Refugee women have healthier pregnancies than US women—why? An unhealthy US culture

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African refugee women experience healthier pregnancies than women born in the United States, despite receiving less prenatal care, found a

recent University at Buffalo study.

Compared to U.S.-born black and white women, African refugee women had fewer pre-pregnancy health risks, fewer preterm births and higher rates of vaginal deliveries. Surprisingly, the refugee women were more likely to delay beginning prenatal care until the second trimester.

The disparity, says the researchers, may be tied to various unhealthy behaviors and practices present within U.S. culture. For African refugee women, acculturation may negatively impact health.

"It is often thought that refugees immigrating to the United States from war-torn nations will experience a better quality of life once here," says Kafuli Agbemenu, Ph.D., assistant professor in the UB School of Nursing and lead investigator on the study, published in February in the *Journal of Women's Health*.

"However, some of the elements of U.S. life such as eating processed food, an increased reliance on cars or buses for transportation, extended inclement weather, a more individualistic society, and drug and alcohol use may, in fact, contribute to African refugee women having poorer reproductive health outcomes."

Reproductive health disparities between U.S.-born white and black women are well documented, says Agbemenu. However, few comparisons have been made between African refugee women and U.S.-born women.

African refugee women are susceptible to numerous health disparities as a result factors such as socioeconomic status, gender, ethnicity, low-levels of education and language. Another risk-factor specific to their population is the high prevalence of past traumatic experiences.

These risks led researchers to believe African refugee women would have poorer reproductive health outcomes than women born in the U.S. The unexpected results reveal that the healthy immigrant effect—a phenomenon where immigrants experience healthier outcomes than native populations—extends to reproductive health.

The researchers examined electronic birth certificate data from hospitals within Erie County, an area of Western New York that resettles a large number of refugees. The data contained clinical, psychosocial, socioeconomic and demographic information, as well as the mother's country of birth.

Women born in Burundi, Democratic Republic of Congo, Eritrea, Rwanda and Somalia were considered of refugee status for the study, due to the large refugee populations in Western New York resettled from these nations.

The data contained information on nearly 60,000 white, almost 17,500 black and close to 800 African refugee women who gave birth from 2007-16. The information was limited to mothers who used Medicaid to cover medical expenses to control for socioeconomic status.

Researchers discovered that African refugee women had significantly less maternal medical risk factors, such as pre-pregnancy hypertension or diabetes, compared to U.S.-born women. Refugee women experienced more vaginal births, and were less likely to undergo cesarean sections or to be medically induced into labor.

Less than 1 percent of refugee women smoked or took illegal drugs during pregnancy, compared to white women (12 percent smoked, 4.5 percent took illegal drugs) and black women (15 percent smoked, 18 percent took illegal drugs).

Refugee women also had the fewest preterm birth (6 percent) compared with white women (9 percent) and black women (13 percent).

While most of the women from all groups began prenatal within the first trimester, African refugee women were more likely to delay prenatal care until the second trimester. Refugee women also received higher amounts of inadequate prenatal care (27 percent) compared to white women (12 percent) and black women (24 percent).

These favorable health outcomes for African refugee women also occurred in spite of the group experiencing higher rates of meconium staining, the earliest stool of an infant that when passed in the womb is a sign of fetal distress.

The high rate of inadequate prenatal care for African refugee women is troubling, says Agbemenu, and indicative of the disconnect between refugee populations and the health care community.

"These women have reported feeling ostracized and marginalized by the medical community," says Agbemenu. "They are at times hesitant to seek care, and when they do, it is typically at a time when the problem has escalated."

The development of culturally-targeted reproductive health education is urgently needed, she says. Health care professionals also need to understand that refugee women are likely to have histories of trauma and, therefore, need care delivered from a trauma-informed perspective.

More information: Kafuli Agbemenu et al, Reproductive Health Outcomes in African Refugee Women: A Comparative Study, *Journal of Women's Health* (2019). DOI: 10.1089/jwh.2018.7314

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