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Gynecologic care utilization in asylum-seeking women in New York City

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ABSTRACT

Introduction: Over 25,000 individuals are granted asylum status in the United States annually. Gender-based violence (GBV) has historically been supported as a claim for persecution to apply for asylum. In women, GBV is a known risk factor for sexually transmitted infections, poor mental health, and worse perinatal outcomes. Less is known about the links between GBV, asylum seekers, and gynecologic outcomes or care utilization. Reported rates of gynecologic care-seeking are low in asylum-seeking women and women with histories of GBV often experience barriers to care. We hypothesized that asylum-seeking women with a history of GBV at the Libertas Center, a comprehensive center for survivors of torture in New York City, would receive low rates of recommended gynecologic screening and infrequent gynecologic care.

Materials and methods: This retrospective cross-sectional study included adult self-identified female patients who had completed intake at the Libertas Center from 2005-2020. In order to examine the relationship between GBV and gynecologic care use, patients were included if they had an electronic medical record (EMR) at Elmhurst Hospital, were female, 18 years of age and older, and had ever experienced GBV in their lifetime. EMRs were reviewed for medical and psychiatric diagnoses as well as routine components of gynecologic care and were linked to intake data from the Libertas Center characterizing patients' torture history. The primary outcome of this study was whether or not patients attended a gynecology visit. Demographic characteristics, medical histories, adequacy of gynecologic care, and gynecologic care-seeking behavior were compared between the gynecologic care group and the no gynecologic care group.

Results: A total of 249 female patients were seen at the Libertas Center from December 2005 until January 2020 at the time of data collection. The prevalence of GBV in this population was 48%. Among women who suffered GBV, 81 received medical care at Elmhurst Hospital and 44 (54%) received gynecologic care. Nearly 50% of those patients who sought care at Elmhurst carried a diagnosis of post-traumatic stress disorder or depression. Women who received gynecologic care were significantly more likely than those who did not receive gynecologic care to have had an Emergency Room visit (68% vs. 41%), an obstetric visit (32% vs 3%), and/or have been seen by a social worker (46% vs 24%; all $p < 0.05$). Women who saw a gynecologist were significantly more likely to have completed four basic gynecologic care measures (Pap smear, gonorrhea/chlamydia screen, pelvic exam, and mammogram if applicable) compared to women who did not (77% vs 8%, $p < 0.05$).

Conclusion: This study characterizes the gynecologic care utilization of female patients within a comprehensive care center for survivors of torture. We found a high lifetime rate of gender-based violence of 48% in this population. Adequate gynecologic care was uncommon among those who experienced GBV. However, gynecologic care was significantly more likely in patients receiving gynecologic specialty care, which frequently occurred after initial interaction with another provider (i.e. Emergency Department providers). These findings highlight the importance of trauma-informed care and establishing pathways to help asylum seeking and refugee women receive adequate gynecologic care. Further research is needed to explore specific barriers to gynecologic care in this population, how programs for asylum-seekers can integrate gynecologic care into existing structures

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for medical and mental healthcare, and how to increase awareness amongst providers on the prevalence of GBV and the gynecologic needs of these patients.

1. Introduction

Over 50,000 people are admitted to the United States as refugees annually; additionally, over 25,000 individuals are granted asylum status annually (Mossaad, 2019). In the US, applicants for asylum must be "unable or unwilling" to return to their home country due to fear of persecution due to an applicant's race, religion, nationality, political or social group (Mossaad, 2019; Asylum | USCIS 2020). Generally, jurisprudence in the US has supported gender as a claim for persecution due to a social group (UNHCR Asylum Lawyers Project 2016). The United Nations High Commission on Refugees defines gender-based violence (GBV) as an act perpetrated against a person's will based on unequal power relationships and gender norms (United Nations High Commissioner for Refugees December 31, 2020). In asylum seekers, GBV has often been the result of attempts to inflict trauma and destabilize certain ethnic groups or communities in conflict settings (Russell et al., 2016). While GBV can be perpetrated against men, women, boys, and girls, in this paper we focus on violence against women.

The exact prevalence of GBV in refugee and asylum-seeking populations is largely unknown, as cited rates vary between different populations and contexts (Stark and Ager, 2011; Araujo J de et al., 2022). Globally, the World Health Organization (WHO) has cited a prevalence of sexual violence of 35% in a woman's lifetime and in the Unites States the rate has been cited as high as 45% (WHO, July 22, 2020; Willie and Kershaw, 2019). In refugees and asylum seekers, these rates are highly variable and in one systematic review were cited with ranges from 0% to 99.8% depending on a woman's country of origin (Araujo J de et al., 2022). One meta-analysis of complex humanitarian emergencies in women from 14 different countries found a rate of sexual violence of 21%, while another study of female asylum seekers in Uganda found a lifetime prevalence of 63% (Vu et al., 2014; Morof et al., 2014). GBV is a known risk factor for poor mental health outcomes. Patients who have experienced GBV have higher rates of depression, PTSD, and disordered alcohol use (Roberts et al., 2018). Additionally GBV has been linked to higher rates of HIV, syphilis, gonorrhea, and chlamydia transmission, as well as a greater number of sexual partners (Russell et al., 2016; WHO July 22, 2020; Roberts et al., 2018).

Existing research has documented the link between refugee/asylum status and poor maternal outcomes. An analysis of pregnant refugee and asylum-seeking women in the UK reported that this population had higher rates of maternal mortality, postpartum depression, preterm delivery/stillbirth, and surgical intervention than the general population (Asif et al., 2015). A global systemic review similarly documented that being a refugee or asylum-seeker is an independent risk factor for worse perinatal outcomes in comparison to other migrant groups (Heslehurst et al., 2018).

Less is known about the relationship between asylum seekers and gynecologic outcomes or care utilization. In an ideal gynecologic care model, patients obtain care for symptom evaluation, as well as regular preventative visits to complete screening tests and immunizations (Well-Women Visit, 2020). In a study of African asylum-seeking and refugee women in a US city, reported rates of gynecologic care seeking were low (<50%) (Mehta et al., 2018). Qualitative analysis showed that women sought out gynecologic care primarily in the setting of pregnancy, and that stigma, not being married, privacy concerns, lack of partner support, and lack of resources were all barriers to seeking gynecologic care (Heslehurst et al., 2018). In one study of female Syrian refugees, only 32% reported easy access to gynecologic care and only 26% had visited a gynecologist within 6 months (Reese Masterson et al., 2014). However, in the same population, the rates of reported gynecologic problems were high: 54% with irregular menses, 53% with pelvic infections, and 52% with pain (Reese Masterson et al., 2014). Additionally, for asylum-seeking women who experienced GBV, many did not seek gynecologic care due to logistical and social barriers, including stigma (Reese Masterson et al., 2014). These barriers may differ by the receiving country, as access to care varies greatly by country and context.

The Libertas Center for Human Rights is a comprehensive care center for survivors of torture and human rights violations at Elmhurst Hospital in Queens, NY. Elmhurst Hospital is part of the New York City (NYC) Health + Hospitals public healthcare system, which serves over one million patients each year (About NYC Health + Hospitals | NYC Health + Hospitals 16, 2022). Close to 90% of Libertas clients are asylum seekers at the time of intake. Using a trauma-informed case management approach, Libertas assists patients with medical and mental healthcare, as well as legal and social services. Libertas patients are referred to a public hospital for medical care, facing fewer issues related to insurance than other US contexts. We sought to utilize the context of an existing comprehensive care system at the Libertas Center with a largely asylum-seeking patient population and high burden of GBV, to understand the adequacy and utilization of gynecologic care in this population. We hypothesized that asylum-seeking women with histories of GBV would infrequently obtain gynecologic care, for either symptoms or prevention, and that this might lead to inadequate completion of gynecologic screening measures. Our study therefore aimed to characterize gynecologic care utilization and factors influencing care-seeking among asylum-seeking female survivors of GBV who sought medical care within a comprehensive care center for survivors of torture. We additionally sought to assess the adequacy of gynecologic care received by these patients.

2. Materials and methods

We conducted a retrospective cross-sectional study of female Libertas Center clients. Patients enroll in the Libertas Center program after being referred by legal or social services agencies, physicians, social workers at the hospital, or through word of mouth. Our study population was adult self-identified female patients who had completed intake at the Libertas Center from December 2005 until January 2020. The Institutional Review Board of the Icahn School of Medicine at Mount Sinai approved this review under IRB number 17-02468.

Patients were included in the study if they had completed the intake process at the Libertas Center, which includes an interview to obtain the patient's trauma history and demographics, as well as an assessment of medical, mental health, legal, and social service needs. Within this population, we included female patients who reported experiencing gender-based violence (GBV) in their lifetime, defined as rape or sexual violence, and had an electronic medical record (EMR) at Elmhurst Hospital. When seeking medical care, patients at the Libertas Center are largely referred to Elmhurst Hospital but occasionally seek care at other New York institutions. Accessible EMRs are available from other NYC Health + Hospitals locations, however were not covered by our IRB, and therefore not included in this study. Additionally, not all clients at the Libertas Center request referrals for medical care and therefore do not all have EMRs at Elmhurst Hospital, as the Libertas Center uses its own patient database for services such as counseling. Patients were excluded from our study if they did not have an associated EMR or if their EMR was blank.

A retrospective chart review was then performed within the EMR. Charts were reviewed for medical and psychiatric diagnoses and routine components of gynecologic care. The data from the EMR was linked with data from the Libertas Center database for each patient. This database

includes demographic data, such as country of origin, marital status, employment status, and religion, as well as a comprehensive evaluation of each patient's torture history including perpetrator and type of torture.

The primary outcome of this study was whether or not patients attended a gynecology visit with a gynecology provider. Secondary outcomes included adequacy of gynecologic care, as measured by a composite score for completion of a Pap smear (screening for cervical cancer, if age-applicable), mammogram (if age-applicable), gonorrhea/chlamydia screen, and pelvic exam, as well as factors that might influence gynecologic care-seeking. Demographic characteristics, medical histories, adequacy of gynecologic care, and healthcare utilization were compared between the gynecologic care group and the no gynecologic care group using Student's *T*-tests or Wilcoxon-Rank Sum tests for continuous measures, as appropriate, and Chi-square or Fisher's exact tests for categorical measures, as appropriate. Results were considered statistically significant at the $p < 0.05$ level of significance. All analyses were conducted using SAS version 9.4 (SAS Institute Inc., Cary, NC).

3. Results

A total of 249 female patients completed intake at the Libertas Center from December 2005 to January 2020. Of these patients, 119 (48%) reported experiencing GBV. Among those with a history of GBV, 81 (68%) received care at Elmhurst Hospital as documented within the EMR and were included in the analysis. At time of chart review for patients included in the study with EMRs, patients had a mean age of 39 years. The majority of patients included in our analysis self-identified as heterosexual/straight (91%), single (35%) or married/living with a partner (40%), Christian (56%), and in stable housing (80%) (Table 1). Our patients originated from 29 countries and spoke 23 languages (Data not shown in tables). Many patients in our study population carried a diagnosis of Post-Traumatic Stress Disorder (PTSD, 57%), depression (46%), or both PTSD and depression (25%) (Data not shown in tables). In addition to GBV, 78% of patients suffered from physical torture and 96% suffered from psychologic torture (Table 2). Most patients (61%) experienced persecution due to their social group and were most commonly persecuted by the police (22%), a partner (21%), or a political party (20%). Patients who were excluded from our study analysis because they did not have an EMR ($n = 38$) differed significantly from included patients only with regards to country of origin, with the majority of those excluded originating from African countries (55%, $p = 0.0010$) (Supplementary Table 1). Otherwise, included and excluded patients were similar demographically; excluded patients had a mean age of 41 ($p = 0.3251$), mostly self-identified as heterosexual/straight (91%, $p > 0.9999$), single or married/living with a partner (36% and 41% respectively, $p = 0.9849$), Muslim or Christian (39% and 42% respectively, $p = 0.1931$) and in stable housing (85%, $p = 0.7760$) (Supplementary Table 1). There was no difference between included and excluded patients in terms of years of schooling or current employment.

In our study population, forty-four patients (54%) received gynecologic specialty care. Patients who had gynecologic care did not differ significantly from patients who did not have gynecologic care with respect to demographic characteristics (Table 1). Patients receiving gynecologic care were significantly more likely to carry a gynecologic diagnosis than those who did not receive gynecologic care (59% vs 8%, $p < 0.0001$). These patients were also significantly more likely to have a history of inter-personal violence (36% vs 30%, $p = 0.0203$) and to have been persecuted due to their social group (75% vs 43%, $p = 0.0036$) or by a partner (30% vs 11%, $p = 0.0392$). In contrast, those who did not seek gynecologic care were significantly more likely than those who did receive gynecologic care to have been persecuted for political reasons (38% vs 16%, $p = 0.0249$) and by the military or soldiers (22% vs 2%, $p = 0.0097$; Table 2).

The majority of patients in our study were seen in the Emergency Department (ED) (56%; Table 3). Of those patients seen in the ED, 16%

Table 1
Demographic characteristics of female gender-based violence survivors by gynecologic care.

	Gynecologic Care ($N = 44$)			No Gynecologic Care ($n = 37$)			*P*-value
	Mean ± SD	Median (IQR)	Range	Mean ± SD	Median (IQR)	Range	
Current Age (years)	40 ± 10.4	37 (32–46.5)	23–66	38.1 ± 9.9	35 (30–43)	25–61	0.3376
	No. (%)			No. (%)			
Sexual Orientation							0.2318
Heterosexual/Straight	40 (95.2)			29 (85.3)			
Lesbian or Bisexual	2 (4.8)			5 (14.7)			
Marital Status							0.3201
Single	9 (33.3)			11 (36.7)			
Married/Living with Partner	9 (33.3)			14 (46.7)			
Divorced/Separated	9 (33.3)			5 (16.6)			
Country of Origin							0.1473
Africa	8 (18.2)			10 (27.0)			
Central/South America	22 (50.0)			10 (27.1)			
Europe/Middle East	5 (11.3)			9 (24.3)			
Asia	9 (20.5)			8 (21.6)			
Religion							0.2588
Christian	26 (59.1)			19 (51.4)			
Muslim	13 (29.5)			9 (24.3)			
Buddhist	1 (2.3)			3 (8.1)			
Hindu	2 (4.5)			1 (2.7)			
Non-believer/Agnostic	1 (2.3)			5 (13.5)			
Years of Schooling							0.0621
0-12 years	18 (54.5)			9 (29.1)			
13-16 years	11 (33.3)			12 (38.7)			
>16 years	4 (12.2)			10 (32.2)			
Currently Employed							0.1055
Yes	14 (36.8)			19 (55.9)			
No	24 (63.2)			15 (44.1)			
Current Housing Status							0.2360
Stable	37 (84.1)			28 (75.7)			
Unstable	6 (13.6)			9 (24.3)			

$N = 5$ patients are missing Sexual Orientation data, $N = 24$ patients are missing Marital Status data, $N = 1$ patient is missing Religion data, $N = 17$ patients are missing Years of Schooling data, $N = 9$ patients are missing Employment data, $N = 1$ patient has a Current Housing Status of 'Other'.

Table 2
Medical histories of female gender-based violence survivors by gynecologic care.

	Gynecologic Care ($N = 44$) No. (%)	No Gynecologic Care ($n = 37$) No. (%)	*P*-value
Medical Diagnosis			0.1334
Yes	24 (54.5)	14 (37.8)	
No	20 (45.5)	23 (62.2)	
Gynecologic Diagnosis *			<0.0001
Yes	26 (59.1)	3 (8.1)	
No	18 (40.9)	34 (91.9)	
Psych Diagnosis			0.4989
Yes	36 (81.8)	28 (75.7)	
No	8 (18.2)	9 (24.3)	
Non-Sexual Torture+			
Physical	35 (79.5)	28 (75.7)	0.6765
Psychologic	43 (97.7)	35 (94.6)	0.5898
Kidnapping	12 (27.3)	12 (32.4)	0.6124
Type of Gender-Based Violence+			
History of Sexual Assault	37 (84.1)	28 (75.7)	0.4610
History of IPV*	16 (36.4)	11 (29.7)	0.0203
History of FGM	4 (9.1)	1 (2.7)	0.0933
Reason for Persecution			
Political Reasons*	7 (15.9)	14 (37.8)	0.0249
Religion	1 (2.3)	1 (2.7)	>0.9999
Ethnicity	1 (2.3)	3 (8.1)	0.3268
Social Activism	2 (4.5)	2 (5.4)	>0.9999
Social Group*	33 (75)	16 (43.3)	0.0036
Other	0 (0)	1 (2.7)	0.4568
Perpetrator+			
Partner*	13 (29.5)	4 (10.8)	0.0392
Community	1 (2.3)	2 (5.4)	0.5898
Police	9 (20.5)	9 (24.3)	0.6765
Family	4 (9.1)	4 (10.8)	>0.9999
Trafficker	2 (4.5)	2 (5.4)	>0.9999
Gang	7 (15.9)	2 (5.4)	0.1700
Military/Soldiers*	1 (2.3)	8 (21.6)	0.0097
Government	4 (9.1)	4 (10.8)	>0.9999
Political Party	8 (18.2)	8 (21.6)	0.6985

+ Non-Sexual Torture, Type of Gender-Based Violence, and Perpetrator types are not mutually exclusive, so the percentages for these categories do not sum to 100%.

* Statistically significant $p < 0.05$

received a referral to a gynecologist and of those with a referral, 100% received gynecologic care. Virtually all patients in our study population had a psychiatry or medicine clinic visit (99%). Women who received gynecologic care were more likely to be seen by social work than those who did not receive gynecologic care (46% vs 24%, $p = 0.0482$).

The majority of patients in our population completed a Pap smear (58%), gonorrhea/chlamydia screen (61%), and/or pelvic exam (59%). Most patients did not receive contraception counseling (79%). Patients who received specialty gynecologic care were significantly more likely to have completed all four care measures of Pap smear (98% vs 14%, $p < 0.0001$), mammogram (80% vs 20%, $p = 0.0035$), gonorrhea/chlamydia screen (98% vs 16%, $p < 0.0001$), and pelvic exam (96% vs 16%, $p < 0.0001$), compared to patients who did not seek gynecologic care (all measures, 77% vs 8%, $p < 0.0001$; Table 4).

4. Discussion

This study characterizes the gynecologic care utilization of asylum-seeking female survivors of GBV within a comprehensive care center for survivors of torture. Gynecologic care utilization is important to track because studies have shown that reproductive healthcare providers are a preferred source of care among women (Hall et al., 2017). Additionally, asylum-seeking women and women with a history of GBV are a high-risk population with a need for universal provision of gynecologic care to ensure adequate healthcare screening.

Table 3
Gynecologic care seeking behavior among female gender-based violence survivors by gynecologic care.

	Gynecologic Care ($N = 44$) No. / No. observed (%)	No Gynecologic Care ($n = 37$) No. / No. observed (%)	*P*-value
ED Visit*			0.0126
Yes	30/44 (68.2)	15/37 (40.5)	
No	14/44 (31.8)	22/37 (59.5)	
Gyn Referral at ED Visit*			0.0010
Yes	13/44 (29.5)	0/37 (0)	
No	17/44 (38.6)	15/37 (40.5)	
Missing/Unknown	14/44 (31.8)	22/37 (59.5)	
OB Visit*			0.0008
Yes	14/44 (31.8)	1/37 (2.7)	
No	30/44 (68.2)	36/37 (97.3)	
Psychiatry/Medicine Visit			0.4568
Yes	44/44 (100.0)	36/37 (97.3)	
No	0/44 (0)	1/37 (2.7)	
Seen by Social Work*			0.0482
Yes	20/44 (45.5)	9/37 (24.3)	
No	24/44 (54.5)	28/37 (75.7)	
Torture History Disclosed			0.2377
Yes	26/44 (59.1)	17/37 (45.9)	
No	18/44 (40.9)	20/37 (54.1)	
Of yes, how many seen by SW*	18/26 (69.2)	6/17 (35.3)	0.0285
Of no, how many seen by SW	2/18 (11.1)	3/20 (15.0)	>0.9999
Torture History Disclosed to Who			
Gynecology*	6/44 (13.6)	0/37 (0)	0.0289
Psychiatry	8/44 (18.2)	11/37 (29.7)	0.2218
Obstetrics	1/44 (2.3)	0/37 (0)	>0.9999
Primary Care	2/44 (4.5)	4/37 (10.8)	0.4043
Social Work	12/44 (27.3)	5/37 (13.5)	0.1298

* Statistically significant $p < 0.05$

We found a rate of gender-based violence of 48% in this population, which is higher than other cited rates of gender-based violence globally and in refugee populations, typically cited around 35% (WHO, 2020; Vu et al., 2017). Given the barriers in screening populations for GBV, it is possible that cited rates are underestimated (Vu et al., 2017). In our population at the Libertas Center, universal screening for GBV is completed at intake, thus likely portraying a more accurate rate. Our findings on mental health among GBV survivors are consistent with other research that has shown high rates of PTSD and depression among survivors of GBV (Roberts et al., 2018). Only 17 women in our study did not carry a psychiatric diagnosis. These findings illustrate the importance of the Libertas Center's core service of providing mental health services for asylum-seekers and survivors of GBV.

In our population of asylum-seeking female survivors of GBV who sought medical care, 54% received gynecologic care, a rate consistent with other studies of asylum-seeking women in the US (Mehta et al., 2018). Previous studies have shown a disconnect between access to gynecologic care in immigrant, and specifically asylum-seeking populations, and reported gynecologic problems (Mehta et al., 2018; Reese Masterson et al., 2014). Our data show that patients who were seen in the Emergency Department (ED) or by a social worker were significantly more likely to see a gynecologist, suggesting that these providers may serve as conduits to gynecologic care. Additionally, we found that patients who carried a diagnosis of both depression and PTSD, and those who experienced IPV were more likely to receive gynecologic care. It is possible this group of patients was generally more willing to see providers, whether for mental or physical health needs, or these findings may reflect an increased need for care in patients with more severe torture histories. It is also possible that these patients had a higher

Table 4
Adequacy of gynecologic care among female gender-based violence survivors by gynecologic care.

	Gynecologic Care ($N = 44$)			No Gynecologic Care ($n = 37$)			
	Mean ± SD	Median (IQR)	Range	Mean ± SD	Median (IQR)	Range	
Avg. Care Measures Completed*,+	3.8 ± 0.5	4 (4-4)	2-4	1.0 ± 1.2	1 (0-1)	0-4	<0.0001
	No. (%)			No. (%)			*p*-value
Pap Smear*							<0.0001
Yes	42 (97.7)			5 (13.5)			
No	1 (2.3)			32 (86.5)			
Mammogram*							0.0035
Yes	17 (79.8)			4 (20.0)			
No	7 (29.2)			16 (80.0)			
Gonorrhea/Chlamydia Screen*							<0.0001
Yes	43 (97.7)			6 (16.2)			
No	1 (2.3)			31 (83.8)			
Contraception Counseling*							0.0004
Yes	13 (38.2)			1 (3.0)			
No	21 (61.8)			32 (97.0)			
Pelvic Exam*							<0.0001
Yes	42 (95.5)			6 (16.2)			
No	2 (4.5)			31 (83.8)			
All Care Measures Completed*,+							<0.0001
Yes	34 (77.3)			3 (8.1)			
No	10 (22.7)			34 (91.9)			

+ "Care Measures Completed" refers to completion of Pap smear, mammogram, gonorrhea/chlamydia screen, & pelvic exam or waiving of care among those who were not eligible. It excludes completion of contraception consult as this was not applicable to all patients.

* $N = 1$ patient was <21 or >65 years and not eligible for Pap smear, $N = 37$ patients were <40 years and not eligible for mammogram, $N = 14$ patients were >50 years and not eligible for contraception consult.

awareness of the availability of gynecologic care, were more likely to be referred, or were more likely to find using medical care acceptable overall.

Patients who did not receive gynecologic care may have faced barriers to care, including those previously described in this population such as language and transportation issues, insurance gaps, stigma towards healthcare seeking as women, and social isolation (Floyd and Sakellariou, 2017; Barnes and Harrison, 2004). In our study population, women who had been tortured by the military/soldiers or for political reasons were significantly less likely to have received gynecologic care. More research is needed to elucidate the etiology of this gap, however it may suggest that women with this type of torture history are fearful of the medical establishment. This phenomenon has previously been reported in the Emergency Department setting (Hexom et al., 2012). Our study is limited by potential selection bias in that we only reviewed records of patients who had EMRs, possibly excluding patients with more significant barriers to care. This is particularly noteworthy in patients originating from African countries, who were excluded due to a lack of EMR more frequently than patients originating from Central/-South America, Europe/Middle East, or Asia. It is possible that Libertas clients who did not seek medical care faced barriers to doing so that were related to these demographic factors or had other characteristics that influenced their care-seeking behavior.

Most research to date has focused on the relationship between GBV survivors and sexual infections or pregnancy. Studies have shown increased rates of both HIV and sexual infections in GBV survivors (Roberts et al., 2018; Reese Masterson et al., 2014). Our study population did not reflect these trends in their gynecologic health history. Libertas patients received gynecologic care for a variety of diagnoses, including abnormal uterine bleeding, spontaneous abortions, and pelvic pain, mostly unrelated to torture or sexual violence. Additionally, only 19% of our study patients obtained obstetric care, compared to 60% in the study by Reese Masterson et al. (2014). This may reflect a higher mean age of female patients at the Libertas center, with a greater need for gynecologic over obstetric care.

We assessed adequate gynecologic care via surrogate measures of a patient receiving age-appropriate Pap smear and mammogram screening, sexual infection screening via proxy of a gonorrhea/chlamydia test, and a pelvic exam, based on the American College of Obstetrics and Gynecology age-appropriate components of a well-woman exam (Well-Women Visit, 2020). Existing data show foreign-born women are two times more likely to have never received a Pap smear compared to women born in the US, and refugee women have had a cited Pap smear rate of only 24% (Barnes and Harrison, 2004). Furthermore, refugee women are less likely to receive mammograms, with one study showing 86% of eligible women over 40 not receiving a mammogram in comparison to 33% of American-born women of the same age (Barnes and Harrison, 2004; CDCMMWR, 2017). Similar data on these measures for asylum-seekers is scarce. In our population, only 48% of patients over age 40 received a mammogram, a number that increased to 80% in those who also received gynecologic care. While barriers to routine care may exist in this population, screening tests carry an extra layer of unfamiliarity that may interfere with women seeking these tests (Piwowarczyk et al., 2013). Women in our study population who received care with a gynecology provider were significantly more likely to have all four of these measures completed than those who did not. Our findings, in addition to the data that Obstetrician/Gynecologists provide half of preventative healthcare visits to reproductive-aged women in the US, highlight the importance of establishing pathways to help asylum seeking women establish routine gynecologic care (Blanchard and Goodall, 2016).

Our study is limited by being a retrospective study at one hospital center. While our patient population is very diverse in geographic origin, it may not reflect gynecologic care utilization in other health systems. Our chart review was limited to Elmhurst Hospital's EMR, limiting our findings, as some Libertas patients sought care at other hospitals within the NYC Health + Hospitals system and may have additionally sought care outside this system as well. Additionally, we did not have data outside Libertas records about those clients without an EMR and their ability to access healthcare. More research is needed to elucidate the barriers these patients face in accessing care, as well as how programs like the Libertas Center can better connect all patients to care.

5. Conclusions

Our findings highlight the need to further integrate gynecologic care with medical and mental health care for survivors of torture and gender-based violence. Only 54% of our population, all women with a history of

GBV seeking medical care, had a gynecology visit, and this appeared to be an important pathway to receive adequate gynecologic screening. In order for our health system to meet the needs of asylum-seeking women, many of whom have experienced GBV, future research should explore barriers to accessing gynecologic care in this population. Programs focused on improving health for asylum-seekers should aim to integrate preventative and symptom-based gynecologic care into existing structures for medical and mental healthcare, and increase awareness amongst providers about the needs for trauma-informed care and routine gynecologic screening in this patient population.

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Declaration of Competing Interest

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

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Supplementary materials

Supplementary material associated with this article can be found, in the online version, at doi:10.1016/j.jmh.2022.100116.

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