THE "HEALTHY IMMIGRANT" EFFECT: ALIVE AND WELL IN THE REPRODUCTIVE OUTCOMES OF AFRICAN REFUGEE WOMEN

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I. A GLOBAL HEALTH EQUITY PARADOX: THE HEALTHY IMMIGRANT

Considering the socio-economic disadvantages that determine the living circumstances and lifestyle of many immigrants to the U.S.—not to mention the stress and potential trauma associated with relocation—you might assume that they would have poorer health outcomes in comparison to people born in the U.S. However, research conducted across the social and health sciences has established the opposite: immigrants are, on average, healthier than their counterparts born in the United States.[1] This phenomenon, known as the healthy immigrant effect, has given rise to additional research, including studies that examine the reproductive health outcomes for foreign-born women. One such study finds that babies born to immigrant and refugee women have a decreased risk of being preterm, controlling for race, late or no prenatal care, and other risk factors.[2]

Recent scholarship by CGHE faculty affiliate Dr. Kafuli Agbemenu further extends these lines of healthy immigrant effect research to include a broad array of

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the reproductive health outcomes of women who have arrived in the U.S. as refugees from African countries.[3] The reproductive health disparities between black and white U.S.-born women are well documented in academic journals and the popular press. However, reproductive health disparities between African refugee and U.S.-born women are understudied. Agbemenu's research addresses an important knowledge gap, and reveals the healthy immigrant effect in the reproductive health outcomes of African refugee women who resettle in the U.S.

We know that female refugees from African countries are susceptible to health disparities in the U.S., including those arising from their socioeconomic status, lack of access to medical and health care provider information, past experiences with gender-based sexual violence—as well as discrimination rooted in racism and xenophobia. However, assessment of the health and health-related behaviors prior to pregnancy of the women in Agbemenu's study reveals a healthier group than U.S. born women. Studies suggest that they had fewer medical risk factors for pregnancy, such as hypertension and diabetes,[4] and they smoked significantly less.[5] Further, they were significantly less likely to use illicit drugs during pregnancy.[6] The body mass index (BMI) of refugee women was similar to that of U.S.-born white women, while U.S.-born black women had a higher average BMI.[7]

Despite the fact that one third of the 789 refugee women in Agbemenu's study delayed initiation of prenatal care until the second trimester—a significantly larger number than their U.S.-born counterparts[8]—refugee women had the fewest preterm births[9] as well as the fewest low birth-weight infants.[10] Moreover, significantly more babies of refugee women were delivered vaginally,[11] with correspondingly fewer born via cesarean section.[12]

Finally, significantly fewer refugee women were medically induced into labor.[13]

II. PRACTICAL TAKEAWAYS:

Antenatal care is underutilized by the refugee population. The lack of prenatal healthcare among many study participants suggests poor health care utilization. Providers of reproductive health services for refugees—including those providing antenatal and birthing-process care—should attend to potential influencing factors, including language barriers and experiences of discrimination within the health care system.

A contributing factor related to this underutilization of antenatal care: **some African refugee women do not believe that antenatal care is necessary**, based on anecdotal pregnancy outcomes in their countries of origin. Moreover, **some perceive antenatal and other preventative care to be a money-making scheme on the part of doctors.** The advantages of prenatal care should be communicated to women in this population.

Understanding that refugees are likely to have survived trauma, including violence, in the journey to resettlement, the **six principles of trauma-informed care** should be incorporated in the provision of all refugee health care, including reproductive health services: empowerment, choice, trust/transparency, safety, collaboration, and understanding of the intersection of social identities.

III. POLICY TAKEAWAYS

1. In addition to causing human suffering, poor reproductive outcomes result in significant economic burdens to taxpayers. For example, the 380,000 annual preterm births in the U.S. cost an estimated $26 billion, which is largely covered by Medicaid. Thus, further research to better characterize the healthy immigrant effect—including its resilience in the face of acculturation, and its impact on reproductive health outcomes—should be prioritized. The return on investment of such research could be profound, as it might be leveraged by practitioners to extend the duration of the healthy immigrant effect, and potentially improve the reproductive health outcomes of other vulnerable groups of women.

2. To encourage appropriate utilization of antenatal health care services, the development of culturally-informed public health communications campaigns—including one specifically designed to inform refugee women about the value of antenatal care—is advised.

3. To address barriers to treatment and promote health equity for refugees, culturally congruent, trauma-informed reproductive health care should be supported.

TABLE 1: SELECTED DEMOGRAPHIC CHARACTERISTICS FOR REFUGEE AND U.S.-BORN MOTHERS

	Refugee (N=789)	U.S.-born White (N=59,615)	U.S.-born Black (N=17,487)
Age			
<20	34	2,352	3,084
20–34	621	46,790	12,931
35+	134	10,473	1,472
Education			
<High school	521	3,728	4,272
≥High school	220	55,528	12,948
Marital status			
Single, no paternity filed	103	5,247	7,140
Unknown, paternity filed	86	14,449	8,054
Married, paternity filed	600	39,919	2,293
Medicaid/self-pay	750	17,228	14,239
Private insurance	39	42,387	3,248
Country of origin			
Somali	539		
Burundi	42		
Democratic Republic of Congo	77		
Eritrea	70		
Rwanda	61		

Table modified from source article: Agbemenu K, Auerbach S, Murshid NS, Shelton J, and Amutah-Onukagha N. "Reproductive Health Outcomes in African Refugee Women: A Comparative Study." *Journal of Women's Health.* June 2019; 28: 6.

FOOTNOTES

1. See, e.g., Kennedy S, Kidd MP, McDonald JT, Biddle N. "The healthy immigrant effect: Patterns and evidence from four countries." *Journal of International Migration and Integration.* 2015; 16:317–332.

2. Miller LS, Robinson JA, Cibula DA. "Healthy immigrant effect: Preterm births among immigrants and refugees in Syracuse, NY." *Matern Child Health J* 2016; 20:484–493.

3. Agbemenu K, Auerbach S, Murshid NS, Shelton J, and Amutah-Onukagha N. Reproductive Health Outcomes in African Refugee Women: A Comparative Study. *Journal of Women's Health.* June 2019; 28: 6. Of the 789 study subjects who arrived in the US as refugees, 68.3% were from Somalia; 9.8% were from the Democratic Republic of Congo; 8.9% were from Eritrea; 7.7% were from Rwanda, and 5% were from Burundi.

4. Refugee: 34.5%; U.S.-born black: 41.3%; U.S.-born white: 44.0%.

5. Refugee: .5%; U.S.-born black: 15.3%; U.S.-born white: 12.2%.

6. Refugee: .6%; U.S.-born black: 18.6%; U.S.-born white: 4.5%.

7. Refugee: mean BMI = 26.72; U.S.-born black: mean BMI = 28.97.

8. Of the refugee study subjects, 33.4% delayed initiation of prenatal care until the second trimester. For the U.S.-born study subjects, 28.4% black women, and 19.2% white women delayed initiation of prenatal care until the second trimester.

9. Refugee: 6.3%; U.S.-born black: 13.6%; U.S.-born white: 8.9%.

10. Refugee: 5.5%; U.S.-born black 13.6%; U.S.-born white: 7.0%.

11. Refugee: 73.4; U.S.-born black: 66.6%; U.S.-born white: 65.3%.

12. Refugee: 13.2%; U.S.-born black: 18.3%; U.S.-born white: 19.1%.

13. Refugee: 19.1%; U.S.-born black: 25.6%; U.S.-born white: 29.7%.

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