presse — Getty Images

THE NEW YORK TIMES
U.S. refugee resettlement drops, falling below Canada in 2018

Number of resettled refugees, in thousands

Note: Nations shown are top four resettlement countries. Complete data for UK prior to 2004 is not available through the UNHCR. Figures rounded to the nearest thousand.

PEW RESEARCH CENTER
## Top states for U.S. refugee resettlement in fiscal 2019

### Number of refugees resettled by state

<table>
<thead>
<tr>
<th>State</th>
<th>Refugees Resettled</th>
</tr>
</thead>
<tbody>
<tr>
<td>Texas</td>
<td>2,500</td>
</tr>
<tr>
<td>Washington</td>
<td>1,900</td>
</tr>
<tr>
<td>New York</td>
<td>1,800</td>
</tr>
<tr>
<td>California</td>
<td>1,800</td>
</tr>
<tr>
<td>Kentucky</td>
<td>1,400</td>
</tr>
<tr>
<td>Ohio</td>
<td>1,400</td>
</tr>
<tr>
<td>North Carolina</td>
<td>1,300</td>
</tr>
<tr>
<td>Arizona</td>
<td>1,200</td>
</tr>
<tr>
<td>Georgia</td>
<td>1,200</td>
</tr>
<tr>
<td>Michigan</td>
<td>1,100</td>
</tr>
</tbody>
</table>

Note: Fiscal year ended on Sept. 30, 2019. Numbers rounded to the nearest hundred.

• Special Immigrant Visas holders (SIVs) assisted or were employed by the United States government in Afghanistan or Iraq
• Same support and resources as refugees
• Arrival statistics are reported separately
<table>
<thead>
<tr>
<th>County</th>
<th>Refugee Arrival, 2012-2016</th>
<th>SIV Arrival, 2012-2016</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>San Diego</td>
<td>13,153</td>
<td>1,490</td>
<td>14,643</td>
</tr>
<tr>
<td>Los Angeles</td>
<td>7,818</td>
<td>511</td>
<td>8,239</td>
</tr>
<tr>
<td>Sacramento</td>
<td>4,348</td>
<td>3,775</td>
<td>8,123</td>
</tr>
<tr>
<td>Other</td>
<td>5,982</td>
<td>3,389</td>
<td>9,371</td>
</tr>
<tr>
<td>California</td>
<td>31,301</td>
<td>9,165</td>
<td>40,466</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Country of Origin</th>
<th>Number of Persons Resettled</th>
</tr>
</thead>
<tbody>
<tr>
<td>Afghanistan</td>
<td>10,387</td>
</tr>
<tr>
<td>Democratic Republic of Congo</td>
<td>1,478</td>
</tr>
<tr>
<td>Iran</td>
<td>20,536</td>
</tr>
<tr>
<td>Iraq</td>
<td>28,095</td>
</tr>
<tr>
<td>Somalia</td>
<td>1,925</td>
</tr>
<tr>
<td>Syria</td>
<td>2,327</td>
</tr>
</tbody>
</table>
MATERNAL HEALTH OUTCOMES OF REFUGEE GROUPS

- Undetected health problems like anemia and hypertension
- Iraqi, Somali, and Bhutanese refugees reported delayed initiation of pre-natal care and had fewer prenatal visits compared to US-born populations
- Refugee populations had higher rates of Cesarean sections, stillbirths, preterm births, and lower birth weights among infants
- Post-partum depression also occurred, but many women did not understand what this was, which prevented them from obtaining necessary treatment
‘Healthy Migrant Paradox’?
SOMALI WOMEN AND PREGNANCY OUTCOMES POSTMIGRATION

- Meta-analysis of Somali women in Australia, Belgium, Canada, Finland, Norway, Sweden
  - Lower preterm birth rates
  - Reduced low birthweight infants
  - Greater prolonged gestation (*postdates*)
  - Higher Cesarean sections (*in first births*)
  - Higher stillbirths
  - Lower Apgar scores
MATERNAL INFANT HEALTH OUTCOMES AMONG SOMALI REFUGEE WOMEN


Compared to US born women, Somali women have

- Increased cesarean delivery due to fetal distress
- Increased delivery after 42 weeks
- Significant perineal lacerations, gestational diabetes, and oligohydramnios
- Poor neonatal outcomes
- Lower 5-minute Apgar scores
- Prolonged hospitalization
- Assisted ventilation
- Meconium aspiration
REFUGEE HEALTH ASSESSMENT AT ARRIVAL TO THE US

- Screening focuses on infectious diseases and mental health issues
- Not designed to provide clinical preventive screening
- No standardized follow up to “referral”
- Review article on Refugee Health to High-Resource country: No assessment of contraception or preconception care needs
Reproductive health questions:
1) Are you pregnant?
2) How regular is your menstrual cycle?
3) How many pregnancies have you had?
4) How many children do you have?

Question on Female Cutting
Evidence-based clinical guidelines for immigrants and refugees

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Competing interests: See end of document for competing interests.


This document has been peer reviewed.

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Key points

- Clinical preventive care should be informed by the person's region or country of origin and migration history (e.g., forced versus voluntary migration).
- Forced migration, low income and limited proficiency in English or French increase the risk of a decline in health and should be considered in the assessment and delivery of preventive care.
- Vaccination (against measles, mumps, rubella, diphtheria, tetanus, pertussis, polio, varicella, hepatitis B and human papillomavirus) and screening (for hepatitis B, tuberculosis, HIV, hepatitis C, intestinal parasites, iron deficiency, dental pain, loss of vision and cervical cancer) should be routinely provided to at-risk immigrants.
- Detecting and addressing malaria, depression, post-traumatic stress disorder, child maltreatment, intimate partner violence, diabetes mellitus and unmet contraceptive needs should be individualized to improve detection, adherence and treatment outcomes.
Encourage use of checklists and algorithms for systematic assessment

Implementation of recommendations may take 3-4 visits; If possible, same PCP screens and provides care for the next two years

Guidelines include testing for cervical cancer, intimate partner violence, contraceptive needs

“To prevent unintended pregnancy, screening for unmet contraceptive needs should begin soon after a woman’s arrival in Canada.”

4.8% refugee women tested positive for being pregnant at the time of the assessment.

1.3% tested positive for chlamydia while 0.6% tested positive for syphilis.
Refugee health assessment not designed to provide clinical preventive screening; referral to primary care

Unclear whether primary care provider (PCP) is familiar with refugee screening guidelines

Delay in accessing primary care: Medicaid enrollment, time to first appointment

Additional delays: Preference for female provider; PCP not providing women’s health services; other priorities at resettlement
Sacramento County Department of Health reorganization 2019

- All primary care clients get a full assessment, regardless the reason of visit.
- Federal refugee assessment is complemented with obstetric and gynecological health, including contraceptive needs.
- Women can stay at same clinic for maternity and gynecologic care. DOH has live interpreters in multiple languages.
- Have to select Medicaid plan that has contract with DOH for continuing primary care.
MEDICAID MANAGED CARE PLANS

- Follow up of new enrollees about access to contraceptive options

Family PACT – Family planning and family-planning related services

For low-income California residents who do not qualify for Medicaid or who need confidential services

- Network of over 2,000 public and private Family PACT providers [www.familypact.org](http://www.familypact.org) - zipcode locator
WHICH BIASES DID YOU OBSERVE IN THE ASSIGNED ARTICLES ON CONTRACEPTIVE USE IN REFUGEE WOMEN?


CONTRACEPTIVE USE AMONG AFGHAN WOMEN: AVOID STEREOTYPES

Preterm Birth Postpartum Contraception Study (2017-18) In-depth interviews with 35 women who had a preterm birth in San Francisco, Alameda, and Fresno counties

Case: 20 yrs, Afghanistan, Pastho-speaking, arrived 6 month pregnant in the U.S.
A family member had her baby a month before at the same hospital and got an IUD.
After talking to her, patient decided to get the IUD as well.
Husband supportive of contraceptive and birth spacing decision.
LESSONS FROM POSTPARTUM CONTRACEPTION STUDY ON FOREIGN-BORN MOTHERS

- Arrival advanced pregnancies (few time to do contraceptive counseling by provider)
- No knowledge about contraceptive options in the US or bad experiences with certain methods
- Medical condition that could not be treated in home country
- Section of methods because of experience of friends and family (local and in home country)
- Men may support to contraceptive use and birth spacing decision
- Transportation and child care important
THE GOVERNANCE STRUCTURE OF REPRONET

STEERING COMMITTEE:
- 6 PTF MEMBERS
- 4 PRSP MEMBERS
- UC RESEARCHERS

THE STEERING COMMITTEE (SC) IS RESPONSIBLE FOR PLANNING MEETINGS AND THE SYMPOSIUM

PANEL OF RESEARCHERS AND SERVICE PROVIDERS:
- RESEARCHERS AND CLINIC REFUGEE SERVICE PROVIDERS

THE PRSP WILL HAVE QUARTERLY MEETINGS

PATIENT TASK FORCE:
- 6 REFUGEE SC MEMBERS
- REFUGEES

THE PTF WILL HAVE QUARTERLY MEETINGS AND WILL NETWORK THROUGH SOCIAL MEDIA.
Engagement award, collaboration of University of California campuses with local refugee communities

- San Diego and Sacramento
- Engage in dialogue with refugee communities to investigate their preferences for reproductive health and well-woman care
- Organize symposium at UCD Medical Center, Sacramento spring 2021 to develop a Research and Policy Agenda with and for refugee women
REPRONET COLLABORATION WITH SACRAMENTO COUNTY DEPARTMENT OF HEALTH - 2020

- Medical chart review of contraceptive use of refugee patients
- Assess pregnancy intention of refugee arrivals after health visit
- COVID-19 phone survey to Afghan and Ukrainian refugees
REPRONET IN TIMES OF COVID-19

- Change from in-person meetings to virtual meetings
- Assess digital readiness of refugee communities and new opportunities (mosque services on zoom)
- Change in service delivery impacts provider priorities
- Internship and volunteer opportunities: Sereen Banna, project coordinator
  serineb@hs.uci.edu

Sign up for ReproNet provider and volunteer contact list:
https://ci-redcap.hs.uci.edu/surveys/?s=L49TD9F9E8
FOR QUESTIONS AND ANSWERS

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REFERENCES


