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Pregnancy health status of sub-Saharan refugee women who have resettled in developed countries: a review of the literature

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ABSTRACT

Objective: to present the literature relating to health status and pregnancy complications among sub-Saharan African women.
Background: sub-Saharan refugee women constitute a new and growing group of maternity service users in developed countries today. These women are perceived to be at high risk of pregnancy complication, based on concurrent disease and unusual medical conditions. As a result of these concerns, midwives may feel ill equipped to provide their pregnancy care.
Method: searches were conducted of CINAHL, Maternity and Infant Care, MEDLINE and PsychINFO databases using the search terms 'migrants', 'Africa', 'sub-Saharan', 'pregnancy', 'refugees' and 'women'. Additional articles were located by pursuing references identified in key papers.
Findings: pregnant sub-Saharan women present as an at-risk population related to poor prior health, co-existing disease and cultural practices such as female genital mutilation. Nonetheless, principal pregnancy complications for this population include anaemia and high parity, rather than exotic disease. Higher rates of infant mortality and morbidity appear to persist following resettlement, and are not explained by maternal risk factors alone. Limited access to care is of concern.
Key conclusions: further research is warranted into the impediments to care uptake among sub-Saharan African women. It is hoped that such research will inform the development of culturally appropriate and acceptable services for African refugees.
Implications for practice: it is important that midwives are aware of common health problems among sub-Saharan women. Midwives also need to act to promote access to health services among this group. Social disadvantage and late access to care may impact on neonatal outcomes and thus warrant investigation.

Introduction

Worldwide trends of refugee resettlement mean that societies in developed countries are becoming more culturally diverse. For more than a decade, much of this increase has related to sub-Saharan[1] African populations, displaced as a result of war and/or famine [Adams et al., 2004; Hampshire et al., 2004]. In Australia, for example, approximately 12,000 refugees holding humanitarian visas are accepted annually [Australian Government Department of Immigration and Multicultural Affairs (DIMIA), 2004, 2005], and approximately 70% come from countries in sub-Saharan Africa. Most are from Eritrea, Somalia, Sudan, Ethiopia and Kenya (DIMIA, 2005; Harris and Zwar, 2006; Smith, 2006). Similar patterns of African refugee resettlement are reported in the USA, the UK and selected European countries (DIMIA, 2005). Globally, this increasing trend gives rise to a number of concerns for midwives, and there is a general perception among health-care professionals that sub-Saharan refugees are at risk for serious pregnancy complications based on pre-existing health issues and diseases, such as malaria, which are common in Africa but unusual in developed countries. Moreover, the real risks for African refugee women giving birth in developed countries are, as yet, unclear. These women constitute a relatively new maternity client group, and currently there is little literature available that explores their prior health status or pregnancy complications following resettlement. Therefore, midwives may be called upon to provide pregnancy care for sub-Saharan refugees without a clear understanding of concurrent health issues. This paper aims to review the current literature around health status and pregnancy complications for sub-Saharan African refugee women. The principal purpose of the review is to raise awareness among midwives of health issues experienced by this group of women.

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[1] 'Sub-Saharan Africa' is the term used to describe the area of the African continent which lies south of the Sahara Desert (Canadian International Development Agency, 2005). It is home to some of the world's poorest people (International Monetary Fund, 2005).

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Search methods

The literature search was conducted using the following electronic databases: CINAHL, Maternity and Infant Care, MEDLINE and PsychINFO. Search terms included: 'migrants', 'women', 'refugees' and 'asylum seekers' in combination with 'pregnancy', 'Africa' and 'sub-Saharan'. Search parameters included publications within the past 10 years (1997–2007), and this time span was chosen as pertinent to the current wave of African refugee resettlement. In total, 238 papers were initially located and were later hand searched for fit with the review's intent. Further searches were conducted based on reference lists cited in retrieved articles. In addition, a number of key documents, such as World Health Organization (WHO) factsheets, were accessed to assist with defining terminology and contextualising some areas. On completion, 83 study papers and three WHO documents were identified as relevant to the search question. All papers were identified and abstracted by the author. The final acceptance criteria were as follows:

- paper published in English;
- related to sub-Saharan populations;
- explored pre- or post-migration health issues;
- relevant to pregnant women and their babies; and
- published between 1997 and 2007.

Findings

At the start of this review, it was hoped to consider papers, from host countries, which focused on the health status and pregnancy dilemmas of sub-Saharan refugee women. However, as the search progressed, it became clear that this pool of literature was very limited, so a decision was made to expand the search to include papers based on studies conducted in sub-Saharan Africa, from where most current refugees originate. The rationale for this expanded search was the likelihood of uncovering details of antecedent health issues among recently arrived sub-Saharan refugees. It was also expected that these writings would augment the sparse literature around resettled sub-Saharan women. Retrieved papers fell into four broad categories: background health status, specific health concerns, pregnancy complications and poorer access to health services. (Table 1)

Table 1
Findings.

Background health status
Poorer general health
Poorer preconceptual health
Poorer nutritional status
Limited availability of health services
Specific health concerns
Anaemia
Sickle cell disease
Malaria
Human immunodeficiency virus/acquired immunodeficiency syndrome
Infectious disease
Sexually transmitted infections
Female genital mutilation
Psychiatric disorders
Maternal and infant mortality and morbidity
Pregnancy complications
Low birth weight
Poorer antenatal attendance
Increased infant mortality
Hypertensive disorders
Preterm delivery
Poorer access to health services
Language barriers
Socio-economic issues
Poor knowledge of services

Background health status

Findings indicate that African refugee women are particularly vulnerable to poorer general health related to suboptimal preconceptual health and frequent pregnancy (El Joud et al., 2002; Eniola et al., 2002). Many are malnourished (Hampshire et al., 2004; Ukoko, 2005) which contributes to iron-deficiency anaemia and poorer immunity (Adam et al., 2005). Pregnancy adds to this burden (Adam et al., 2005), while psychological trauma, associated with political conflict and displacement, contributes to poorer general maternal health (Harris et al., 2006; Schweitzer et al., 2006).

Against this background of poorer general health and nutrition, many African women commence childbearing at an early age (Gupta and Mahy, 2003; Brookman-Amissah and Moyo, 2004), and bear many children in their lifetimes (Emina Be-Ofuriyua, 2002). For most, breast feeding (associated amenorrhoea) is the principal means of family spacing (Simondon et al., 2003) and high parity is common (Harris et al., 2006). High parity, in turn, is associated with complications such as anaemia and haemorrhage (El Joud et al., 2002; Eniola et al., 2002). Similarly, higher parity tends to be a predictor for higher rates of infant mortality in sub-Saharan Africa (Tabutin and Schoumaker, 2004). When sub-Saharan women resettle in a new country, trends of high parity and closely spaced pregnancies often continue, at least initially (Harris et al., 2006; Bledsoe et al., 2007). For the most part, these higher birth rates are in stark contrast to birth rates among local populations (Harris et al., 2006; Bledsoe et al., 2007).

Finally, the circumstances of war and famine, which have created refugee crises, generally affect basic amenities, services and infrastructure in sub-Saharan Africa (Adams et al., 2004). This disruption, in turn, contributes to limited availability of health services, reproductive services, antenatal care and immunisation against disease. All are key factors for maternal and fetal well-being. This limited access to services adds to the conundrum of poorer pre-migration health for sub-Saharan women (Krause et al., 2002).

Specific health concerns

Evidence suggests that sub-Saharan migrants suffer from a range of disorders, particularly anaemia, malaria, human immunodeficiency virus/acquired immunodeficiency syndrome (HIV/AIDS) and infectious diseases such as tuberculosis (TB). Cultural practices such as female genital mutilation (FGM) may also contribute to poorer maternal health. All have the potential to impact significantly on pregnancy and postpartum health.

Anaemias

Iron-deficiency anaemia is commonplace among sub-Saharan refugees arriving in host countries (Adams et al., 2004). As previously mentioned, its incidence relates to poor diet, concurrent illnesses and frequent childbearing (El Joud et al., 2002; Adams et al., 2004). It is therefore not uncommon for sub-Saharan women to present for antenatal care in a host country with a haemoglobin level below 7.4 g/dl (Ukoko, 2005; Harris et al., 2006). For most Western women, anaemia of this severity would be highly symptomatic; however, because of its long duration, sub-Saharan women are often asymptomatic at low haemoglobin levels (Ukoko, 2005).

For childbearing women resident in sub-Saharan Africa, anaemia is particularly troublesome. Adam et al. (2005) suggest