Maternal Health Care for Refugees and Forced Migrants

Martha C. Carlough, MD, MPH

AAFP Global Health Conference

October 2017

with thanks to Drs. Gretchen Heinrich, Janine Young and Elizabeth Kvatch for the use of some slides as presented at AAFP FCMC 2017 conference

AMERICAN ACADEMY OF FAMILY PHYSICIANS
STRONG MEDICINE FOR AMERICA

Disclosure Statement

It is the policy of the AAFP that all individuals in a position to control content disclose any relationships with commercial interests upon nomination/invitation of participation. Disclosure documents are reviewed for potential conflicts of interest. If conflicts are identified, they are resolved prior to confirmation of participation. Only participants who have no conflict of interest or who agree to an identified resolution process prior to their participation were involved in this CME activity.

All individuals in a position to control content for this session have indicated they have no relevant financial relationships to disclose

Learning Objectives

1. Identify potential cultural beliefs and practices that may impact maternal and child health and health care for refugees.
2. Identify best practices for the care of refugee pregnant patients, including language interpretation, cultural assessment, and collaboration with community resources.
3. Discuss and share through cases culturally sensitive approaches to specific issues

"Healthy Immigrant effect" doesn't necessarily pertain to pregnancy/childbirth

- Dutch study[1] demonstrating that maternal morbidity in refugees and asylum seekers RR=4.5 (CI=3.3-6.1) - late or limited prenatal care, HIV and other infections, grand multiparity, previous CS deliveries
- Bollini study[2] (2009) – increased risk of LBW, prematurity, perinatal mortality and congenital malformations
- Risk may be greater based on immigrant women's birth place[3]
  - South Asian and Sub-Saharan African women at higher risk than North African or native counterparts from other regions

1. Van Hanegem, 2011. 2. Bollini, 2009. 3. Gagnon, 2009

Maternal Health Issues

- Infectious Disease
  - Parasites – Strongyloides, malaria, schistosomiasis
  - HIV (pre-travel screen no longer includes!), TB, Hepatitis B and C – higher prevalences
- Previous poor pregnancy outcomes or unclear interventions
  - High rates of CS deliveries, recurrent stillbirth due to infectious risk and malnutrition, undiagnosed hypertension, pre-eclampsia, gestational diabetes
  - In general, even with a vertical skin incision from previous CS unless the indication would make a classical CS likely (e.g. preterm breech) usually considered safe for TOLAC
- Lack of preventive care
  - Cervical cancer is the leading cause of cancer death in women in the "two thirds world" – MOST women will NEVER have been screened
  - Undiagnosed hypertension, diabetes, asthma, etc.
  - Unclear or incomplete vaccinations, undernutrition/micronutrient deficiencies

Pimentel and Eckardt. 2014

Intake Considerations for Pregnant Refugee/Forced Migrant Women

- Routine prenatal care (prenatal labs, PNVs) with full physical and PAP smear. Evaluate for FGM considering region (though maybe not on the first visit...)
- Refugee screening labs, including lead if "high risk country" or exposures
- Hemoglobin electrophoresis for African and Mediterranean refugees
- Screen for malaria and parasites (O&Px3), schistosomiasis (IgG)
- Assessment for TB/latent TB is important but depending on risk and exposure, consider waiting until postpartum to initiate treatment. Evaluate nutritional status, refer to WIC
- Screen for sexual assault history, domestic violence, consider risk of human trafficking

http://www.cdc.gov/nceh/lead/publications/leadandpregnancy2010.pdf

Guidelines in Pregnancy - Malaria

- If asymptomatic and NOT pregnant, NO presumptive treatment
- If **asymptomatic AND pregnant** or **breastfeeding an infant > 5kg in weight AND within 3 months of living in SSA** → Send MRDT (Malaria rapid diagnostic test) AND thin/thick smear blood.
- If **POSITIVE** → admit and treat as per CDC/ID guidelines

Guidelines in Pregnancy - Tuberculosis

- Screen all high risk women with interferon-gamma release assay (IGRA)
- If positive
  - Obtain CXR after first trimester
  - If CXR negative, initiate LTBI treatment with INH (plus B6) starting 12 weeks postpartum or Rifampin x 4 months
  - INH and Rifampin are safe in breastfeeding
  - If suspect active TB, consult ID and CDC

Guidelines in Pregnancy – Hepatitis B

- If positive HBSAg:
  - Check LFTs, HBsAb, HBcAb, HbeAg, HBeAb, HBV viral load, HCV
  - Elevated viral load (>200k or 5.3 log IU/mL) confers 5-10% risk of vertical transmission, even with HBIG administration to infant at birth. If vertically transmitted Hep B, infant has a 90% chance of developing chronic Hep B
  - Avoid FSE in labor
- Infant needs HBIG and HBV vaccination series immediately after delivery (within 12-24 hours), plus follow up testing of HBsAg and HBsAb at 9-18 mo. Infant still has 5% risk of developing Hep B.
- Lactation: No evidence of mother to infant transmission of HBV through breast milk.

Guidelines in Pregnancy – Hepatitis C

- Screen all immigrant/refugee women from regions with ≥2% prevalence of HCV or who are high risk
- Risk factors: History of surgery, blood transfusion, hospitalization in place with low health resources (e.g. reuse of needles/IVs), FGM, IVDA, tattoos.
- Vertical transmission rate is 5%
  - No evidence to support routine C/S
  - Avoid FSE during labor
- Need follow-up testing of infant, breastfeeding safe

Case study #1

- Enua is a 24 YO G3P1011 who had one previous infant in a refugee camp in Kenya and has now been in the USA for 6 months. She complains of fatigue and has a history of fevers at home. Her initial prenatal labs demonstrate eosinophilia and a hemoglobin of 7.2 and her BMI is 16.5
  - What history questions might you ask?
  - What would you look for on examination?
  - What additional labs would you obtain, and how MIGHT you make plans for her treatment and care?

Case study #2

- Basra is a 25yo G3P3003 Somali refugee who just gave birth by NSVD after a very short labor. The patient had type 3 female genital mutilation (FGM). De-infibulation was performed during stage 2 of labor. While you are doing her repair she says, *"Can you sew me back up the way I was before? That's what they did for my last delivery in Ethiopia.*"
  - If you had seen Basra during prenatal visits, how would you have cared for her? What would you have discussed?
  - How do you answer her question now and what would you do?
  - What would you talk to her about in terms of future care and personal hygiene?

Female genital mutilation (FGM)

FGM covers a spectrum of procedures:

- **FGM I** – excision of prepuce +/- clitoris. This is also commonly referred to as "sunna circumcision"
- **FGM II** – excision of clitoris and labia minora
- **FGM III** – incision of clitoris, labia majora, labia minora and re-approximation of remnant tissue (infibulation)
- **FGM IV** – pricking, piercing, incising and scraping but no flesh removed

WHO, 2008 and Banks, 2006.

Affects 85-115 million women and girls worldwide, most prevalent in North Africa and the Middle East

Not required by any religion, most girls undergo FGM at 5-8 years of age, rarely in a medical setting (except Egypt) – declining but far from abolished

Potential health consequences:

- Pelvic pain/scarring, recurrent urinary and vaginal infections, infertility (25-30%), fistula formation, obstructed labor (for FGM II and III), postpartum hemorrhage, perinatal death.

WHO FGM Classification

Type	Description
Type I	Partial or total removal of the clitoris and/or the prepuce (clitorectomy)
Type II	Partial or total removal of the clitoris and the labia minora, with or without excision of the labia majora (excision).
Type III	Narrowing of the vaginal orifice with creating of a covering seal by cutting and appositioning the labia minora and/or the labia majora, with or without excision of the clitoris (infibulation)
Type IV	Unclassified

WHO, 2008

Best Practice Recommendations - FGM

- Ask all women and children from countries where FGM is performed if they have been cut and perform an exam with their permission, documenting findings and being sure all providers involved in a woman's care are aware
- Ask all women from countries where FGM is performed if they have have thought about or have plans to cut their daughters
- Educate women and girls about the illegality of cutting and the legal repercussions if they perform or undergo "vacation cutting"
- Consider FGM performed in US or as "vacation cutting" as a form of child abuse and reportable offense

General Guideline for delivery after FGM

- **If urinary meatus is visible or 2-3 fingers or a speculum can be passed into the vagina without discomfort, FGM is unlikely result in major physical barriers at delivery but it is important to watch closely for prolonged labor**.
- Prior to crowning, perform an "anterior episiotomy" as necessary – If possible, insert foley catheter, then raise the scar tissue over underlying finger, locally anesthetize, clamp two kellys on either side of scar and and excise midline to expose urethra and clitoris – ***not beyond*** (which may increase risk of hemorrhage). Approximate on either side with absorbable subcuticular sutures
- This significantly reduces risk of obstructed delivery for FGM III-IV as well as severe PPH and extension anteriorly. It MAY also decrease likelihood of women pursuing "tightening" surgery in postnatal period

Care of women who have undergone FGM during pregnancy and childbirth

- Be sensitive and non-judgmental and record any discussion and plan for other providers to follow, including detailed discussion about what the woman understands will happen at/after delivery
- If even careful exam with a small speculum is not possible, consider referral for evaluation and potential de-infibulation under regional anesthesia during second trimester.
- Consider your own comfort level as a provider in FGM care and your approach to de-infibulation/repair/reconstruction after delivery. Communicate this to the patient in advance
- ACOG, AAFP, SOGC and FIGO ALL have no formal guidelines on re-infibulation; FGM is illegal in every US state – re-infibulation is less clear

Case Study #3

- Asha is a 16 YO Bhutanese/Nepali background patient who comes for her first prenatal exam at 7 months gestation with an older woman accompanying. On questioning she is living with "extended family" but is not in school (you are told that she will start next year) and she does not have any insurance documentation nor has she applied for Medicaid.
- She is visibly anxious and you note what appear to be self-inflicted scratches on her both of her arms.
- Otherwise her initial exam is normal except for a BMI of 17 and fundal height 2 cm less than expected.
  - What issues does this raise for you as a provider?
  - How would you approach the appointment?
  - What other evaluations/labs would you obtain?
  - Where would you turn for assistance?

Human Trafficking

- Clues
  - May present with controlling individual, have inconsistent story, present late (often visit emergency departments) may be fearful or unclear of where they are, lack of documentation (passport, insurance info, etc.)
- Questions to consider (not validated)
  - Are you free to come/go by yourself? Have you ever been threatened if you tried to leave? Have you had to exchange something you value (or access to food, shelter) for sex?
- Assistance/Education for Providers
  - National Human Trafficking Resource Center – 1-888-373-7888
  - HEAL Trafficking – www.healtrafficking.org – educational resources, training for providers
  - Physicians for Human Rights – www.physiciansforhumanrights.org – training to provide examinations for those seeking asylum

Case study #4

- Fazilah is a 24yo G7P1051 Sudanese refugee at 41w0d GA (by LMP = 8wk U/S) who presents for routine prenatal visit. Pregnancy has been uncomplicated, FHTs 150s, FH 39 cm.
- At this appointment, she is withdrawn and is unwilling to respond to questions through the telephone translator line about depression or her home life. When you attempt to discuss post-dates IOL she adamantly refuses and leaves the appointment. A home visit is attempted by a care coordinator but no one at home opens the door. Almost two weeks later Fazilah presents to the hospital for decreased fetal movement and is found to have an IUFD.
  - How would you care for her while she is in the hospital for induction with IUFD? What other issues would you try to talk with her about or find resources for?

Explanatory Model Approach Questions

- What do you call this problem?
- What do you believe is the cause of this problem?
- How serious is it?
- What do you think this problem does in your body?
- How does it affect your mind?
- What do you fear most about this condition?
- What do you fear most about the treatment?

Psychosocial and Mental Health Issues

- Interventions we consider "routine" may be declined – induction, continuous monitoring, CS
- Violence during pregnancy is more common among refugees (and immigrants) than in the general US population.
- Increased risks of PTSD, depression, somatization
  - Pathways to Health: Refugee Health Screener-15 http://www.lcsnw.org/pathways/pdf/RefugeeHealthScreener.pdf
- Increased incidence of previous sexual trauma
- Pregnancy is a vulnerable time, labor/delivery may be additionally traumatic and isolating…

Chronic Health Issues

- Often non-communicable and chronic illness is suppressed or not fully cared for in refugee camps and in transition
- "Healthy immigrant effect" lost
- Exacerbated by acute and chronic stress and loss of resilience, and dealing with poverty, loss of work – poor self-care
- Information gaps in health literacy and cultural influences
  - *"I finished my medicine"* after a month on hypertensive medication
- Preventive care and screening are globally uncommon practices, misunderstood
- Lack of access to culturally appropriate, ongoing primary care for chronic disease is a gap

Best Practices

- Use available resources and multi-disciplinary teams to understand the context as much as possible (language, ethnic group, country of origin and country and situation of transitional placement)
- Be an informed, sensitive provider – *TAKES TIME…*
- Use professional interpreters and (if possible) hire/engage those from the community in services
- Think longer term – connect with primary care and community resources while access to care is more possible
- Integrate mental health screening but don't try to solve all long term issues, all at once
- Be patient, listen generously, be a safe and available haven

References: Maternal Care for Refugees and Forced Migrants – AAFP Global Health 2017

ACOG Committee on Obstetric Practice. (2012). ACOG Committee Opinion No. 533: Lead screening during pregnancy and lactation. *Obstet Gynecol*. 120:416-20.
ACOG Committee on Obstetric Practice. ACOG Committee Opinion No. 495: Vitamin D: Screening and supplementation during pregnancy. Obstetrics and gynecology. 2011 Jul;118(1):197.
Adams KM Gardiner LD, Assefi N. Healthcare challenges from the developing world: post-immigration refugee medicine. British Medical Journal. 2004;328(7435):1549-1552.
Baldwin SB, Eisenman DP, Sayles JN, Ryan G, Chuang KS. Identification of human trafficking victims in health care settings. Health Hum Rights 2011; 1(13): 36-46.
Banks E, Meirik O, Farley T, Female Genital Mutilation and Obstetric Outcome: WHO collaborative prospective study in six African Countries. Lancet 2006; 367: 1835-1841.
Berry, JW. Conceptual approaches to understanding acculturation. Acculturation: Advances in theory, measurement and applied research. Eds: KM Chun PB Organista and G Marin. Washington DC: American Psychological Association. 2003
Bollini P, Pampalona S, Wanner P, Kupelnick B. Pregnancy outcome of migrant women and integration policy: a systematic review of the international literature. Social science & medicine. 2009 Feb 28;68(3):452-61.
Bollini P, Pampalona S, Wanner P. Pregnancy Outcome of migrant women and integration policy: A systematic review of the international literature. Soc Sci Med. 2009; 68: 452-461.
Centers for Disease Control and Prevention. Current presumptive immunization schedule. http://www.cdc.gov/immigrantrefugeehealth/guidelines/overseas/interventions/presumptive-immunizations.html. Accessed May 2016. E22-27.
Centers for Disease Control. Refugee Health Guidelines – Intestinal Parasites Overseas Recommendations. Recommendations for Overseas Presumptive Treatment of Refugees Destined for the United States. CDC: Atlanta, GA. 2014
Centers for Disease Control. Screening for Lead at the Domestic Refugee Medical Examination. http://www.cdc.gov/immigrantrefugeehealth/exams/lead-guidelines.html. Accessed May 2016
Centers for Disease Control. Summary Checklist for the Domestic Medical Examination for Newly Arriving Refugees. CDC/US Department of Health and Human Services/National Center for Emerging and Zoonotic Infectious Disease. Division of Global Migration and Quarantine. http://www.cdc.gov/immigrantrefugeehealth/pdf/panel-refugee-health.pdf. Accessed May 2016.
Deshpande NA, Noor N. Sex trafficking of women and girls. Rev Obstet Gynecol 2013; 6: e22-27.
Dionne-Odom J, Tita AT, Silverman NS, Society for Maternal-Fetal Medicine (SMFM. # 38: Hepatitis B in pregnancy screening, treatment, and prevention of vertical transmission. American journal of obstetrics and gynecology. 2016 Jan 31;214(1):6-14.
Dovydaitis T. Human Trafficking: The Role of the Health Care Provider. J Midwifery Womens Health. 2010; 55(5): 462-467.
Dunkelberg JC, Berkley EM, Thiel KW, Leslie KK. Hepatitis B and C in pregnancy: a review and recommendations for care. Journal of Perinatology. 2014 Dec 1;34(12):882-91.
Edelstein, B. Primary Care for Refugees. Am Family Physician. 2011; 83(4): 429-436.
Fazel M, Reed RV, Panter-Brick C Stein A. Mental Health of displaced and refugee children: resettled in high income countries: risk and protective factors. Lancet 2012: 379(9812): 266-282.
Franco-Paredes C, Dismukes R, Nicolls D, Hidron A, Workowski K, Rodriguez-Morales A, Wilson M, Jones D, Maruyma P, Korzeniky P. Short Report: Persistent and Untreated Tropical Infectious Diseases Among Sudanese Refugees in the United States. Am J Trop Med Hyg. 77(4): 2007. 633-635.
Gagnon AJ, Zimbeck M, Zeitlin J. The ROAM Collaboration: Migration to western Industrialized countries and perinatal health: A Systematic review. Soc Sci Med. 2009; 934-946.
Gibbons P, Hann S. Identification and Treatment of Human Trafficking Victims in the Emergency Department: A Case Report. The Journal of Emergency Medicine. 2016. 1-6.
Gushulak BD and MacPherson DW. The basic principles of migration health: Population mobility and gaps in disease prevalence. Emerg Themes Epidemiol. 2006; 3: 3
Gushulak BD, Weekers J, MacPherson DW. Migrants in a globalized world –health threats risks and challenges: an evidence-based framework. Emerging Health Threats Journal 2009, 2:e10
Gutierrez A, Spiegel P. The State of the World's Refugees. Adapting Health Responses to Urban Environments. JAMA. 2012 (308(7): 673-674.
Hussain M, Zimmerman C, Abas M, Light M, Watts C. The relationship of trauma to mental disorders among trafficked and sexually exploited girls and women. Am J Public Health. 2010; 100: 2442-2449.
Immigration and Refugee Services of America (IRSA). Health Challenges for Refugees and Immigrants. Refugee Reports. March/April 2004; 4(2): 1-19.
Kleinman A, Benson P. Anthropology in the clinic: the problem of cultural competency and how to fix it. PLoS Med. 2006; 31(10); e294.
Nour NM, Michels KB, Bryant AE. Defibulation to Treat Female Genital Cutting: Effect on Symptoms and Sexual Function. *Obstetrics and Gynecology*. 2006. 108:55-60.
Pimentel VM, Eckardt MJ. More than Interpreters Needed: The Specialized Care of the Immigrant Pregnant Patient. Obstet and Gynec Survey. 2014; 69(8): 490-500.
Rew KT, Clark SL, Gross W, Savin D. Immigrant and Refugee Health. FP Essentials. No 423. Leawood, KS: American Academy of Family Physicians. August 2014.
Rushwan, H. Female genital mutilation management during pregnancy, childbirth and the postpartum period. IJGO. 70(2003): 99-104.
Sandvig J. The New Face of Refugee Resettlement in Wisconsin: What it Means for Physicians and Policy Makers. Wisconsin Medical Journal. 2006. 105(3): 36-40.
Seybolt LM, Christiansen D, Barnett ED. 2006. Diagnostic evaluation of newly arrived asymptomatic refugees with eosinophilia. Clin Infect Dis 42: 363-367.
Smith D, Stringer E, Vladutiu CJ, Zink AH, Strauss R. Risk of uterine rupture among women attempting vaginal birth after cesarean with an unknown uterine scar. American journal of obstetrics and gynecology. 2015 Jul 31;213(1):80-e1.
Stauffer WM, Kamat D, Walker PF. Screening of international immigrants, refugees and adoptees. Prim Care. 2002; 29(4): 879-905.
Stauffer WM, Newberry AM, Cartwright CP, Rosenblatt JE, Hanson K, Sloan L, et al. Evaluation of malaria screening in newly arrived refugees to the United States by microscopy and rapid antigen capture enzyme assay. Pediatr Infect Dis J. 2006;25(10
Stewart DE Gagnon AJ, Merry LA, Dennis CL. Risk factors and health profiles of recent migrant women who experience violence associated with pregnancy. J Women's Health. 2012; 21(10): 1105-1106.
United Nations High Commission on Refugees. Mid Year Trends 2015. UNHCR: Geneva, Switzerland, 2015.
van Hensgen N, Mitterbauer AE, Zwart JJ, Bloemenkamp KW, Van Roosmalen JO. Severe acute maternal morbidity in asylum seekers: a two-year nationwide cohort study in the Netherlands. Acta obstetricia et gynecologica Scandinavica. 2011 Sep 1;90(9):1016-
Wallis C. Emerging paradigms in the mental health care of refugees. Soc Sci Med. 2001; 52(11): 1709-1718.
Wirtz A, Pearson M, Zimmerman C, War and Sexual Violence – Mental health care for survivors. N Eng J Med. 2013; 368(23): 2182-2184.
World Health Organization. Female Genital Mutilation: The Prevention and Management of the Health Complications. Policy Guidelines. Geneva, Switzerland. 2001.

RESOURCES

WEBSITES:

- **Refugee Health Information Network http://rhin.org/**
- **Dept of Health and Human Services – Office of Refugee Resettlement –http: www.acf.hhs.gov/programs/orr**
- **US Committee For Refugees and Immigrants**
- **http://www.refugees.org/**
- **United Nations High Commission on Refugees – www.unhcr.org**
- **CDC Refugee Health Guidelines – http://www.cdc.gov/ncidod/dq/refugee/rh_guide/**
- **CDC Division of Global Migration and Quarantine**
- **http://www.cdc.gov/ncezid/dgmq/**
- **Center for Applied Linguistics http://www.cal.org/**

Texts:

- **Refugee and Immigrant Health: a handbook for health professionals (Kemp, Charles and Rasbridge, Lance)**
- **Refugee Health: an approach to emergency situations. Medecines Sans Frontieres**
- **The Health of Refugees: Public Health Perspectives from Crisis to Resettlement (Pascal Allotey)**

Good reads:

- **My heart is delicious (Bilionge Young)**
- **The Middle of Everywhere: Helping Refugees Enter the American Community (Mary Pipher)**
- **The Latehomecomer: a Hmong Family Memoir (Kao Kalia Yang)**
- **What is the What (Dave Eggers)**
- **The Translator (Daoud Hari)**

Movies: The Good lie, Rain in a Dry Land, Salaam Neighbor, Walk to Beautiful