AAMC Maternal Health Equity Series Part Three

Advancing Maternal Health Equity in Refugee Communities
What is AAMC CHARGE?
AAMC CHARGE is a forum for investigators, clinicians, and community partners who design and implement research that eliminates health and health care inequities.

What does AAMC CHARGE do?
- Share accomplishments and crowdsource opportunities for professional achievement.
- Facilitate innovative multi-sector partnerships, collaborations, and research that contribute to the evidence base for solutions to health and health care inequities.
- Collaborate on policy work that impacts health equity at institutional, local, state, and federal levels.

How can I get involved?
Email healthequityresearch@aamc.org to join!
Advancing Maternal Health Equity in Refugee Communities

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Advancing Maternal Health
Equity in Refugee Communities

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Outline

• The Global Refugee Crisis
• Refugee Reproductive Health Disparities
• Female Genital Cutting
• Model of Care
• Addressing COVID-19
• Advancing Health Equity
Two Global Crises

A Global Refugee Crisis

- 79.5M Forcibly Displaced
  - 26M Refugees
  - 45.7M Internally Displaced
  - 4.2M Asylum-seekers
  - 3.6M Venezuelans displaced

UNHCR 6/18/20

A Global COVID-19 Pandemic Crisis

- GLOBAL
  - 9,263,570 confirmed cases
  - 477,584 deaths

- USA
  - 2,347,022 confirmed cases
  - 121,228 deaths

JHU CSSE Dashboard 6/23/20
Who is a Refugee?

The Refugee Act of 1980

A refugee is a person who is outside their home country and unable or unwilling to return due to persecution or a well-founded fear of persecution based on their:

- Race
- Religion
- Nationality
- Membership in a social group
- Political opinion
Challenges Specific to Gender/Sex

- Confusion over who is a ‘woman-at-risk’
- Inconsistency in resettlement criteria
- Lack of adequate staff training
- Disregard of rape and sexual abuse as sufficient grounds for resettlement
- Culture of distrust of refugees’ stories
- Disbelief of extent of abuses women/girls face
- Lack of access:
  - Resettlement
  - Education
- Poor quality
  - Physical
  - Social
  - Legal protection
- Slow response time among resettlement countries

NGO Statement on Women at Risk/International Council of Voluntary Agencies, 2006
Post-Resettlement: Immediate Protection Benefits

- Removal from abusive, exploitive situation
- Removal from hostile environment
- Prevention of future acts of violence, rape, kidnapping, forced marriage
Post-Resettlement: New Vulnerabilities Emerge

- Health concerns
- Supporting dependent children
- Disrupted family ties/Social isolation
- Illiteracy
Post-Resettlement: New Vulnerabilities Emerge

Health concerns
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Medical care
- Mental health evaluation
- Emotional support
- Literacy/Language training
- Low skilled jobs with low salaries
- Lack of child care
Post-Resettlement: New Vulnerabilities Emerge

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- Literacy/Language training
- Low skilled jobs with low salaries
- Lack of child care

Challenges attaining economic self-sufficiency
‘Healthy Migrant Paradox’

Fuentes-Afflick et al, 1999; Muening & Fahs, 2002; Neria, 2000; Singh & Siahpush, 2001; Read 2005; Urquia ML et al, 2012
Influence of refugee status and secondary migration on preterm birth

Wanigaratne S et al, 2016 J Epidemiology & Community Health
Predictors of Emergency Cesarean Delivery among Migrant Women

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Odds Ratio (95% CI)</th>
</tr>
</thead>
<tbody>
<tr>
<td>First delivery</td>
<td>5.94 (3.12 – 11.29)</td>
</tr>
<tr>
<td>Birth weight &gt; 4000 g</td>
<td>3.48 (1.87 – 6.49)</td>
</tr>
<tr>
<td>No health insurance</td>
<td>2.81 (1.24 – 6.35)</td>
</tr>
<tr>
<td>Gave birth on a Friday</td>
<td>2.19 (1.23 – 3.89)</td>
</tr>
<tr>
<td>Income &lt; $30,000</td>
<td>1.86 (1.16 – 2.98)</td>
</tr>
<tr>
<td>Induced</td>
<td>1.84 (1.13 – 3.01)</td>
</tr>
<tr>
<td>Refugee</td>
<td>0.45 (0.20 – 0.99)</td>
</tr>
<tr>
<td>Asylum seeker</td>
<td>0.29 (0.15 – 0.57)</td>
</tr>
</tbody>
</table>

Cesarean Section Rates Differ by Migration Status and Region of Origin

Gagnon A et al, Arch Gynecol Obstet, 2013
Cesarean Section Rates Differ by Migration Status and Region of Origin

Gagnon A et al, Arch Gynecol Obstet, 2013
Destination Also Matters

• Compared with native-born women, African, Latin-American and Caribbean migrants are at higher odds of Low Birthweight in Europe but not in the USA

• South-central Asian women are at higher odds on both continents

Urquia ML et al, 2010 J Epidemiology Community Health
Severe Maternal Morbidity and Immigration

• 479,986 Immigrants giving birth in Australia, Canada and Denmark

• **African women – highest risk severe maternal morbidity**

• Severe Pre-Eclampsia (most common diagnosis across all groups)

• Uterine rupture (most common among African women)

Urquia ML et al 2015 European J Public Health
513,000 women and girls affected by or at risk of FGM/C in the United States

Improving Health Care Services for Women and Girls in the United States Affected by Female Genital Cutting

1. Conducted Community based survey of 879 Somali women to identify FGC-related health care needs and services for women in Arizona.

2. Identified gaps, barriers, and/or assets in care

3. Trained 655 providers to improve culturally competent care for FGC-affected women.

4. Engaged in community and educational outreach to over 216 community members, increasing their awareness of FGC-related health issues, prevention and services
Psychologic Distress

15.51% positive screens
25.53% experienced regret for undergoing FGM/C

Method: Multivariate Logistic Regression:
  • Positive RHS-13 screen = dependent variable

Predictors of Psychologic Distress
  History of Trauma (Odds ratio 9.64)
  Immediate FGM/C complications (OR 3.76)
  Perceived discrimination (OR 2.93)
  Somali Bantu ethnicity (OR 2.62)

Adverse physical and psychological experiences at the time of FGM/C has an independent effect on psychological distress

Michlig G et al. Manuscript under peer review
Ongoing Health Concerns

A few ongoing health issues independently associated with psychologic distress

- **Difficulty with first intercourse**: OR 3.73 p=.001*
- **Lack of pleasure during sex**: OR 2.07 p=.019*
- **Poor genital self image**: OR 1.13 p=.000*
- **Infertility**: OR 3.62 p=.032*
- **Extensive vaginal tearing or hemorrhage at childbirth**: OR 5.2 p=.000*, OR 3.01 p=.035*
- **Recurrent UTIs or vaginal infections**: OR 2.82 p=.032*, OR 4.19 p=.003*

Exact relationships require additional analysis and theoretical orientation. No factor above, including summative health issues over the lifecourse, contributed to the final model.

Michlig G et al. Manuscript under peer review
Violence against women comprises:

- FGM/C
- War/conflict, torture, human rights abuses
- Gender-based violence (e.g., rape as a weapon of war)
- Domestic violence
- Child abuse, abduction, trafficking
- Forced/child marriage
- Involuntary family separation

The Victimization-Health Link

Health problems among victims vs. non-victims

Exposure to violence means more healthcare needs for Somali women and girls in Arizona

<table>
<thead>
<tr>
<th>Service</th>
<th>Victims</th>
<th>Non-victims</th>
</tr>
</thead>
<tbody>
<tr>
<td>General health care</td>
<td>35%</td>
<td>14%</td>
</tr>
<tr>
<td>Women’s health care</td>
<td>28%</td>
<td>11%</td>
</tr>
<tr>
<td>Dental care</td>
<td>22%</td>
<td>10%</td>
</tr>
<tr>
<td>Eye care</td>
<td>19%</td>
<td>8%</td>
</tr>
<tr>
<td>Education on FGM/C</td>
<td>22%</td>
<td>6%</td>
</tr>
<tr>
<td>Mental health care</td>
<td>16%</td>
<td>2%</td>
</tr>
</tbody>
</table>

A Patient-Centered, Community-Driven Clinic

OUR MISSION:

• To provide culturally and linguistically appropriate health services to the refugee and immigrant women in Phoenix

• To reduce/eliminate health disparities and cultural barriers to care
Locally Accessible. Globally Minded.

Overcoming Barriers.

Empowering Women.

Eliminating myths surrounding labor & delivery and preventative health services
59 COUNTRIES
Our Integrated Care Model – 5C’s

1. Cultural health navigation
2. Communication to promote health
3. Care coordination
4. Community partnered engagement
5. Capacity building
Community Partners

Refugee Women’s Health Community Advisory Coalition (RWHCAC)

- Cultural Health Navigators (CHNs)
- Grassroots Ethnic Community-based Organizations (ECBOs)
- Community & Social Services
- Academic Institutions
- Faith-based Community Organizations
- Arizona Refugee Resettlement Program
- Public Health Department
- Refugee Resettlement Agencies (VOLAGs)

Primary Care Providers

Grassroots Ethnic Community-based Organizations (ECBOs)
Addressing COVID-19
Universal Testing – Labor & Delivery

• All patients tested upon admission
• Cepheid rapid PCR
• Results within ~45 minutes
• 5/6/20 – 5/26/20
• N=105 tests
• Screen Positives
  • 27% among refugees
  • 6% among general population
  • PR 4.5 (1.4 – 14.8)

Johnson-Agbakwu et al. Manuscript in preparation
Community Mapping
Refugee-specific Challenges

**Multi-generational households**
- Cramped housing conditions
- Inability to self-isolate
- Caring for elders
- Asymptomatic carriers

**Employment conditions**
- (Meatpacking, Laundering facilities)
- Lack of paid sick leave
- Lack of social distancing
- Inadequate PPE

**Denial/reluctance to disclose symptoms**
- Fear of losing job
- Delays in screening/testing
- Not seeking care unless sick

**Language/Communication Barriers**
- Limited Health Literacy
- Limited Computer Literacy
- Cultural Disconnect
- Travel- pharmacies, grocery stores, families/friends/neighbors

**Contact Tracing**
- English/Spanish language only
- Text messaging/Blocked numbers
- Phone lines disconnected
- MEDSIS reporting

**Distrust**
- Privacy
- Confidentiality
- Stigmatization
- Myths
Health Disparities & Social Determinants of Health

Dahlgren and Whitehead, 1991
Strategies

Public Safety Net

- Care Coordination across 3 refugee clinical service lines – Women’s, Pediatrics, Family Medicine
- Contact Tracing within affected families
- Public Health reporting – include language specific data
- Multilingual audiovisual resources on COVID-19

County and State Level

- Data matching to identify apartment complexes of concern
- Greater specificity in reporting beyond traditional race/ethnicity categories
  - Language, nativity
- Robust testing, contact tracing, isolation
- Community outreach, education
  - Cultural Health Navigators
  - Community and faith leaders
  - Family-centered
- Temporary housing, rental assistance, assistance with cell phone bills, opportunity to engage employers
A Canary in the Coal Mine

Strengths

• One of first known reports of COVID-19 prevalence among refugee women receiving maternity care

• Profound disparity in refugee population facilitates timely and enhanced public health response

Limitations

• Limited generalizability
  • Just one public hospital’s approach
  • Only capture women during childbirth
  • Antenatal care
  • Other family members/support person(s)

• Potential for underreporting due to false negative results

• Small sample size (data collection efforts ongoing)

Johnson-Agbakwu et al. Manuscript in preparation
Global COVID-19 Pandemic Crisis

Consequences to the health & human rights of women and girls

- Gender-based Violence (31 million)
- Child Marriage (13 million)
- FGM/C (2 million)
- Unintended Pregnancy (17 million)
- Disruption in programs, services, safe spaces, care and support
- Fear
  - Lack of PPE
  - Decrease Service Use

United Nations Population Fund (UNFPA), 2020
Research/Policy Directives to Advance Health Equity

• Improved national epidemiologic surveillance on health outcomes
  – Emerging Infectious & Chronic Diseases
  – Patient Disease Registries (RedCap)
  – National Health Data Sets capture refugee-specific information
  – Ethno-Cultural Specificity
  – Longitudinal Outcomes
  – Quality Improvement Metrics
Research/Policy Directives to Advance Health Equity

• Integrated Models of Care
  – Community Health Workers/Cultural Health Navigation
  – Mental health and primary care
  – Innovative reimbursement models for care coordination/patient navigation
  – Racial-Ethnic Disparities Patient Safety Bundles
  – Interprofessional/Multidisciplinary Team-Based Approaches to Care

Semere W et al. AJPH 2016
Research/Policy Directives to Advance Health Equity

• **Equitable access to:**
  – Health Insurance
  – Transportation
  – Appropriate Interpretation
  – Culturally Competent Providers
  – Greater network of refugee care providers
  – High quality care
Research/Policy Directives to Advance Health Equity

1. Community-Based Research Engagement
2. Address Social Determinants of Health
3. Validated measures for working with low literate populations
4. Innovative approaches to enhance health literacy
5. Asset-based strength approach
6. Advocacy given global refugee crisis, current U.S. immigration policy, and anti-refugee/anti-immigrant political rhetoric, systemic racism, racial injustice
7. Local/National/Global Collaborative Partnerships/Networks
“The attainment of the highest level of health for all people.”

Healthy People 2030

Advancing Health Equity
THANK YOU!
FGM/C 
Pocket Guides & Posters

Download Online
https://sirc.asu.edu/content/resources

For Hard Copy Print Orders:

John Keeney
Phone: 480.965.3094
E-mail: john.keeney@asu.edu
Multi-lingual Audiovisual Resources on COVID-19 for Refugee Communities

https://www.youtube.com/playlist?list=PLm7yXhXaGwFVTn6RTYELuJxAOX8hfUFlk

- English
- Spanish
- French
- Arabic
- Lingala
- Somali
- Maay Maay
- Burmese
- Karen
- Kinyarwanda
- Kirundi
- Swahili
AAMC Health Equity Research and Policy

AAMC Maternal Health Equity Webinar Series

Part One: Context Past & Present
WATCH THE RECORDING
bit.ly/3bsCHrw

Part Two: Bridging the Urban-Rural Divide
WATCH THE RECORDING
bit.ly/2VaEPPi

This series highlights the unique role of academic medicine in the fight for maternal health justice and features physicians, community leaders, and researchers who are committed to eliminating inequities.
Thank you
healthequityresearch@aamc.org