

Reproductive Health in Refugee Women

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Objectives

- Identify statistics of refugee arrivals to the US
- Compare Canadian and US refugee screening guidelines for contraceptive use
- List impact of refugee status on maternal morbidity
- Describe the Refugee Reproductive Health Network (ReproNet)



Poll questions

The US does not receive any refugees at this moment.

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

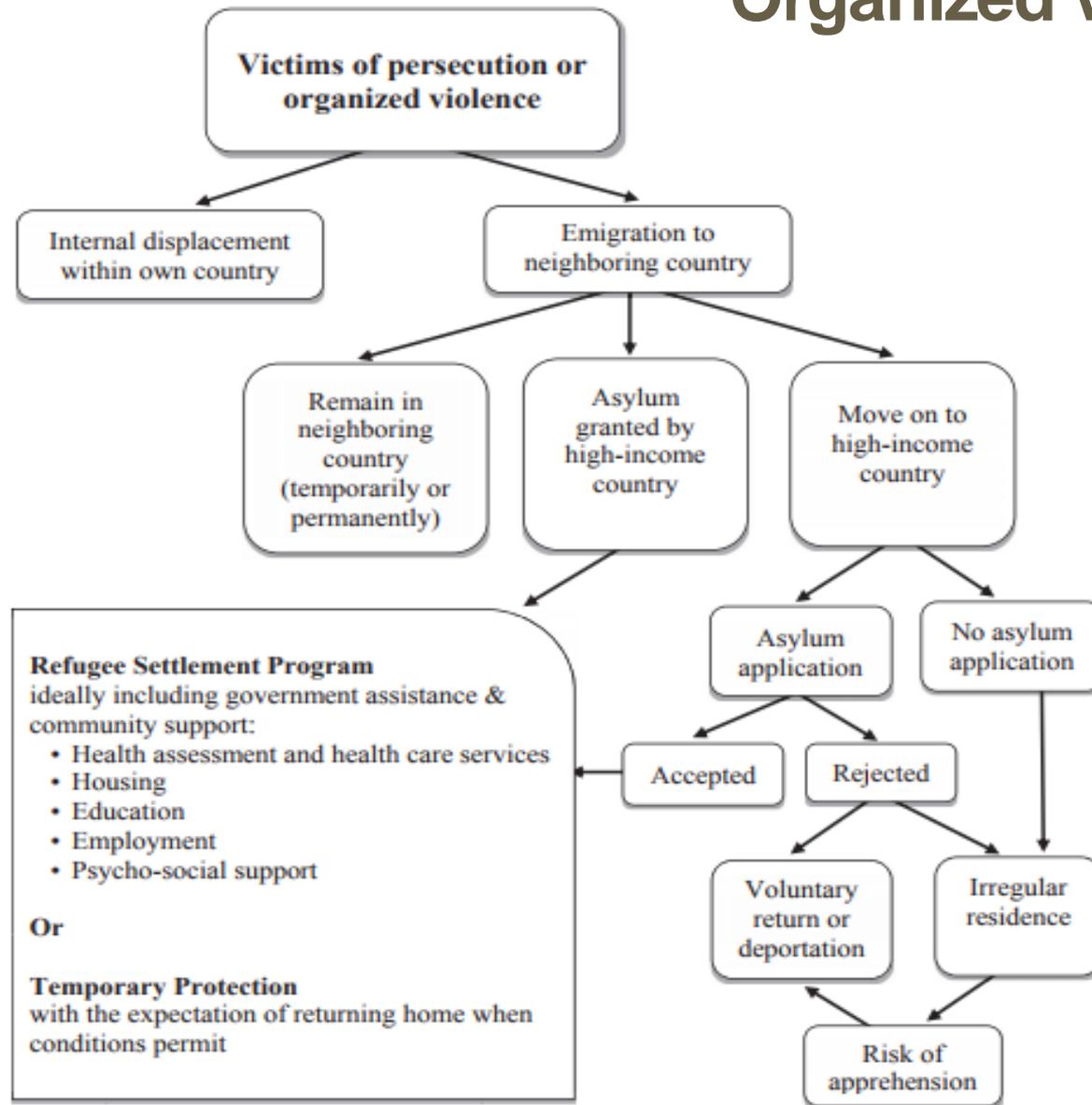
10% of refugees to the US arrive in California

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

- Specific date of entry
 - 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
- Assistance for asylum seekers varies by state

U.S. Refugee Admissions

Number of Refugees Per Fiscal Year



US Refugee Processing Center

■ Number of Refugees Per Fiscal Year

https://www.wrapsnet.org/documents/Graph%20Refugee%20Admissions%20FY2020_03_31.pdf

The New York Times

Sept 17, 2018

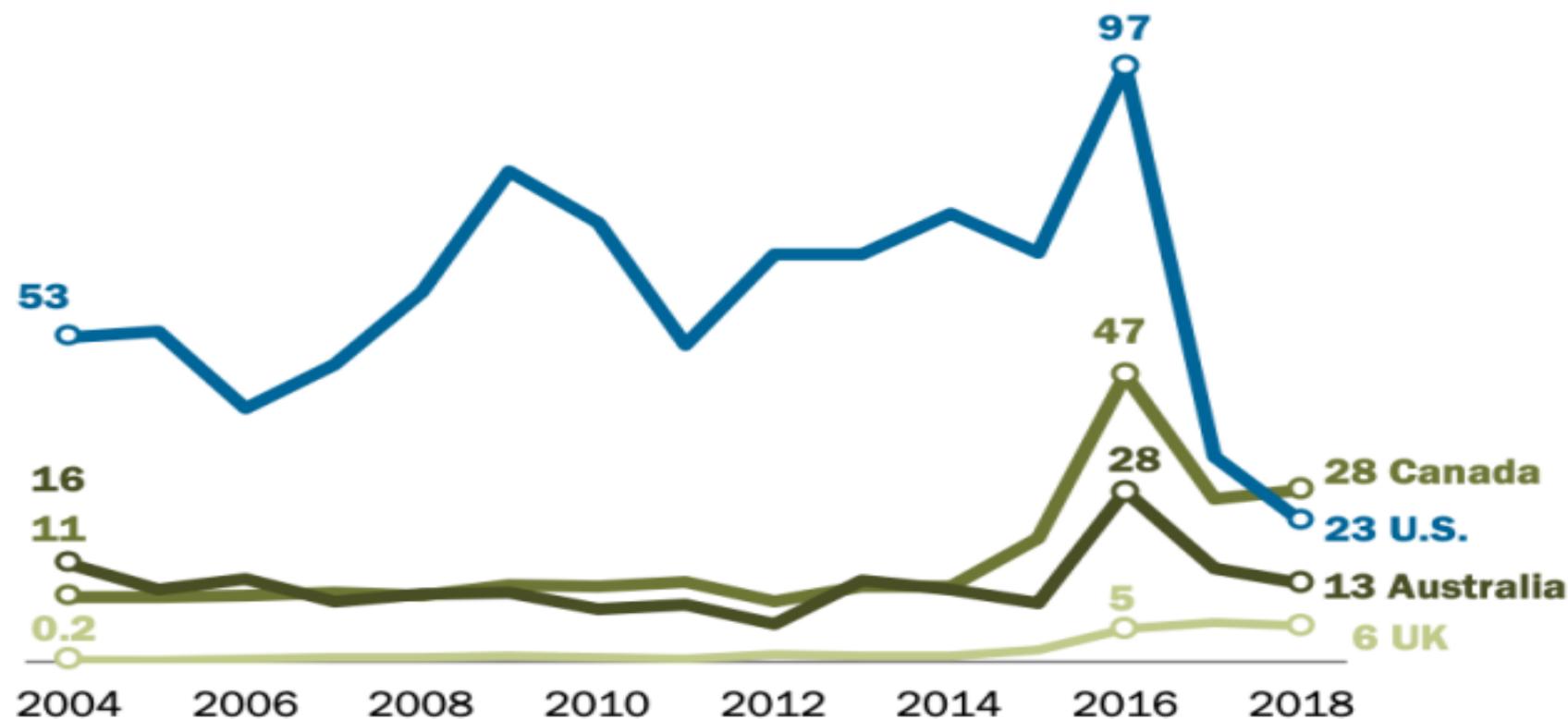
Trump to Cap Refugees Allowed Into U.S. at 30,000, a Record Low



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

U.S. refugee resettlement drops, falling below Canada in 2018

Number of resettled refugees, in thousands

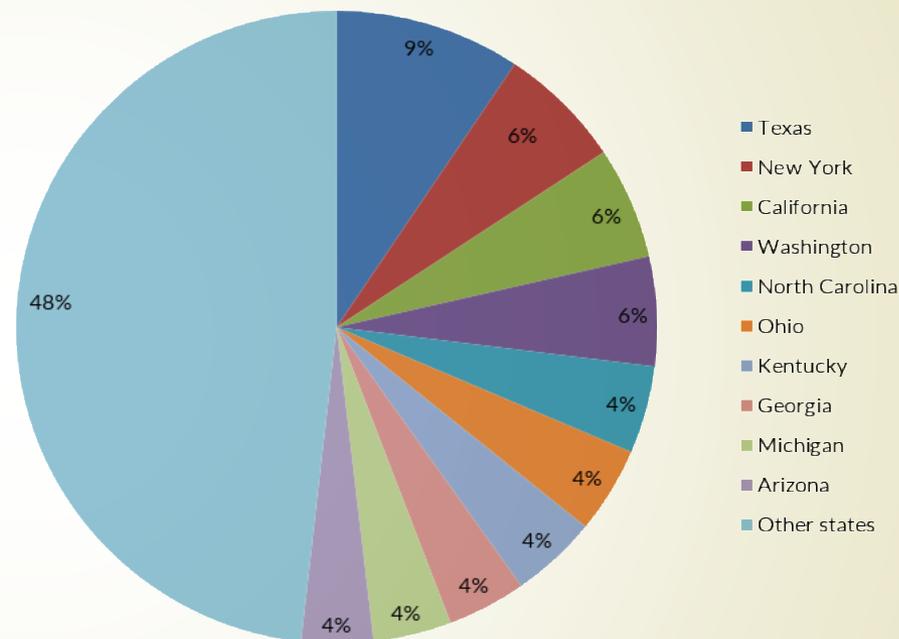
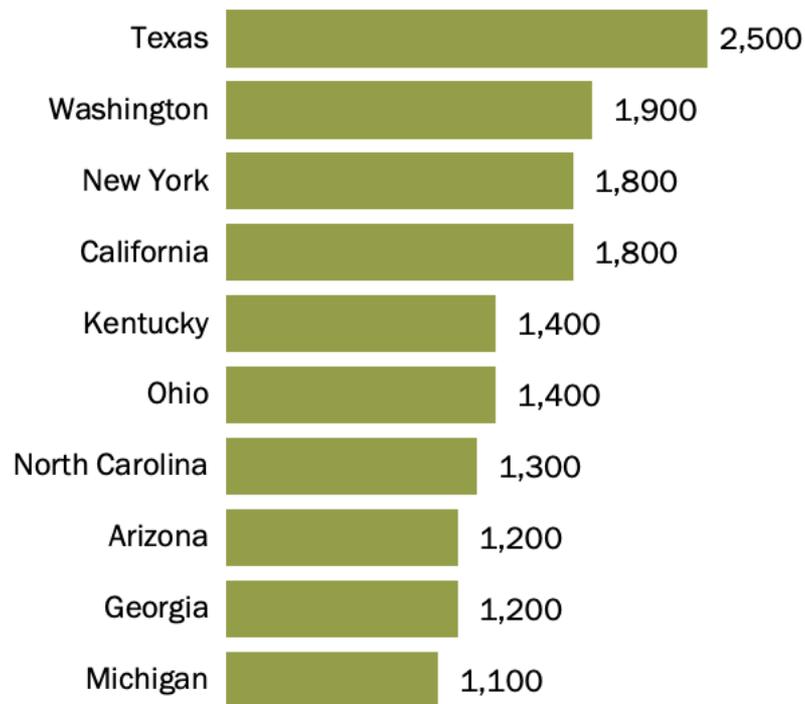


Note: Nations shown are top four resettlement countries. Complete data for UK prior to 2004 is not available through the UNHCR. Figures rounded to the nearest thousand.
Source: Pew Research Center analysis of United Nations High Commissioner for Refugees data, accessed June 12, 2019.

US Refugees by state, 2019

Top states for U.S. refugee resettlement in fiscal 2019

Number of refugees resettled by state

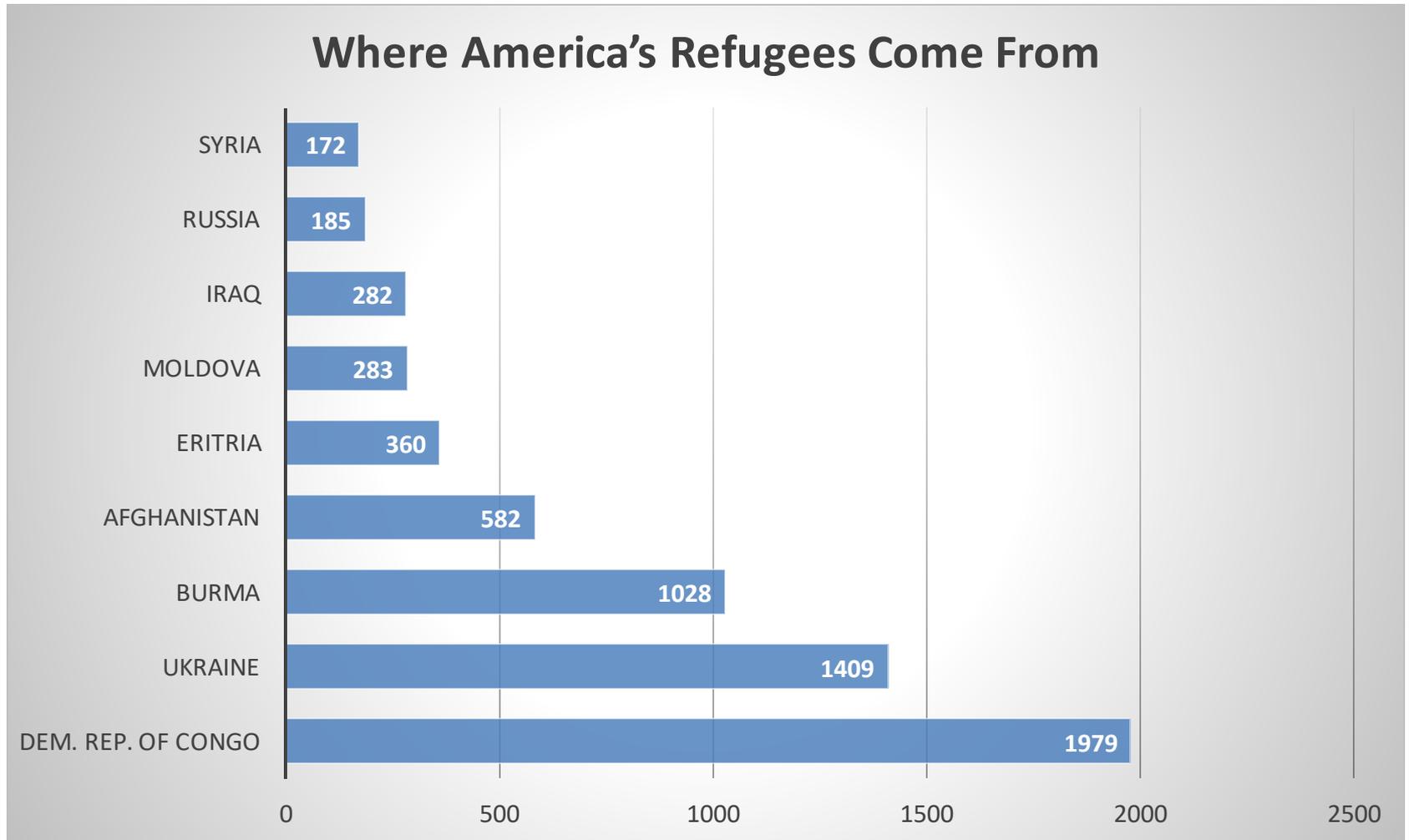


Note: Fiscal year ended on Sept. 30, 2019. Numbers rounded to the nearest hundred.

Source: U.S. State Department's Refugee Processing Center, accessed Oct. 1, 2019.

PEW RESEARCH CENTER

Top 10 Countries of Origin of Refugees (10/2019 - 05/2020)



Source: Refugee Processing Center,

<https://www.wrapsnet.org/documents/Arrivals%20by%20Nationality%20-%20Map%203-31-20.pdf>



Afghan and Iraqi SIV Arrivals

- 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

County	Refugee Arrival, 2012-2016 ¹	SIV arrival, 2012-2016 ²	Total
San Diego	13,153	1,490	14,643
Los Angeles	7,818	511	8,239
Sacramento	4,348	3,775	8,123
Other	5,982	3,389	9,371
California	31,301	9,165	40,466

¹ Refugee Processing Center. *Admissions and Arrivals*. U.S. Department of State
<http://www.wrapsnet.org/admissions-and-arrivals/>.

² California Refugee Arrivals Data. California Department of Public Health.
<http://www.cdss.ca.gov/inforesources/Refugees/Reports-and-Data/Arrivals-Data>

California Refugees (10/2019-03/2020) and SIVs (10/2019-05/2020) By Nationality

Country of Origin	Number of Persons Resettled
Afghanistan	8,588
Democratic Republic of Congo	1,979
Iran	61
Iraq	438
Somalia	108
Syria	172

California Refugees (2008-2018) and SIVs (2016-2018) By Nationality

Country of Origin	Number of Persons Resettled
Afghanistan	10,387
Democratic Republic of Congo	1,478
Iran	20,536
Iraq	28,095
Somalia	1,925
Syria	2,327



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

Washington State birth certificates and hospital discharge 1993 – 2003

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
- Thiel de Bocanegra et al.: Annals of Epidemiology 28 (2018) 411-419





Reproductive health questions in refugee screening guidelines

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

GUIDELINES

CMAJ

Evidence-based clinical guidelines for immigrants and refugees

Kevin Pottie MD MCISc, Christina Greenaway MD MSc, John Feightner MD MSc, Vivian Welch MSc PhD, Helena Swinkels MD MHSc, Meb Rashid MD, Lavanya Narasiah MD MSc, Laurence J. Kirmayer MD, Erin Ueffing BHSc MHSc, Noni E. MacDonald MD MSc, Ghayda Hassan PhD, Mary McNally DDS MA, Kamran Khan MD MPH, Ralf Buhrmann MDCM PhD, Sheila Dunn MD MSc, Arunmozhi Dominic MD, Anne E. McCarthy MD MSc, Anita J. Gagnon MPH PhD, Cécile Rousseau MD, Peter Tugwell MD MSc; and coauthors of the Canadian Collaboration for Immigrant and Refugee Health

Competing interests: See end of document for competing interests.

Coauthors of the Canadian Collaboration for Immigrant and Refugee Health:

Deborah Assayag, Elizabeth Barnett, Jennifer Blake, Beverly Brockest, Giovanni Burgos, Glenn Campbell, Andrea Chambers, Angie Chan, Maryann Cheatham, Walter Delpero, Marc Deschenes, Shafik Dharamsi, Ann Duggan, Nancy Durand, Allison Eyre, Jennifer Grant, Doug Gruner, Sinclair Harris, Stewart B. Harris, Elizabeth Harvey, Jenny Heathcote, Christine Heidebrecht, William Hodge, Danielle Hone, Charles Hui, Susan Hum, Praseedha Janakiram, Khairun Jivani, Tomas Jurcik, Jay Keystone, Ian Kitai, Srinivasan Krishnamurthy, Susan Kuhn, Stan Kutcher, Robert Laroche, Carmen Logie, Michelle Martin, Dominique Elien Massenat, Debora Matthews, Barry Maze, Dick Menzies, Marie Munoz, Félicité Murangira, Amy Nolen, Pierre Plourde, Hélène Rousseau, Andrew G. Ryder, Amelia Sandoe, Kevin Schwartzman, Jennifer Sears, William Stauffer, Brett D. Thombs, Patricia Topp, Andrew Toren, Sara Torres, Ahsan Ullah, Sunil Varghese, Bilkis Vissandjee, Michel Welt, Wendy Wobeser, David Wong, Phyllis Zelkowitz, Jianwei Zhong, Stanley Zlotkin.

Editor's note: See Appendix 1, available at www.cmaj.ca/lookup/suppl/doi:10.1503/cmaj.090313/-/DC1, for affiliations and contributions of coauthors.

This document has been peer reviewed.

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CMAJ 2011. DOI:10.1503/cmaj.090313

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.

Canadian refugee health screening guidelines

- ▶ 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**



Canadian refugee health guidelines

- *“To prevent unintended pregnancy, screening for unmet contraceptive needs should begin **soon after a woman’s arrival in Canada.**”*
- For the complete evidence review populations, see Appendix 18, www.cmaj.ca/lookup/suppl/doi:10.1503/cmaj.090313/-/DC1

California Refugee Health Assessment Females (2017) ⁽⁵⁾

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.

Table 2. Screening Tests* by Results - California FFY 2016-2017

Screening Tests	Availability of valid data* for screening test		Cases with positive/elevated† results	
	No.	%	No.	%
Hepatitis B Surface Antigen (HBsAg)	9661	83.6%	116	1.2%
Schistosomiasis	106	0.9%	30	28.3%
Strongyloides	7049	61.0%	160	2.3%
Human Immunodeficiency Virus (HIV) Antibody	9364	81.0%	12	0.1%
Syphilis	6416	55.5%	40	0.6%
Chlamydia	820	7.1%	11	1.3%
Total Cholesterol	1540	13.3%	702	45.6%
High-density Lipoprotein (HDL) Cholesterol	1547	13.4%	794	51.3%
Low-density Lipoprotein (LDL) Cholesterol	1523	13.2%	562	36.9%
Triglycerides	1539	13.3%	796	51.9%
Pregnancy	2620	22.7%	126	4.8%
Serum Glucose (Random)	6616	57.2%	827	12.5%
Serum Glucose (Fasting)	696	6.0%	80	11.5%
Blood Lead	3893	33.7%	1078	27.7%

*A total of 11,993 cases were screened for FFY 2016-2017.
† Case responses with missing values or "not applicable" were excluded.





Refugee screening and primary care

- ▶ 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



Integration of refugee assessment in primary care

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
- zipcode locator

Which biases did you observe in the assigned articles on contraceptive use in refugee women?

Shabaik SA, Awaida JY, Xandre P, Nelson AL

Contraceptive Beliefs and Practices of American Muslim Women. J Womens Health (Larchmt). 2019 Jul;28(7):976-983. doi: 10.1089/jwh.2018.7500. Epub 2019 May 22.

<https://www.ncbi.nlm.nih.gov/pubmed/31120322>

Budhwani H, Anderson J, Hearld KR. **Muslim Women's use of contraception in the United States.** Reprod Health. 2018 Jan 5;15(1):1. doi: 10.1186/s12978-017-0439-6.

<https://www.ncbi.nlm.nih.gov/pubmed/29304829>

Contraceptive use among Afghan women: Avoid stereotypes

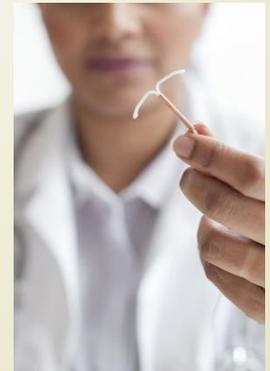
Preterm Birth Postpartum Contraception Study (2017-18)
In-depth interviews with 35 women who had a preterm birth in San Francisco, Alameda, and Fresno counties

Case : 20 yrs, Afghanistan, Pashto-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

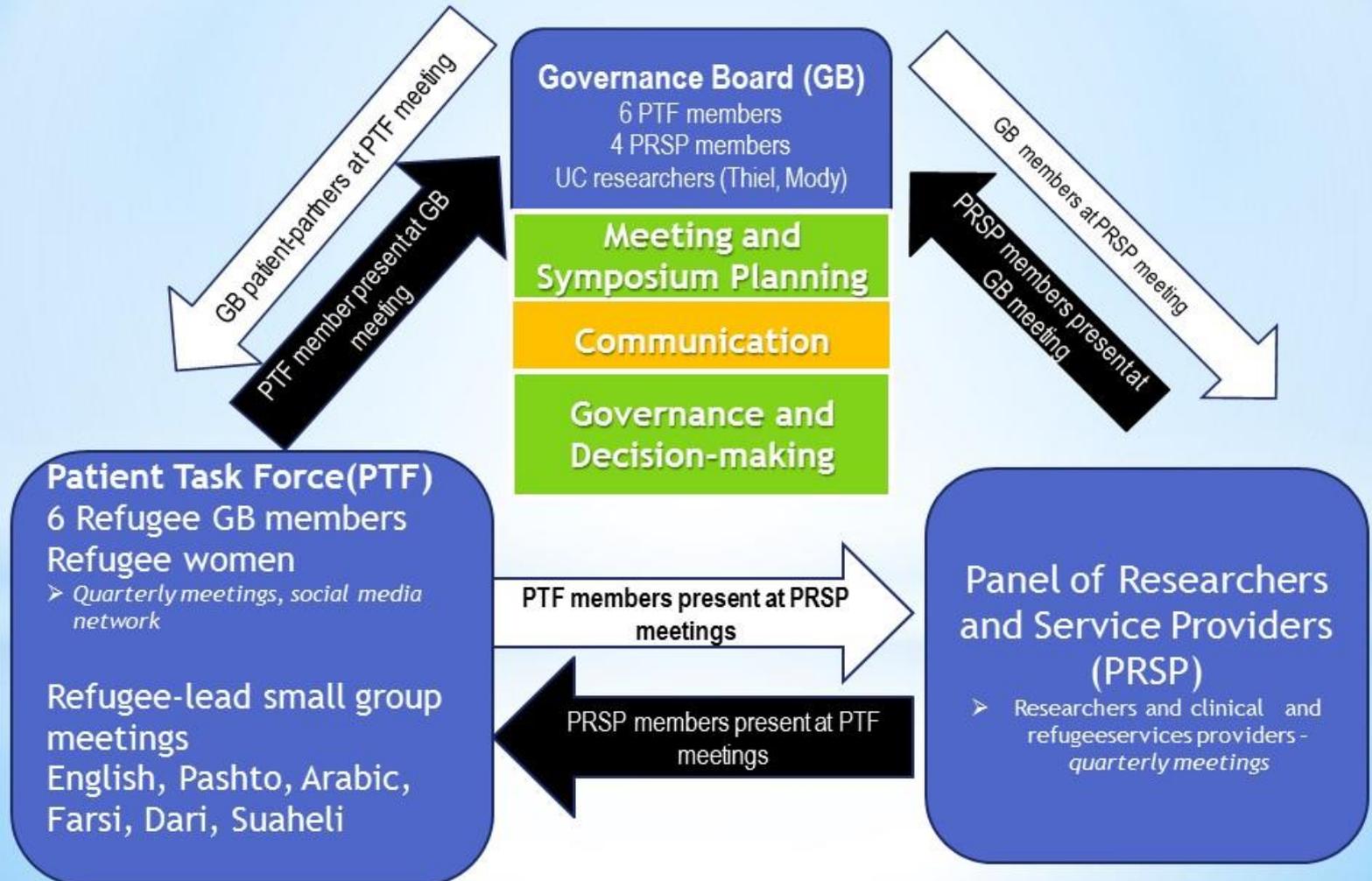
- Arrival advanced pregnancies (few time to do contraceptive counseling by provider)
- No knowledge about contraceptive options in the US or bad experiences with certain methods
- Medical condition that could not be treated in home country
- Selection of methods because of experience of friends and family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



Reproductive Refugee Network (Repro-Net)

- ▶ 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

**Figure 1: Refugee Reproductive Health Network (RRHN)
Governance Structure**

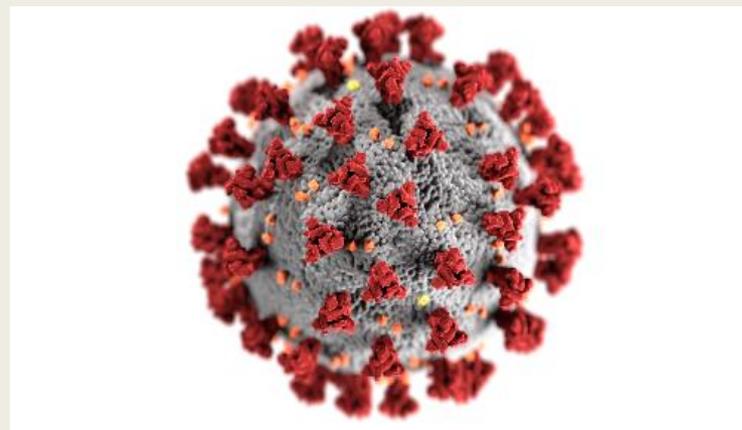


ReproNet collaboration with Sacramento County Department of Health - 2020

- 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
sybanna@ucdavis.edu
- [Sign up for ReproNet provider and volunteer contact list:](https://ci-redcap.hs.uci.edu/surveys/?s=L49TD9F9E8)
<https://ci-redcap.hs.uci.edu/surveys/?s=L49TD9F9E8>





Questions and Answers

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Thiel de Bocanegra H, Kenny J, Saylor K, Turocy M, Ladella S. Experiences with Prenatal and Postpartum Contraceptive Services among Women with a Preterm Birth. *Womens Health Issues*. 2019 Dec 16.

Van Egmond K, Naeem AJ, Verstraelen H, et al. Reproductive health in Afghanistan: results of a knowledge, attitudes and practices survey among Afghan women in Kabul. *Disasters*. 2004;28(3):269-282

World Health Organization, Global Health Observatory country views, Afghanistan statistics summary (2002-present). <http://apps.who.int/gho/data/node.country.country-AFG?lang=en>

	Stage	Health threats
1	Pre-conflict	<p>Depend on the country in question, as well as on socioeconomic status, age, sex, etc.</p> <p>WIDE VARIATIONS both within and between countries</p>
2	Conflict	<p>Physical violence (including torture); deprivation of physical, mental and social needs; separation, loss, traumatic events</p>
3	Flight	<p>Immigration policies of destination countries increasingly expose would-be asylum seekers to severe threats, including exploitation, violence and death by drowning, hunger or thirst</p>
4	Shelter	<p>Can be in neighboring region or high-income country, pending legal assessment. Risk of poor conditions, prolonged inactivity</p>
5	Resettlement	<p>Poor access to health services, unfavorable position in society, discrimination and marginalization. Difficulties in attaining economic self-sufficiency</p>