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Women's health in United States immigrant and refugee communities

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WOMEN'S HEALTH IN UNITED STATES IMMIGRANT AND REFUGEE COMMUNITIES

by

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ABSTRACT

The United States is home to approximately 44.5 million immigrants and refugees, and these numbers continue to grow. To ensure a healthy immigrant and refugee population, it is important to address the unique health needs of these communities. Migrant women face many obstacles in obtaining women's health services, including language and cultural barriers, difficulty finding childcare to attend medical appointments, and transportation difficulties. These factors are compounded by systemic difficulties in receiving health insurance coverage. Published literature describes women's health in immigrant and refugee women living in the United States, but much of this literature either focuses on specific cultural or religious groups rather than looking at overall trends in women's health care or does not differentiate between women's and men's health services in immigrant and refugee populations.

Through reviewing published studies, the aim of this paper is to analyze general trends about the accessibility of women's health services to immigrant and refugee women living in the United States. This paper will also look at specific examples of cultural and religious groups in the United States to examine the variation in women's health preferences and issues among immigrant women of different backgrounds. Finally, this paper will explore potential ways to improve women's health services available to immigrant and refugee women living in the United States.

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LIST OF ABBREVIATIONS

CDC……..……Centers for Disease Control and Prevention

CurrMIT……Curriculum Management & Information Tool

DSM……Diagnostic and Statistical Manual of Mental Disorders

EPDS……..……. Edinburgh Postnatal Depression Scale

IPV……Intimate Partner Violence

NCTSN……...……..... National Child Traumatic Stress Network

PDPI……Postpartum Depression Predictors Inventory

PTSD……..…Posttraumatic Stress Disorder

US ..... United States

WIC.....Women, Infants, and Children Nutrition Assistance Program

WMH-CIDI……...World Mental Health Composite International Diagnostic Interview

BACKGROUND

There are over 44.5 immigrants and refugees in the United States, and up to 18 million children in the United States (US) live with at least one immigrant parent (Chang, 2018). Immigrants make up nearly 14% of the US population, but many of them face obstacles in receiving health care services. Many immigrants, and particularly immigrant women, face factors such as poverty, lack of health insurance, fear of stigma and deportation, and low health literacy that disproportionately impact health outcomes (Chang, 2018). These health disparities can hinder access to preventive care and often result with a later presentation of advanced symptoms of different illnesses, including breast cancer (Shahawy, Deshpande, & Nour, 2015). Female immigrants are particularly vulnerable to health disparities, as they often face prejudice for being female as well as migrants, and specific women's health needs are often overlooked in health care settings (Adandu, 2009). Women are also at greater risk of domestic violence as well as sexual abuse (Adandu, 2009), which makes it critical to understand how to improve access to health care and health outcomes in immigrant women living in the United States.

WHAT IS WOMEN'S HEALTH?

To examine women's health in immigrants and refugee communities living in the United States, it is first important to define women's health. Perspectives on women's health have shifted throughout the history of the United States. The initial view of women's health in the 19th century was primarily biological and focused on reproductive health; motherhood was viewed as the core of a women's societal role, and female

reproductive organs were said to control a women's entire physical and mental health (Weisman, 1997). Throughout the 20th century, the definition of women's health became much broader and included a woman's overall physical and mental health during her entire lifetime from birth through death (Weisman, 1997). A biopsychosocial view of women's health was adopted, in which women's health is viewed through the intersection of biological, psychological, and social factors impacting overall health (Weisman, 1997). Women have also been historically underrepresented in biomedical research. There is more research devoted to diseases found more often in men, such as coronary heart disease (Verdonk, et al., 2008). Much women's health research focuses on reproductive diseases, while ignoring systemic issues more frequently found in women, such as rheumatism (Verdonk, et al., 2008). Finally women's health is becoming more inclusive to transgender and non-binary individuals, who were assigned a certain gender at birth and now identify with a different gender identity. Thus, women's health also includes those who identify as female, regardless of the reproductive organs present (Stroumsa & Wu, 2018).

MEASURES OF WOMEN'S HEALTH

Measures of women's health are important when discussing women's health in immigrant and refugee communities. The Centers for Disease Control and Prevention (CDC) routinely publishes data related to women's health measures, including biological and non-biological factors. Data is available related to women's overall health status, smoking, physical activity, causes of death, and insurance status. The data is broken

down by age range, race, education level, employment status, income level, region, and marital status (National Health Interview Survey, 2016). Other measures of women's health include: mental and physical well-being of a woman; reproductive health, such as fertility and family planning; preventative measures, such as screenings for conditions women are more susceptible to, such as breast cancer; and diagnosis and treatment of conditions, whether related to physical or mental health (Karney, 2000). In examining measures of women's health, it is important to also identify non-biological factors impacting health, such as socioeconomic status, as these factors play a role in determining health status as well as prevalence of certain diseases (Karney, 2000). These non-biological factors will play a large role in analyzing women's health in immigrant and refugee communities in the United States.

CHALLENGES MIGRANT WOMEN FACE THAT IMPACT HEALTH

Migrant women, whether immigrants or refugees, face unique challenges that migrant men often do not face at all or at the same level of severity. Economic migrants migrate from low income to high-income countries, like the United States, to improve quality of life (Adanu & Johnson, 2009). Other migrants flee war and conflict in their native countries, and some of them are classified as refugees. Refugees are defined by the 1951 Geneva Convention as individuals forced to leave their home country based on fear of persecution (Reidpath, 2003).

There are many political challenges associated with migration to the United States. For undocumented immigrants in particular, being caught or denied entry to the

United States is a frequent occurrence. The Department of Homeland Security estimates that in 2015, approximately 50% of individuals attempting to unlawfully cross the US border were caught (Fazel-Zarandi, Feinstein, & Kaplan, 2018). Increased border patrol, new technologies, such as video imaging and night vision goggles, and more fences are responsible for the high rates of apprehension at the border (Fazel-Zarandi, Feinstein, & Kaplan, 2018). Undocumented immigrants also face risks of family separation if caught at the border. Between October 2016 and January 2017, nearly 54,000 parents and their children were caught at the US-Mexican border (MacKenzie, et al., 2017). Separating children from their parents adversely impacts the children's health and wellbeing due to such a traumatic experience occurring at a young age. In "Adverse Childhood Experiences and the Risk of Premature Mortality" authors Brown et al. describe research that links exposure to traumatic experiences at a young age with increased risk of premature death (Brown, et al., 2009). Other immigrant groups, such as Muslims, face additional political challenges when it comes to migrating to the United States. In September 2017, President Donald Trump banned entry to the United States for citizens of five Muslim-majority countries: Iran, Syria, Somalia, Libya, Yemen. Non-Muslim majority countries North Korea and Venezuela are also included in the ban (Panduranga, Patel, Pierce, 2017). Since 2015 the number of anti-Muslim hate groups in the United States have tripled (Raymond-Flesch, 2018). With Islamophobia on the rise, Muslims also face lasting health effects. Immigrants, including Muslims and other communities, facing xenophobia are at increased risk of reactive depression, psychosomatic symptoms,

such as headache and insomnia, and the threat of physical violence (Suleman, Garber, Rutkow, 2018).

Women, regardless of reason for migration, frequently migrate with their children and frequently overlook their own health needs in the process (Adanu & Johnson, 2009). Women fleeing conflict are more vulnerable than men to acts of sexual violence, such as rape, as these heinous acts are sometimes used as weapons of war (Adanu & Johnson, 2009). In Syria, for instance, thousands of Yazidi women were captured forced into sexual slavery (United Nations, 2017). Sexual violence is typically underreported in conflict zones due to fear and lack of trust in many justice systems (United Nations, 2017). Women are also frequently victims of human trafficking. They are often fearful of retribution by traffickers and have faced great psychological and/or physical trauma (Adanu & Johnson, 2009). Thus, with higher incidence of violence against women as well as greater childrearing responsibilities than men, migrant women face unique health challenges. Victims of sexual violence often face physical effects, such as injury or sexually transmitted diseases. They may face a myriad of psychosocial effects as well, such as depression, post-traumatic stress disorder, and stigmatization within one's community (Stark & Wessells, 2012). Women also typically lack access to health services during times of conflict, further exacerbating effects of sexual violence (Adanu & Johnson, 2009).

Migrant communities also face different health challenges than native-born United States communities. Undocumented migrant women, for instance, face stressors United States women often do not have experience with, including fear of imprisonment,

torture, sexual violence, and financial desperation (Chang, 2018). Undocumented migrant women also are not eligible for federal medical insurance coverage, such as Medicaid, which creates a major barrier to accessing health care (Chang, 2018). Even documented immigrants often face obstacles in accessing health services, due to language barriers as well as distrust of the United States health system (Chang, 2018). Poverty is another challenge disproportionately affecting immigrant communities in the Unites States. Poverty leads to food and housing insecurity, lower rates of educational attainment, and transportation barriers that can translate into poor health outcomes (Chang, 2018).

Women's health entails a woman's mental and physical wellbeing throughout the course of her life, including specialized reproductive and sexual health care. With a sizeable immigrant and refugee population in the United States, it is important to evaluate women's health among these communities to ensure that their quality of life is akin to that of American women. Women's health has many biological and social determinants, and it particularly important to identify these factors in order to improve health outcomes in immigrant and refugee communities.

SPECIFIC AIMS

There is a decent amount of published research relating to women's health in refugee and immigrant communities in the United States. However, much of this literature examines specific ethnic group's experiences with a certain medical condition or screening tool. Few published studies discuss women's health in immigrant and refugee communities in the United States or any trends that exist in this target population. Since more research leads to more knowledge of how to improve the quality of life of communities, it is important to study communities often excluded from research. The goal of this thesis is to provide a review of previous literature relating to women's health in migrant women living in the United States. Some literature focuses on overall trends, such as health disparities among migrant women, while other literature focuses on specific ethnic groups and/or specific women's health conditions. This thesis will also evaluate migrant women accessing women's access to health services in the United States as well as health outcomes related to both overall well-being and management of specific conditions or events, such as childbirth. Finally, this thesis will explore potential solutions for gaps in women's health services and outcomes in immigrant and refugee women living in the United States.

PUBLISHED STUDIES

The following literature review will analyze overall trends in women's health among immigrants and refugees living in the United States. PubMed was a critical database in obtaining previous research studies. It will provide more depth to some of the background information given earlier. Then this literature review will examine women's health outcomes in specific immigrant and refugee groups, such as undocumented women.

HEALTH DISPARITIES BETWEEN MIGRANT WOMEN AND AMERICAN-BORN WOMEN

Making up nearly 14% of the United States population, immigrants and refugee communities are a considerable demographic (Chang, 2018). According to "Immigrant Health Inequalities in the United States: Use of Eight Major National Data Systems" by Singh et al., the United States' surveillance of health and disease in immigrant communities is lacking. Many surveys and questionnaires used in public health studies do not ask about immigration status (Singh, Rodriguez-Lainz, & Kogan, 2013), which means there is less data available to examine health disparities. However "A Trajectory Model for Understanding and Assessing Health Disparities in Immigrant/Refugee Communities" by Cleary et al. provides an overview of health disparities in immigrant and refugee communities, though it does not focus specifically on female migrants. It is still important to describe factors leading to disparities, as women are greatly impacted. The authors explain factors contributing to health disparities in immigrants and refugees living in the United States. Nearly 21% of children living with immigrant parents in the

United States are in poverty versus 14% of children living with native-born parents (Cleary, Edberg, &Vyas, 2010). Immigrants are four times more likely than native-born Americans to live in crowded, cramped housing (Cleary, Edberg, &Vyas, 2010). Furthermore, many immigrants avoid seeking out government assistance, even when they are eligible to participate, as they believe it could impact their legal status (Cleary, Edberg, &Vyas, 2010). These adverse socioeconomic conditions lead to health problems due to psychosocial stress from difficult living situations, poor access to health care due to lack of insurance coverage as well as other impediments to accessing health care, such as transportation barriers (Cleary, Edberg, &Vyas, 2010).

Another study, "Access to health care for uninsured Latina immigrants in South Carolina" by Luque et al. highlights even more factors that exacerbate health disparities. Reaching a medical facility does not guarantee medical services will be effective for immigrants and refugees. Health disparities are further exacerbated by obstacles during patient visits at medical facilities, such as language barriers and lack of interpreters, discrimination against immigrants by medical providers, and inability to afford treatments or prescriptions (Luque, et al., 2018). Language barriers impact every aspect of women's health, as women find it difficult to make appointments, read health-related literature to better understand their condition, and communicate with medical staff.

Latina migrant women also report intense social isolation upon moving to the United States, as they feel disconnected from their communities in their home country (Luque, et al., 2018). Children of immigrants face pressure to serve as a liaison between their parents and society, since they often have greater English fluency and familiar with

American culture and logistics, such as public transportation (Cleary, Edberg, &Vyas, 2010). Many women balance working with raising their children and do not feel like they have the time or money to visit the doctor. Many women also report failing to refill prescriptions due to the expense, leading to uncontrolled chronic conditions, such as hypertension and diabetes (Luque, et al., 2018). Another health-related challenge for migrant women is nutrition and exercise. Latina immigrants reported having difficulty finding inexpensive fresh fruit and vegetables in the United States compared to their home countries. Thus, they shift their diets so they can cheaply nourish their families. Many women acknowledge their diets have deteriorated due to greater reliance on fatty foods, which can lead to poor health of them and their families (Luque, et al., 2018).

Health disparities among immigrant and refugee communities result from a myriad of interacting factors, including poverty, language barriers, and lack of health insurance. The interplay among these factors often results in migrant women not visiting health providers as often as needed or not seeking treatment for medical conditions such as hypertension.

RELIGION AND HEALTH: MUSLIM MIGRANT WOMEN

There are approximately 3.45 million Muslims living in the United States, and this number continues to rise (Mohamed, 2018). “Culture and religious beliefs in relation to reproductive health” (Arousell & Carbom, 2016) challenges the stereotypes of Muslims being a uniform group of individuals in regards to their health care choices. Some people erroneously assume all Muslims follow the exact same religious practices

and make the same decisions regarding health, when in reality Muslims are an incredibly diverse group of people. Muslims come from different religious sects, ethnic, linguistic, and cultural backgrounds. Muslim women also have different socioeconomic statuses as well as interpretations of Islam (Arousell & Carbom, 2016). Muslim women fare better in the health care system when providers recognize these differences between Muslims of different backgrounds. This article is critical in fighting stereotypes about Muslim women, including inaccurate beliefs that Muslim women have little bodily autonomy. The authors argue for patient-centered care, in which health providers consider the patient as a whole and recognize their individual concerns, rather than focusing strictly on their assumed religious beliefs (Arousell & Carbom, 2016).

Like many other minority communities described in this literature review, such as undocumented women, Muslim women face obstacles in getting the health care services they need (Shahawy, Deshpande, & Nour, 2015). These health care disparities hinder the ability of Muslim women to receive preventative health care and often present with advanced symptoms of different illnesses, including breast cancer. Coupled with a lack of preventative care, many Muslims women face stigmatization in the United States, and non-Muslim health care providers in the United States often do not understand cultural differences that may further impact the women's health care Muslims receive. Furthermore, relatively little research has been done on women's health care in Muslim women living in North America (Saadi, Bond, & Percac-Lima, 2015).

Nearly 46% of refugees to the United States are Muslim (Krogstad & Radford, 2017). Nearly 161,000 Bosnian refugees came to the United States after the genocide in

the 1990s (Sadikovic, 2017). Between 2001 and 2018, approximately 143,000 Iraqi refugees came to the United States, and many of these refugees are Muslim (Micinski, 2018). “Bosnian, Iraqi, and Somali Refugee Women Speak: A Comparative Qualitative Study of Refugee Health Beliefs on Preventive Health and Breast Cancer Screening” (Saadi, Bond, & Percac-Lima, 2015) discusses the historical contexts of war in which refugees from Bosnia, Iraq, and Somalia came to the United States. The authors discuss research participants’ attitudes and beliefs surrounding preventative breast cancer screening, as many Muslim women are diagnosed with advanced cases of breast cancer. When questioned about low breast cancer screening rates, many women cited fear of pain from the mammogram or fear of a cancer diagnosis. Other women mentioned barriers such as difficulty taking off work or finding childcare to go to a mammogram (Saadi, Bond, & Percac-Lima, 2015). Some study participants mentioned other reasons for not getting mammograms, including not being used to the American health system’s emphasis on preventative. One woman mentioned in her home country of Iraq, medical visits were in response to a problem rather than to receive preventative screenings, so she was getting used to the American system (Saadi, Bond, & Percac-Lima, 2015). The study participants’ responses regarding barriers to receiving mammograms intersects with other non-Muslim migrant women’s barriers to health care, which means that overcoming barriers to care can be incredibly beneficial to many different communities of migrant women.

In “Cross-Cultural Obstetric and Gynecologic Care of Muslim Patients” authors Shahawy et al. discuss how the women’s Islamic faith may impact their health, as well as

their patient-physician relationship when seeking women's health care (Shahawy, Deshpande, & Nour, 2015). The article discusses Islamic traditions and beliefs surrounding pregnancy, childbirth, and sexual health. The Quran emphasizes well-being and health, which thus makes health care an important part of Islamic life (Shahawy, Deshpande, & Nour, 2015). Many Muslim women dress rather modestly, and some women feel uncomfortable undressing in front of male health providers during a medical exam or screening. Thus, it is important Muslim women have access to female health providers if requested, and male health providers must also understand the discomfort some female Muslim patients may face when seeing them. The article then goes on to discuss the holy month of Ramadan, where many practicing Muslims fast from sunrise to sunset. Health providers should be aware when Ramadan takes place, since it is based off the Islamic lunar calendar rather than the Western calendar. This way, when completing blood tests, health providers are aware that results may be distorted due to fasting during the day (Shahawy, Deshpande, & Nour, 2015). This is an important article that explains cultural differences that may impact women's health care of Muslim patients in the United States and provides a context for non-Muslim health care providers to better understand the needs of their patients. It should also be noted that Muslim women may practice their faith differently, so not every woman will share the beliefs described above.

"Muslim Women's use of contraception in the United States" by authors Budhwani et al. analyzes contraceptive usage patterns among different ethnic groups of Muslim women. The study looked at women of different cultural backgrounds and Islamic sects, including Shia, Sunni, and other Muslim women not belonging to any

particular sect (Budhwani, Anderson, & Hearld, 2018). Approximately 79% of the Muslim women in the study reported using contraceptives. This is a higher rate than non-Muslim American women, in which the rate of contraceptive use is between 65% and 72% (Budhwani, Anderson, & Hearld, 2018). However, the Muslim women in the study also tended to be of higher socioeconomic status, and the majority of them had private health insurance, which may describe higher rates of contraceptive usage as access to health insurance allows women to receive the health care services more readily. An interesting finding was that Muslim women tended to use short-term contraceptive options, such as pills and condoms, rather than longer-term options, such as birth control implants. Both Shia women as well as women identifying as Muslim but with no formal sect tended to be more likely to use contraceptives than Sunni women (Budhwani, Anderson, & Hearld, 2018). This study provided a great first step towards analyzing contraceptive use among Muslim women of different backgrounds.

Table 1 Characteristics of Muslim Women

	Muslim Women $N = 224$ (%)
Contraception	
Contraception use	79.46
Oral contraceptive pill use	65.63
Condom use	66.07
Withdrawal use	32.14
IUD use	15.63
Demographic Characteristics	
Age (M/SD)	32.19/0.50
Marital Status	
Married	66.52
Single/Widowed/Divorced	33.48
Ethnicity	
Middle Eastern or North African	25.89
South Asian	44.20
Other Ethnicity	29.91
Nativity	
U.S. Born	38.39
Education	
High School	2.74
Some College or Vocational	11.42
College Graduate	31.96
Graduate or Professional School	53.88
Socioeconomic Characteristics	
Household Income	
Under $24,999	9.77
$25,000 to $74,999	34.88
$75,000 to $99,999	12.09
Over $100,000	43.26
Employment Status	
Employed	73.21
Not Employed	26.79
Religious Characteristics	
General Islam	15.18
Shia	46.43
Sunni	38.39
Worship attendance	
Less than once a month	38.75
Once a month	4.05
Multiple times a month	14.86
Once a week	17.57
Multiple times a week	24.77
Health Insurance Coverage	
Uninsured	5.61
Public Insurance	11.21
Private Insurance	83.18

Table 1. Descriptive characteristics of Muslim women included in the study looking at contraceptive use among Muslim women living in the United States. Note that Muslim women tend to be privately insured and use more short-term birth control options. (Budhwani, Anderson, & Hearld, 2018).

UNDOCUMENTED WOMEN

Current estimates show there are approximately 12.1 million undocumented immigrants living in the United States, and around 5.1 million children living with at least one undocumented parent (Chang, 2018). Undocumented immigrants do not qualify for most federal insurance programs, though they do qualify for Emergency Medicaid if they are pregnant, have children, are elderly, or disabled. This includes emergency care for acute illness or injury or going into labor (Chang, 2018). Even with emergency services available, many undocumented women still do not seek out medical services due to fear of their immigration status getting them in trouble (Ansari-Thomas, Desai, & Hasstedt, 2018). With undocumented women largely excluded from the health care system, finding women's health research is more difficult, yet there are a few comprehensive research articles.

From 1996-2010, the state of Nebraska offered non-emergency Medicaid coverage to pregnant women in the state, including prenatal care and labor and delivery services. (Atkins, et al., 2016). During this time period, 60% of undocumented women had access to Medicaid, while 32% did not (Atkins, et al., 2016). In comparing the two groups, women with access to Medicaid gained more weight during the pregnancy, had better prenatal care, and saw deliveries of more newborns with "abnormal conditions" (Atkins, et al., 2016). In the group of women without access to Medicaid, more women were obese before pregnancy, fewer women had access to prenatal care, and fewer had deliveries where newborns had abnormal conditions.

The authors wish to see further research exploring higher rate of abnormal conditions in women with Medicaid access. One theory in the article postulated as to why more mothers with Medicaid access give birth to children with abnormal conditions. Women with access to Medicaid often give birth in more advanced hospitals with neonatal intensive care units, where abnormal conditions could be easily addressed and tracked (Atkins, et al., 2016). In 2010, the federal government no longer authorized Medicaid funds for undocumented pregnant women, and undocumented women lost non-emergency Medicaid coverage. The authors state that it was injudicious to cut off Medicaid coverage to pregnant undocumented women, as they then flood emergency rooms, which is extremely costly. Cutting off Medicaid coverage also illustrates the health inequalities undocumented women face, since they cannot readily access preventative health services and instead are relegated to using emergency services (Atkins, et al., 2016).

Pregnancy Characteristics of Undocumented Women.

Variable	% All women, $N = 6,262$	% Medicaid access 2007-2009, $n = 4,249$	% No Medicaid access 2010-2011, $n = 2,013$	p
Gestational diabetes	5.46	5.20	6.01	.19
Gestational hypertension	1.79	1.79	1.79	.99
Weight gain				
Low	33.18	33.33	32.89	.73
Normal	54.74	53.87	56.58	.04*
High	12.07	12.80	10.53	.01*
Smoking during pregnancy	0.45	0.49	0.35	.42
Prenatal care				
Inadequate	8.02	6.94	10.28	.00***
Intermediate	9.90	9.60	10.53	.25
Adequate	14.26	13.74	15.35	.09
Adequate plus	16.88	17.86	14.80	.00**
Excessive	50.94	51.85	49.03	.04*

*$p < .05$. **$p < .01$. ***$p < .001$.

Table 2. Pregnancy characteristics of undocumented women in Nebraska. Note that undocumented women were less likely to have received adequate prenatal care. (Atkins, et al., 2016).

The undocumented immigrant population in the United States is estimated to be 16.7 million people (Fazel-Zarandi, Feinstein, & Kaplan, 2018), and of approximately 80% of the undocumented population living in the United States is Latino. Of this percentage, 63% of undocumented immigrants are from Mexico (Montealegre & Selwyn, 2014). Most health research focuses on undocumented immigrants from Mexico. However one women's health study focuses on undocumented women from Central America, specifically women from El Salvador, Guatemala, and Honduras. Approximately 8% of undocumented Latin Americans living in the United States are Central American (Montealegre & Selwyn, 2014). The study examined undocumented Central American women living in Houston, Texas. There were 160 participants in the study, and of the women participating, nearly two-thirds reported making less than $1200 in monthly income, over half did not have more than a sixth-grade education, and most participants are married. The older women in the study, ages ranging from 35 to 44, were more likely to have health coverage (Montealegre & Selwyn, 2014). The article then examined barriers to health care among the study participants. Nearly 83% of participants reported lack of health insurance and the high cost of health care as a barrier to getting medical services (Montealegre & Selwyn, 2014). The two next largest barriers to accessing medical services, with 49% of participants identifying each of them as barriers, were transportation as well as "not knowing where to go" (Montealegre & Selwyn, 2014).

Like other migrant communities in the US, such as Muslim women, undocumented women living in the US face serious barriers to accessing medical

services. Many women lack health insurance and cannot afford to pay for medical expenses out of pocket. With no health coverage, more undocumented women end up being seen in emergency rooms, which is very costly compared to if a woman received routine preventative health services that insurance would cover (Atkins, et al., 2016). Undocumented women also live in fear of being reported to immigration authorities (Montealegre &Selwyn, 2014), which makes a trip to the doctor even more difficult. Undocumented women often cannot obtain a driver's license and fear being caught driving without a driver's license (Carney, 2015), so transportation is yet another barrier to accessing health resources. There is also sometimes underlying distrust in the United States health system. Some Central American women, for instance, recall past political misdeeds of the United States government, including installing problematic leaders in their home countries. This leaves some women with little belief in the United States health system (Cleary, Edberg, & Vyas, 2010).

Table 3 Barriers to healthcare use among undocumented Central American immigrant women who do and who do not have healthcare coverage; Houston, Texas, 2010

Barriers	Total	Have healthcare coverage	
	(n = 205) %	Yes (n = 71) %	No (n = 134) %
Didn't have money or insurance	82.6	76.4	86.0
Couldn't get transportation	49.0	50.6	48.1
Didn't know where to go	48.6	51.7	46.8
Doctor or clinic staff don't speak Spanish	35.2	43.6	30.5
Didn't have anyone to leave my children with	34.6	43.2	29.6
Didn't have time	29.5	26.4	31.2
Afraid of being reported to immigration	25.4	30.4	22.6
Didn't have a family doctor	23.3	29.0	20.0
Scared of being told that sick/afraid of doctors	20.8	19.4	21.8
Clinic wasn't open when needed	20.8	22.7	19.8
Clinic couldn't see me that day	20.6	31.1	14.8
Other barrier	11.4	22.0	5.5
No barriers reported	8.3	12.9	6.0

Participants could report more than one barrier to healthcare use

Table 3. Reported Barriers of Central American Immigrant Women Receiving Health Care. (Cleary, Edberg, & Vyas, 2010).

The Houston study provides a hopeful piece of information that older, more settled undocumented women living in the United States are more likely to gain some type of health insurance. Since the Houston study shows older participants are more likely to have some health coverage, it is important younger immigrants, who came to the United States more recently are better directed to existing safety net health resources, such as community clinics offering free or low cost medical services (Montealegre & Selwyn, 2014).

Many undocumented women living in the United States are very resilient, even with the major obstacles to getting health care. Women find creative options to get access to health care. Nutrition is one key component of staying healthy, but undocumented women report having trouble affording nutritious, fresh foods (Luque, et al., 2018). Undocumented women with children born in the United States who are U.S. citizens can sign their children up for government-run food assistance programs, such as SNAP and the Women, Infants, and Children Nutrition Assistance Program (WIC), but many women do not enroll in these programs due to fearing being arrested by immigration authorities (Carney, 2015). In a California study that used semi-structured interviews and dietary questionnaires, many women explained that feeding their children healthy food is incredibly important, so many turn to privately-run food pantries. Women can get an array of healthy foods from the pantries, which allows them to feed their families healthy meals and prevent certain disorders linked to nutrition, such as diabetes. However, the pantries offer more than just healthy foods. Privately-funded pantries run nutrition and health literacy courses as well as occasional free health screenings, but food pantry

volunteers would also field several general health-based questions, such as how to deal with diabetes or the common cold (Carney, 2015). The food pantry essentially became the women's health resource, since many did not have access to a doctor's office. Many women reported the food pantry as very helpful in ensuring both they and their children can eat nutritious foods, while also providing a setting for informal preventative health care (Carney, 2015).

Undocumented women face an unreasonable number of barriers to receiving medical services. From the lack of insurance coverage to transportation barriers to fears of being deported, the barriers seem insurmountable. However, women, such as those in the California study, continue to overcome certain barriers through creative, informal channels like visiting a food pantry.

REPRODUCTIVE AND SEXUAL HEALTH

Reproductive health is particularly important to women during their childbearing years. Women across the United States and world often make different decisions about their reproductive health, as there are many preferences when it comes to family planning. This section of the literature review will look at reproductive health trends in immigrant and refugee women living in the United States.

Contraception is one key component of reproductive health for women. For many women, access to contraceptives gives women the autonomy to make decisions about their body and when/if they want to have kids. Immigrant noncitizen women, both lawfully present and undocumented, are far less likely to have health coverage than

American-born women, at 34% uninsured versus 9% uninsured respectively (Ansari-Thomas, Desai, & Hasstedt, 2018). Immigrant women living in the United States are less likely than American-born women to use contraceptives. Approximately 67% of American-born women of childbearing age have received information about contraceptives or contraceptive services themselves, while only 50% of immigrant women living in the United States have received contraceptives or information about contraceptives (Ansari-Thomas, Desai, & Hasstedt, 2018). Furthermore, immigrant women were more likely to use less effective contraceptive methods, such as the withdrawal method or using a spermicide. Nearly 34% of immigrant women reported using less effective contraceptive methods compared to only 21% of United States-born women (Tapales, Douglas-Hall, & Whitehead, 2018).

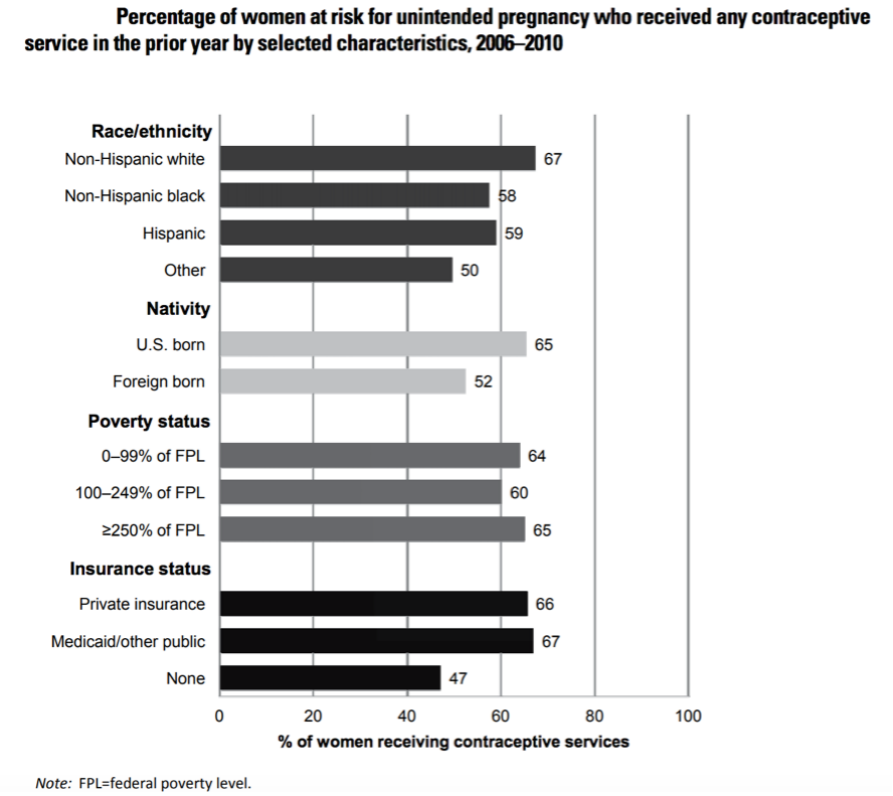

Table 4. Women Using Contraceptives based on ethnicity, place of birth, poverty level, and insurance status. Note that in general foreign born women tend to be less likely to use contraceptives. (Frost, 2014).

Contraceptive Use among South Asian Women

Contraceptive use among immigrant women living in the United States also sees a lot of variation among women of different ethnicities. In the United States, nearly 5% of the population is of Asian descent, and 18% of the Asian population living in the United States is South Asian (Farid, et al., 2013). South Asian immigrant women were more likely to be highly educated compared to United States-born women, with nearly 51% of South Asian women holding a graduate degree versus 33% of non-South Asian American women. However, even with differences in education level, South Asian women were

less likely to use contraceptives than American women. Approximately 68% of South Asian women living in the United States used contraceptives compared to 85% of non-South Asian women living in the United States (Farid, et al., 2013). South Asian women were also less likely to talk to their daughters about contraceptive compared to non-South Asian women. Nearly 13% of South Asian women in the study mentioned they would not discuss contraceptives with their daughters compared to 2% of non-South Asian women living in the United States. This difference was statistically significant, and many South Asian women said that they would not discuss contraceptives with their daughters since it is "not culturally advised" or "unnatural" (Farid, et al., 2013). Even while living in the United States, these results show that many South Asian women follow cultural norms even while away from their home countries.

Many South Asian women also identified barriers to accessing contraceptives, including pressure from family to have children, lack of education about contraceptives, as well as worries about side effects (Farid, et al., 2013). South Asian women also reported using fewer contraceptive methods than non-South Asian women living in the United States did. South Asian women tend to mostly use oral contraceptive pills and condoms. There are theories as to why these methods are frequently chosen among South Asian women, and it could be related to ease of use as well as short-lived effects of these contraceptive methods (Farid, et al., 2013). Finally, education level among South Asian women also played a role in determining contraceptive use. More highly educated women are more likely to use contraceptives, with 90% of women with a graduate level degree using contraceptives, compared to only 20% of women with a high school degree

(Farid, et al., 2013). The authors elaborate on the link between educational level and contraceptive use, stating that more highly educated women are more likely to work outside the home and have more bodily autonomy compared to less educated women (Farid, et al., 2013).

Contraceptive practices by SA ethnicity

Characteristic	All respondents (n=190)	SA (n=42)	Non-SA (n=143)	p value for χ^2
Ever used contraception	72%	67%	85%	.01
Method of contraception ever used				
Female sterilization	6%	0%	6%	.10
Male sterilization	0.7%	0%	0.7%	.59
Intrauterine devices	8%	5%	10%	.31
Injection	4%	0%	5%	.12
Implant	2%	2%	1%	.66
Pill	48%	33%	42%	.02
Male condom	44%	29%	50%	.02
Female condom	0%	0%	0%	.22
Diaphragm	4%	0%	4%	.08
Foam/Jelly	7%	0%	7%	.59
Emergency contraception	0.7%	0%	0.7%	.72
Breastfeeding	3%	2%	4%	.39
Rhythm	5%	2%	6%	.18
Withdrawal	10%	5%	12%	
Who makes decision to use contraception				.52
Self	21%	25%	30%	
Husband	3%	7%	3%	
Joint	48%	68%	68%	
Primary source of contraceptive knowledge				
Doctor	53%	55%	54%	.92
Pharmacy	0%	0%	0%	.08
Friends	24%	14%	27%	.03
Parents	15%	5%	18%	.38
School	28%	24%	31%	
No method of contraception currently used	52%	48%	52%	
If you had a daughter, would you discuss contraception with her				.001
Yes	78%	88%	98%	
No	3%	13%	2%	
At what age would you discuss contraception with daughter				
Age		Mean (standard deviation)		p value for t test
		15.5 (2.35)	13.6 (2.34)	.001

Table 5. Contraceptive Preferences of South Asian Immigrant Women. (Farid, et al., 2013).

South Asian women are one group of migrant women living in the United States, and their reproductive health choices largely reflect their cultural values as well as education level. The next study will examine contraceptive usage among another immigrant population living in the United States.

Contraceptive Usage Among Latina Immigrants

Latino immigrant communities in the United States are growing quickly, making them an important community to focus on when looking at reproductive health among immigrant women living in the United States. Latina women living in the United States are less likely than non-Latina women to use contraceptives. Only 48% of Latina women included in one study reported using contraceptives, compared to 78% of non-Latina women in the study (Garcés-Palacio, Altarac, & Scarinci, 2008).

Current use of contraceptives [a]

	Hispanics (*n*=113)	Non-Hispanics (*n*=113)	p
Injectables	20 (37%)	11 (12.5%)	.001
Oral contraceptive	11 (20.4%)	41 (46.6%)	.002
Tubal ligation	4 (7.4%)	20 (22.7%)	.009
Condom	13 (24.1%)	14 (15.9%)	NS
Rhythm	4 (7.4%)	2 (2.3%)	NS
Intrauterine device	2 (3.7%)	2 (2.3%)	NS
Vasectomy	0	4 (4.5%)	NS
Total (any contraceptive)	54 (47.8%)	88 (77.9%)	<.0001

[a] Percentages do not add to 100% because some women (8) use two methods or other methods (implant, 1; spermicides, 1).

Table 6. Latina Women's Contraceptive Preferences. Note that Latina women are more likely to use injectable contraceptives. (Garcés-Palacio, Altarac, & Scarinci, 2008).

Unlike non-Latina women living in the United States and South Asian women described in the study above, Latina women living in the United States are less likely to use oral contraceptives. In this study, Latina women reported preferences for injectable contraceptives (Garcés-Palacio, Altarac, & Scarinci, 2008). The authors of the study attempted to explain lower rates of contraceptive use among Latina immigrant women living in the United States. The authors posit that some women have been misinformed about contraceptives, leading to less usage. Other factors that may influence Latina women's contraceptive choice include marital status, family size, and assimilation into the dominant United States culture (Garcés-Palacio, Altarac, & Scarinci, 2008). This study describes contraceptive use among a Latina communities living in the United States. Latina immigrants show different preferences for contraceptives than South Asian women. Thus, it is important for health providers to consider differences in cultural groups when discussing reproductive health with patients.

Preventative Women's Health and Screenings

When studying reproductive health in immigrant women living in the United States, it is also important to look at preventative health care and screenings. Many serious women's health conditions, such as cervical cancer, can be quickly detected through screenings. Breast cancer is the most common cancer affecting women in the United States (Lee, Stange, & Ahluwalia, 2015). Cervical cancer is the second most common cancer among women worldwide (Adegboyega & Hatcher, 2016). Many serious women's health conditions, such as cervical cancer, can be quickly detected through

screenings. Thus, it is important for immigrant women living in the United States to have equal access to preventative women's health care and screenings in order to maintain health.

One study examined cancer screening participation among immigrant women living in the United States compared to United States-born women. The study specifically looked at mammograms for breast cancer detection as well as Pap smears for cervical cancer detection. Immigrant women were overall less likely to get mammograms, with a 14-point percentage difference between immigrant non-citizen women and United States-women (Carrasquillo & Echeverria, 2006). A similar trend holds for non-citizen immigrant women versus United States-born women when it comes to getting Pap smears. There is an 11-point percentage difference between Pap smear screenings between the two groups' women (Carrasquillo & Echeverria, 2006). Thus public health interventions must focus on preventative health and screenings for immigrant women living in the United States.

Similar to variation among different cultural and ethnic groups in contraceptive usage, there are different rates of preventative reproductive health screenings among different immigrant communities. Asian-American women have lower breast cancer rates than non-Latina white women, but among Asian-American women, mortality rates are higher than non-Latina white women (Lee, Stange, & Ahluwalia, 2015). Immigrant women of Asian descent are less likely to get breast cancer screenings than American-born women of Asian descent. Korean-American women have the lowest mammography rate during the early 2010s (Lee, Stange, & Ahluwalia, 2015). Korean immigrant women

living in the United States are more likely to get a mammogram if they have been residing in the United States longer, are married, or they have more fluency in English. Barriers to Korean immigrant women receiving mammograms include cost of receiving a mammogram, lack of health insurance, and limited English language skills (Lee, Stange, & Ahluwalia, 2015).

Another study examined cervical cancer screenings among African immigrant women and found that immigrant women were far less likely to have received a Pap smear in order to screen for cervical cancer (Adegboyega & Hatcher, 2016). Only 5% of American-born women have never had a Pap smear, whereas 18% of immigrant women in the United States have never had a Pap smear (Adegboyega & Hatcher, 2016). The sub-Saharan African immigrant population in the United States totals 1.5 million and has significantly lower cervical cancer screening rates than United States-born African American women. Approximately 26.4% of African immigrant women received a Pap smear, compared to 55.4% African American women (Adegboyega & Hatcher, 2016). With less screening for cervical cancer, women risk finding cancer discovered at later stages, which increases mortality from the cancer.

Sub-Saharan African immigrant women face many barriers to receiving cervical cancer screenings. Many women are unaware of the risks of cervical cancer prior to arriving in the United States. Some women view the Pap smear procedure as very invasive, and some younger women report fears that a Pap smear risks their virginity. In some sub-Saharan African cultures, sexual health is not openly discussed, and a cervical cancer screening can be viewed as a source of embarrassment (Adegboyega & Hatcher,

2016). Another barrier to getting a Pap smear is a preference for a same-gender health provider, particularly among Somali women (Adegboyega & Hatcher, 2016). If a woman does not have access to a female physician performing the Pap smear, she may be less likely to get the screening. Other barriers include limited English language abilities and difficulty in finding childcare and transportation to make it to a screening appointment (Adegboyega & Hatcher, 2016). Some African immigrant women reported bias against them during doctor's visits, where health providers and office staff were condescending and assumed the women did not know anything about their health (Adegboyega & Hatcher, 2016).

Health providers must be aware of specific challenges faced by sub-Saharan immigrant women, rather than taking a one-size-fits-all approach to patient care. Providers must understand patients' difficulties making appointments as they face transportation and childcare issues. Providers must also respect cultural differences that lead to some patients' worries about screenings, such as a Pap smear. They must also avoid making assumptions about a patient's health literacy, as it can be very demeaning for patients to feel talked down to by health care providers.

There is a lot of variation among immigrant cultural and ethnic groups when it comes to women's reproductive and sexual health care. Many immigrant women face similar obstacles to getting care, including financial difficulties, language barriers, and lack of health literacy. Efforts must be made to ensure immigrant women can get the reproductive and sexual health care they need.

MENTAL HEALTH

Mental health must be addressed when examining women's health in United States immigrant and refugee communities. Migration for any reason involves many stressors that may influence a woman's mental health. Women often move away from social support systems, face discrimination in the United States, and learn to navigate in a new place and culture. Some immigrants and refugees come to the United States often fleeing violence and persecution in their home countries, which can have a big impact on their mental health. Several studies assess mental health services and outcomes in immigrant and refugee communities in the United States.

Immigrants and refugees tend to be at high risk for various mental health conditions. Traumatic events before, during, and after immigration can adversely affect mental health. Adult immigrants and refugees largely report depression and anxiety—often manifesting as post-traumatic stress disorders—as the main mental health conditions impacting them. Children are similarly impacted by these same conditions and are at greater risk depending on their parents' emotional states (Pumariega, Rothe, & Pumariega, 2005). It is important to detail some of the specific stressors that may lead to diminished mental health in immigrant and refugee communities.

Prior to moving to the United States, many immigrants and refugees have lived through conflict in their home countries. As more people leave their home countries, people's social support systems in their home countries often collapse. Upon leaving their home countries, some displaced persons are forced to live in crowded refugee camps.

After finally reaching the United States, many immigrants and refugees face problems securing employment and housing. Furthermore, many individuals are subject to discrimination in the United States (Pumariega, Rothe, & Pumariega, 2005). These stressors all contribute to poor mental health outcomes in immigrant and refugee communities in the United States.

One study examined trauma exposure as well as utilization of mental health services among immigrant, refugee, and United States-born children. The study was not specific to women, but did provide an important overview of mental health among immigrants and refugees before more specific examples are presented. The National Child Traumatic Stress Network (NCTSN) conducted a six-year study of children living in the United States who have faced traumatic experiences. The study produced a Core Data Set that allowed researchers to study mental health needs and services used in immigrant, refugee, and US-born communities (Betancourt, et al., 2018).

Compared to immigrant and US-born children, refugees were likely to have reported more types of trauma and loss. Displacement and acculturation also greatly impact immigrant children living in the United States, yet refugee children have mostly experienced other forms of trauma as well, such as having an impaired caregiver and higher rates of community violence than immigrant children (Betancourt, et al., 2018). More community violence exposure may be a result of refugees being resettled in areas with lower cost housing, since they have few financial assets that would allow them to settle in a neighborhood with less community violence (Betancourt, et al., 2018).

In terms of mental health services sought out, refugee children reported more frequently attending special classes at school to receive more individualized attention. Refugee children also received more in-home counseling services than US-born children did. Compared to immigrant children, refugee children were also more likely to address mental health needs with a primary care physician, such as a pediatrician (Betancourt, et al., 2018). Another curious takeaway from the study is that a large number of refugee children seeking out mental health services were addressing present-needs, such as acculturation in the United States, rather than past traumas, such as home country violence (Betancourt, et al., 2018). The study authors also were in support of making available more group-based mental health services in order to decrease feelings of isolation and give children a supportive environment in which they can heal (Betancourt, et al., 2018).

Mental health providers based in the United States must be aware of stressors that may lead to a deterioration of mental health as well as the way symptoms may present in different populations. Different cultural groups may have different beliefs about mental health and how to treat mental health conditions. In some cultural groups, mental health care may be stigmatized (Chang, 2018). According to one study, many Vietnamese immigrants with mental health conditions are more likely to visit local physicians, naturalists, and folk healers that speak Vietnamese. Mexican immigrants, on the other hand, are likely to use their primary care doctor for their mental health needs (Pumariega, Rothe, & Pumariega, 2005). Thus, it is important for health providers to be culturally competent and be aware of cultural preferences for receiving mental health services as

well as different ways mental health conditions may manifest in immigrant and refugee women. It is also important to look specifically at a couple immigrant and refugee communities, as communities may face different mental health issues.

Arab Immigrant and Refugee Women

Arab immigrant communities are growing in the United States, so it is important to understand common mental health conditions affecting Arab immigrant and refugee women living in the United States. What was formerly known as postpartum depression, now called peripartum depression, is a pressing mental health condition facing Arab immigrant and refugee women (Alhasanat, Fry-McComish, & Yarandi, 2017). Peripartum depression is a debilitating mood disorder that can occur during a woman's pregnancy or in the four weeks following childbirth. Peripartum depression can impair a woman's ability to care for children, which makes for a very rocky start to child's life (Alhasanat, Fry-McComish, & Yarandi, 2017). Peripartum depression occurs in approximately 14% of American-born women who are pregnant or have recently given birth. Studies conducted in Arab countries showed a significant range of rates of peripartum depression, from 10% to 37% (Alhasanat, Fry-McComish, & Yarandi, 2017). "Risk For Postpartum Depression Among Immigrant Arabic Women in the United States: A Feasibility Study" (Alhasanat, Fry-McComish, & Yarandi, 2017) is one of very few studies examining peripartum depression in Arab women living in the United States. Arab immigrant and refugee women in the United States are shown to be at higher risk for peripartum depression than their American-born counterparts. Fifty women were

included in the study, and the women were recruited from a Dearborn, Michigan Women, Infants, and Children (WIC). WIC enrollees are limited to women facing financial hardships, so all the participants in the study were lower income women (Alhasanat, Fry-McComish, & Yarandi, 2017).

Women completed the Edinburgh Postpartum Depression Scale (EPDS), which was translated into Arabic for women whose first language is Arabic. Women also completed Postpartum Depression Predictors Inventory (PDPI)-Revised, which is a tool that looks at factors that may influence development of peripartum depression. An Arabic translation of the PDPI is not available, so women met with a bilingual researcher who walked them through the inventory verbally (Alhasanat, Fry-McComish, & Yarandi, 2017).

Data analysis highlighted some of the risk factors in developing peripartum depression. The PDPI results showed that 46% of the study participants were at high risk for developing peripartum depression, while the EPDS showed that 36% of research participants were at high risk for developing peripartum depression (Alhasanat, Fry-McComish, & Yarandi, 2017). EPDS and PDPI scores are correlated, meaning that there is a relationship between the scores on both questionnaires. What factors predicted the development of peripartum depression? Anxiety and depression prior to pregnancy, stress, lack of social support systems, and "maternity blues" were all statistically significant risk factors for developing perinatal depression in the Arab immigrant and refugee women who took part in the study (Alhasanat, Fry-McComish, & Yarandi, 2017).

Descriptive Statistics and Frequency of Demographic Characteristics of 50 Postpartum Immigrant Women of Arabic Descent Living in the United States	
Demographic Characteristic	Value
Education, mean (SD), y	10.82 (3.52)
Maternal age, mean (SD), y	30.16 (6.45)
Infant age, mean (SD), mo	3.02 (2.09)
Duration in the United States, mean (SD), y	6.36 (3.10)
Religion/Muslim, n (%)	50 (100)
Marital status, n (%)	
Married	50 (100)
Pregnancy intendedness, n (%)	
Unplanned	15 (30)
Planned	35 (70)
Parity, n (%)	
Primiparous	9 (18)
Multiparous	41 (82)
Infant gender, n (%)	
Female	24 (48)
Male	26 (52)
Infant feeding, n (%)	
Breastfeeding	8 (16)
Formula	16 (32)
Both	26 (52)
Household income, n (%), USD	
< 20,000	26 (52)
20,000-39,999	24 (48)
Immigration status, n (%)	
Immigrant	47 (94)
Refugee	3 (6)
Country of origin, n (%)	
Egypt	1 (2)
Iraq	5 (10)
Jordan	1 (2)
Lebanon	15 (30)
Palestine	2 (4)
Qatar	1 (2)
Saudi Arabia	1 (2)
Yemen	24 (48)
Language spoken with health care provider,[a] n (%)	
Arabic	32 (46)
English	12 (24)
Both	6 (12)

[a]All women in this study speak Arabic language and answered the questionnaires in Arabic; 64% speak only Arabic with health care provider, 24% speak English with their health care provider, and 12% speak both languages with health care provider as needed.

Table 7. Demographics of Arab Immigrant Women in the Peripartum Depression Study. Note that the majority of the women included in the study are immigrants rather than refugees. (Alhasanat, Fry-McComish, & Yarandi, 2017).

Chi-square Analysis of the Relationship Between Risk for PPD as a Dichotomous Outcome Measured by EPDS[a] and Risk Factors Measured by the PDPI-R in a Sample of 50 Postpartum Immigrant Women of Arabic Descent Living in the United States		
Risk Factors (PDPI- R)	χ^2	*P*
Antenatal anxiety	12.5	< .0001
Antenatal depression	10.59	.001
Unplanned pregnancy	.15	.70
Lack of social support		
Family	6.75	.009
Friends	5.82	.016
Partner	.62	.43
Life stress		
Marital problems	1.30	.25
Death in the family	.30	.58
Serious illness in family	.02	.88
Financial problems	1.94	.16
Child care stress	.87	.77
Infant temperament	.34	.56
Maternity blues	2.12	.15
History of depression	3.70	.06

Abbreviations: EPDS, Edinburgh Postpartum Depression Scale; PDPI-R, Postpartum Depression Predictors Inventory-Revised; PPD, postpartum depression.
[a]A score of ≥10 on the EPDS was used to define risk for PPD.

Table 8. Risk Factors for Peripartum Depression in Arab Immigrant Women. Note the statistically significant risk factors, such as antenatal anxiety, antenatal depression, lack of social support among family and friends, and a history of depression. (Alhasanat, Fry-McComish, & Yarandi, 2017).

Strong social support systems are critical to mitigating some of the risks of developing peripartum depression. Culturally, many Arab women rest for 40 days following giving birth. Family members and friends often assist the new mother with childcare, chores, and provide company. Women can also freely discuss challenges associated with pregnancy and childbirth in an affirming environment (Alhasanat, Fry-

McComish, & Yarandi, 2017). Many Arab immigrant and refugee study participants reported that their social support systems were disrupted upon arriving in the United States, with many feeling lonely and isolated. These feelings can greatly contribute to developing peripartum depression, so the study emphasizes strong social support systems as one way of protecting against peripartum depression (Alhasanat, Fry-McComish, & Yarandi, 2017). While not discussed in the article, strengthening of social support systems can come through establishing cultural community centers or a "buddy system" where individuals from a certain culture already living in the United States pair up with newly arrived immigrants and refugees to provide emotional support and help them navigate their new settings.

Mental Health in Black Caribbean Immigrants

Mental health prevalence is similar in black and white individuals, yet in the United States, mental health needs of black individuals are often unaddressed. Furthermore, black communities, and especially immigrant black communities, are underrepresented in health research (Williams, et al., 2007). Black Caribbean immigrants make up 4.4% of the black population living in the United States and make up nearly 25% of the black population in cities such as Boston and New York City. Even with significant black Caribbean communities in the United States, few studies have been done addressing their mental health needs (Williams, et al., 2007).

One study assessed effects of intimate partner violence (IPV) among Caribbean black women living in the United States. Caribbean black women, like African-American

women, face more institutionalized stressors, such as mass incarceration, and poverty than white women. With more stressors and poverty, Caribbean black women are at greater risk for IPV as well as poor physical and mental health outcomes (Lacey & Mouzon, 2016). IPV has been previously correlated with several mental health conditions, such as posttraumatic stress disorder (PTSD) and substance abuse disorders.

"Severe Physical Intimate Partner Violence and the Mental and Physical Health of U.S. Caribbean Black Women" (Lacey & Mouzon, 2016) assessed the physical and mental health of Caribbean black women living in the United States who have experienced severe IPV (SIPV). Data collection was completed through phone interviews with 949 Caribbean black women. Women were asked if they had any history of being beaten by a partner. Of the 949 participants, 836 had no history of SIPV, while 113 women did. Study participants completed the World Mental Health Composite International Diagnostic Interview (WMH-CIDI), which assessed a number of mental health disorders included in the Diagnostic and Statistical Manual (DSM) IV (Lacey & Mouzon, 2016).

Women with a history of SIPV had no significant difference in marital status or US region of residence than women with no history of SIPV. However, women with a history of SIPV were more likely to be less educated and make less income than women without a history of SIPV (Lacey & Mouzon, 2016). There were also significant differences when it came to prevalence of mental health disorders in women with and without a history of SIPV.

Women with a history of SIPV had double the rates of major depressive episodes than women without a history of SIPV, at 28.5% versus 13.5% (Lacey & Mouzon, 2016). The same trend applies for mood disorders. Women who had a history of SIPV had double the rates of mood disorders than women without a history of SIPV, at rates of 33.6% in women with a history of SIPV and 14.6% in women without a history of SIPV (Lacey & Mouzon, 2016). For bipolar disorder, women with a history of SIPV had ten times the rate of women with no history of SIPV at 12.4% versus 1.3%. Caribbean black women with a history of SIPV also had higher rates of substance abuse disorders at rates of 6.1% to 2.2%, though no significant difference was found for alcohol dependence (Lacey & Mouzon, 2016). A less commonly studied mental health condition in this particular population is eating disorders. The study results showed women with a history of SIPV also had higher rates of eating disorders, such as bulimia and binge eating (Lacey & Mouzon, 2016). There are theories that eating disorders may be part of a coping strategy to deal with IPV, though more research must be completed on the subject. Finally suicide attempts and ideations were ten times more likely in women with a history of SIPV compared to those without, at 12.7% versus 1.4% (Lacey & Mouzon, 2016). All of the rates presented in this section showed statistically significant differences between women with and without a history of SIPV, unless otherwise noted.

Since Caribbean black women living in the United States who have a history of SIPV have higher rates of mental health conditions, it is very important to conduct further research studies on the topic and ensure black Caribbean women can get access to mental health resources they need. The article authors suggest universal SIPV screenings in

health facilities to intervene early and reduce the risks of developing mental health disorders (Lacey & Mouzon, 2016), which could be an important tool in protecting women from violence and connecting them to resources if they have suffered from physical violence. This study is also valuable in that it addresses a community often left out of other mental health studies.

Mental health is a key component of women's health. Immigrant and refugee women face increased risks for different mental health conditions, so it is important they have access to mental health resources. Further research involving specific immigrant and refugee communities is needed, as many communities have been excluded from much mental health research, which hinders the ability of clinicians and community members to find the best ways to address mental health issues. Strong social support systems and universal mental health screenings are two means of protecting immigrant and refugee women from debilitating mental health conditions.

DESCRIPTIVE STATISTICS FOR U.S. CARIBBEAN BLACK WOMEN WITH AND WITHOUT HISTORY OF SEVERE PHYSICAL INTIMATE PARTNER VIOLENCE, 2001–2003 NATIONAL SURVEY OF AMERICAN LIFE

Characteristics	*No history of SPIPV* n = *836*	*History of SPIPV* n = *113*	*Group differences*
Age of respondents (%)			
18–24	18.7	12.5	
25–34	19.7	25.8	
35–49	34.8	39.5	$p=0.544$
50–64	16.1	14.1	
>65	10.8	8.1	
Marital status (%)			
Married	28.9	21.2	
Partnered	11.2	15.7	
Separated or divorced	20.3	31.0	$p=0.332$
Widowed	6.6	5.3	
Never married	33.1	26.8	
Education (%)			
Less than HS	20.3	25.8	
HS graduate	28.1	43.4	$p=0.010$[a]
Some college	29.8	24.2	
College	21.9	6.6	
Household income (%)			
<$25,000	36.5	58.4	
$25,000–$34,999	15.3	26.2	
$35,000–$49,999	17.6	5.4	$p=0.002$[b]
$50,000–$74,999	17.3	7.0	
>$75,000	13.3	2.9	
Employed status (%)			
Employed	72.1	60.5	
Unemployed	9.5	16.7	$p=0.375$
Not in the labor force	18.4	22.8	
Home ownership (%)			
Own home	46.8	17.0	$p=0.001$[c]
Rented	53.2	83.0	
Region (%)			
Northeast	63.3	60.3	
Midwest	3.4	6.9	$p=0.655$
South	27.8	25.3	
West	5.5	7.6	

[a] $p<0.05$.
[b] $p<0.01$.
[c] $p<0.001$.
SPIPV, severe physical intimate partner violence; HS, high school.

Table 9. Demographics of Caribbean Black Immigrant Women with and without a History of SIPV. Note that statistically significant difference among women with less education, women with lower household incomes, and women that do not own homes. (Lacey & Mouzon, 2016).

LIFETIME PREVALENCE OF MENTAL DISORDERS AMONG U.S. CARIBBEAN BLACK WOMEN WITH AND WITHOUT A HISTORY OF SEVERE PHYSICAL INTIMATE PARTNER VIOLENCE, 2001–2003 NATIONAL SURVEY OF AMERICAN LIFE

Disorders	*No history of SPIPV %*	*History of SPIPV %*	*Differences χ^2/p value*
Mood disorders			
Any	14.6	33.6	46.83[a]
MDE	13.5	28.5	31.79[b]
Dysthymia	2.01	6.04	12.13
Major depressive disorder	13.1	21.3	9.86
Bipolar disorder	1.3	12.4	84.62[c]
Anxiety disorder			
Any	14.4	38.3	72.19[c]
Panic disorder	1.9	11.9	60.98[c]
Agoraphobia	2.7	4.8	2.90[b]
Generalized anxiety disorder	2.2	9.9	35.93[b]
Obsessive-compulsive disorder	0.6	4.6	28.04[a]
PTSD	5.7	28.9	125.83[c]
Substance disorder			
Any	2.2	6.1	10.32[b]
Alcohol abuse	1.8	5.5	11.26[b]
Alcohol dependence	0.7	3.4	12.57
Drug abuse	1.8	3.9	4.10
Drug dependence	0.7	3.7	15.76[a]
Eating disorder			
Any	6.1	19.5	45.75[b]
Anorexia	na	na	na
Bulimia	2.8	7.9	14.78[b]
Binge eating	6.1	19.5	45.75[b]
Suicide			
Attempts	1.4	12.7	88.17[c]
Ideation	8.6	27.2	64.98[a]
Any disorder	29.6	60.7	79.26[c]

"na" indicates there were insufficient data.
[a] $p < 0.01$.
[b] $p < 0.05$.
[c] $p < 0.001$.
MDE, major depressive episode; PTSD, posttraumatic stress disorders.

Table 10. Prevalence of Mental Health Conditions among Black Caribbean Women with and Without a History of SIPV. (Lacey & Mouzon, 2016).

LITERATURE REVIEW CONCLUSION

The above literature review examined several case studies and trends related to women's health in immigrant and refugee communities. It is important to contextualize

these trends and discuss conflicting literature as well as provide some recommendations for improving women's health outcomes in immigrant and refugee communities in the United States. The next section will discuss the published studies by providing feedback on the studies, providing recommendations and next steps, and highlighting some of the overall trends in women's health in immigrant and refugee communities.

DISCUSSION

Many studies evaluate women's health outcomes and needs related to specific cultural groups. Few studies provide a full overview of women's health in immigrant and refugee communities in the United States, but some of these trends can be inferred through analyzing many cultural group-specific studies. Many immigrants and refugee women living in the United States face similar challenges obtaining health care. Undocumented women, for instance, are barred from receiving health care from federal programs, such as Medicaid. The exception is in the case of emergency services, where undocumented women do have some access to health coverage (Chang, 2018). However, health insurance is still very difficult to obtain by lawfully present immigrants. Many immigrant women wishing to enroll in Medicaid or the Children's Health Insurance Program (CHIP) must wait for five years while living in the United States before they are eligible for these programs (Ansari-Thomas, Desai, & Hasstedt, 2018). Only 25% of American-born women report being uninsured, while this percentage of uninsured women is 54% in the United States immigrant population (Ansari-Thomas, Desai, & Hasstedt, 2018).

Immigrants and refugees living in the United States also face greater risk for mental health conditions, as they often face additional stressors, such as feelings of displacement and isolation as they move away from their social support systems in their home countries (Pumariega, Rothe, & Pumariega, 2005). Mental health research often excludes many immigrant and refugee communities, so it is important to focus more on such communities in order to identify specific community mental health needs. For

instance, Arab women living in the United States are at higher risk of peripartum depression, which is largely influenced by weakened social support systems upon moving to the United States (Alhasanat, Fry-McComish, & Yarandi, 2017). However, with greater knowledge of this problem through research, the Arab immigrant community can focus on ways to improve social connectedness among community members. Thus mental health needs must always be considered when examining immigrant and refugee women's health, and efforts must be made in the research world to be more inclusive of foreign-born individuals.

While most of the trends indicate that immigrant and refugee women face more challenges receiving health care services than American-born women do, it is also important to mention the areas where the literature was rather inconsistent. While health disparities that adversely affect immigrant and refugee women were addressed by several studies, some studies also pointed out protective factors unique among immigrant and refugee communities. "Immigrant Health Inequalities in the United States: Use of Eight Major National Data Systems" (Singh, Rodriguez-Lainz, & Kogan, 2013) explains that immigrant communities often have better health than those born in the United States. Life expectancy is often higher in immigrant communities, and rates of disability and mortality are often lower in immigrant communities. One proposed reason for better health found in immigrant and refugee communities is termed the "healthy immigrant effect" (Singh, Rodriguez-Lainz, & Kogan, 2013) where immigrants who move to the United States tend to be healthier than immigrants who stay behind in their home countries. Furthermore, many immigrants to the United States have healthier lifestyle

habits than many Americans, including a better diet and less drinking (Singh, Rodriguez-Lainz, & Kogan, 2013).

One study examines the traditional Mexican diet and compares it to the American diet. The Mexican diet includes a large amount of fresh fruits, vegetables, whole grains, and legumes (Santiago-Torres, et al., 2016). The American diet, on the other hand, contains plenty of refined carbohydrates, vegetable oils, processed meats and other foods, and sweetened beverages. The study included 58 healthy women of Mexican descent and randomly assigned them to one of two groups: one following the Mexican diet for 24 days and one following the American diet for 24 days. During the course of the study, participants had four blood draws to look for biomarkers related to diet (Santiago-Torres, et al., 2016). Compared to the American diet, the Mexican diet decreased insulin by 14%, meaning that there was increased insulin sensitivity in the Mexican diet, which can help prevent Type II Diabetes (Santiago-Torres, et al., 2016). However, as Mexican immigrant women spend more time living in the United States, it is likely their diets will be modified to more closely resemble the American diet, which can influence development of metabolic diseases, such as diabetes (Santiago-Torres, et al., 2016).

Another study discusses the "healthy immigrant effect" but explains that health advantages in newly arrived immigrants decreases after they have spent more time living in the United States (Edberg, Cleary, & Vyas, 2010), just as the above study described. This is referred to as the "health paradox". Factors for a decline in health include difficulty obtaining health care, lack of insurance, poverty, and discrimination (Edberg, Cleary, & Vyas, 2010). While studies may disagree over the onset of poor health

outcomes and access to medical services in immigrants and refugees, it is important to note that nearly all studies included in this literature review take into account health disparities that have the potential to adversely affect immigrant and refugee communities.

There is also disagreement within the literature about social support systems in immigrant and refugee communities in the United States. In the study detailing peripartum depression in Arab immigrant women, the authors cite that lack of social support systems can be a major factor influencing the development of peripartum depression (Alhasanat, Fry-McComish, & Yarandi, 2017). However, in other studies, authors cite that in several cases immigrant women still have the social support of their families and local communities. "A Trajectory Model for Understanding and Assessing Health Disparities in Immigrant/Refugee Communities" by Cleary et al. suggests that identifying with a certain group—a religious or cultural group for instance—and following some of those group practices can have a protective effect on health, even when faced with prejudice and isolation (Edberg, Cleary, & Vyas, 2010). Another study discusses women's health in Chinese immigrants living in Chicago. Many women who participated in the study described the key role that their adult children play in their lives, since many of their children provide transportation and language interpretation at doctor's visits (Simon, et al, 2018). Women were adamant about not overburdening their children with requests for help, but did feel very supported by their adult children. This study does challenge some studies positing that women lack social support systems, but it seems to be an exception rather than a rule. In the same study there is even some debate over the strength of social support systems. While adult children tend to provide great

support to immigrant women, many women report that they seem to not receive much emotional support from their spouses. Some report attempting to avoid family conflict by going along with their spouse's thoughts about their health and medical care (Simon, et al, 2018). Therefore, social support systems, even when present, often have gaps reported by women. Though not addressed in this study, it is also important to note that individual circumstances may vary wildly from one immigrant or refugee family to another. In some situations, family members all immigrate to the United States together. In other cases, families are split up, which can lead to increased feelings of isolation and loneliness among immigrant women. Thus, social support systems may greatly fluctuate even within the same cultural group. This may help explain the inconsistencies in literature presented.

RECOMMENDATIONS FOR THE FUTURE

With many of the health-related challenges immigrant and refugee women face presented throughout this paper, it is also important to consider how these obstacles can be overcome to improve the health and quality of life for immigrant and refugee women living in the United States. There are several solutions tailored to specific cultural or religious groups detailed in the sections above, but this section will examine some general recommendations eliminating some of the barriers to receiving women's health care.

Many potential improvements in providing better women's health care for immigrant and refugee women start at the health provider level. Health providers are shaped by personality traits as well as education and training. It is helpful to examine what is taught in medical school curricula to assess the preparedness of American health providers to work with diverse patient populations. Looking at general women's health curriculums leads to some concerns that if curriculums do not fully address general women's health, immigrant and refugee women's health is also not addressed. "What Do Medical Schools Teach about Women's Health and Gender Differences?" by authors Henrich and Viscoli probes into medical school curriculums at 95 schools that participate in Association of American Medical Colleges' Curriculum Management and Information Tool (CurrMIT), which allows schools to enter specific curriculum details into a database that can be readily searched to see what topics are covered (Henrich & Viscoli, 2006). Only ten courses at nine of these 95 schools provided an interdisciplinary course or clerkship related to women's health. Sixty schools provided even more details about their

curriculums into the database, and the study authors conducted further research about these curriculums. The CurrMIT tool identifies 18 women's health specific topics, as well as another 24 gender-specific topics, such as gender differences in pharmacology (Henrich & Viscoli, 2006). Of the 60 schools included in this more detailed section of the study, more than 50% of school curriculums covered 11 of the 18 women's health specific topics, whereas less than 30% of the school curriculums covered the gender-specific content (Henrich & Viscoli, 2006). With interdisciplinary women's health courses and clerkships as well as gender-specific content lacking in many medical school curriculums, it is imperative to expand medical school curriculums to teach women's health more comprehensively so that future health providers understand gendered differences in health care.

It is also important for medical schools to integrate immigrant and refugee health into their curriculums, as immigrants and refugees make up a large portion of the United States population and often face marginalization and health disparities. One study details an experiential learning experience that integrates refugee health into the medical school curriculum at Johns Hopkins University (Bernhardt, et al., 2018). Johns Hopkins University has partnered with a local Baltimore refugee resettlement agency, and preclinical medical students are each paired with a newly arrived refugee family. Students are trained to visit their assigned families every month and accompany them to doctor's visits to assist them in navigating the United States health care system. Students also complete reflection activities throughout the course of the program (Bernhardt, et al., 2018). Medical students report highly positive experiences through participating in the

program. They gain greater understanding of their paired family's unique needs and gain more confidence caring for patients from different cultural and linguistic backgrounds (Bernhardt, et al., 2018). The program greatly emphasizes the humanistic side of medicine, where medical students get to know their patients as people and not just as a set of symptoms. If implemented on a large scale in the United States, future physicians can be trained to be acutely aware of refugee health needs, and perhaps it can be expanded to also address immigrant health needs. Doctors better trained to work with immigrants and refugees have more skillsets to improve the quality of life of immigrant and refugee women.

Another important way to eliminate health disparities among immigrant and refugee women is to actively recruit women, and more specifically, immigrant and refugee women into the health field. Women from certain cultural and religious groups, such as Somali women, prefer to see a same-gender health care provider (Adegboyega & Hatcher, 2016), so it is important that female immigrant and refugee patients can readily find a same gender physician. Female physicians are also advantageous as they understand many aspects of women's health care from a personal perspective as well. "Comparison of Hospital Mortality and Readmission Rates for Medicare Patients Treated by Male vs Female Physicians" by authors Tsugawa et al. finds that female physicians who treat hospitalized patients insured through Medicare tend to have better outcomes than male physicians who treat the same populations (Tsugawa, Jena, & Figueroa, 2017). Patients treated by female physicians had lower mortality rates as well as lower hospital readmission rates. Theories to explain this result include female physicians practicing

more patient-centered medicine as well as being more likely to practice evidence-based medicine (Tsugawa, Jena, & Figueroa, 2017). Patient-centered care is especially important in immigrant and refugee women, as their unique circumstances must be taken into account by health providers.

It is also important to increase numbers of nonwhite and non-American-born health providers. With a more diverse workforce of health care providers, immigrant and refugee patients can more easily find physicians that may come from a similar background. With similar backgrounds, it is possible language barriers may be alleviated as both may speak the same non-English language. The patient and physician may also both understand issues specific to their cultural or religious group (Marrast, Zallman, & Woolhandler, 2014).

To improve women's health of immigrant and refugee women living in the United States, several steps can be taken. Medical school curricula can be expanded to encompass all critical women's health topics. Moreover, implementing similar programs to Johns Hopkin's refugee health program provide medical students with early exposure to working with refugee populations, which can impact their future practice of medicine. Finally, diversifying the medical field to include more female, nonwhite, and polylingual health providers can introduce many more compassionate health care providers well-equipped to work with female immigrants and refugee patients.

CONCLUSION

Women's health incorporates the overall well-being of a woman, including general health, reproductive health, as well as mental health. Immigrant and refugee women are susceptible to many women's health conditions, given their backgrounds of displacement and acclimating to a new country. Many immigrant and refugee women living in the United States face barriers to receiving the health care services they need. Difficulty obtaining health insurance, especially for undocumented women who do not qualify for federal health insurance programs, is frequently cited as a major barrier to accessing expensive health care services. Other significant barriers to accessing women's health care services include difficulties finding transportation and childcare. Some women cite language barriers and fear of discrimination at doctor's visits as additional barriers (Chang, 2018). While American-born women, especially low income American-born women, may also face some of these same barriers, for many immigrant and refugee women these obstacles compound into insurmountable barriers that prevent them from receiving the women's health care services they need (Chang, 2018).

Many steps can be taken to eliminate these health disparities, though some steps are more difficult to implement than others. Federal medical aid programs can be expanded to be more inclusive of immigrant women, removing wait times for lawfully present immigrants to receive federal health aid and allowing undocumented women to receive some health coverage. In Atkins et al.'s study of Nebraska's former health coverage program that included undocumented women, women received preventative and prenatal health services that prevented them from costly emergency room visits. Thus, a

similar nationwide program would be necessary to ensure undocumented women can access preventative health services before presenting at an emergency room. While this would be politically difficult to implement, it has potential for being included in future national health care reform plans.

Other actions to eliminate women's health disparities for immigrant and refugee women include better training health care providers to work with immigrant and refugee patient populations. Curricula can be enhanced to include more detail about women's health and immigrant and refugee health (Henrich & Viscoli, 2006). With more training, future health providers will be more prepared to work with immigrant and refugee women, which can help eliminate some of the attitudes of fear and distrust in immigrant and refugee patients. It is also important to continue recruitment efforts to ensure health care providers come from diverse backgrounds (Marrast, Zallman, & Woolhandler, 2014). Having a physician or nurse that can speak the same language as immigrant and refugee women will remove a language barrier and may increase comfort of patients.

Finally, it is essential to understand that immigrant and refugee communities are not monolithic. Women of different cultural and religious backgrounds may have distinct needs and preferences when it comes to receiving health care services. South Asian and Latina immigrants have different contraceptive preferences for instance (Garcés-Palacio, Altarac, & Scarinci, 2008). In women's home countries, different types of preventative screenings may be more or less common than in the United States, so screening rates for different women's health conditions may vary from American-born women. In treating immigrant and refugee women, health providers must keep in mind cultural and religious

differences, and not simply assume immigrant and refugee women are uninformed about women's health options available in the United States. There are only some immigrant and refugee women who already have experience with many of the same medical services and tools available in the United States as American-born women have.

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