

**Refugees in Rochester**  
**The Challenges of Cross-Cultural Care**

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## Learning Objectives

- Learn the definition of a refugee
- Learn where refugees come from, both from a geographic and cultural perspective
- Learn common barriers to improved health outcomes, including medication compliance
- Explore options for improving communication
- Conflict of Interest – None

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## Overview

- Define refugee
- Origins and Destinations
- Life prior to refugee status, as a refugee, and after resettlement
- Common medical conditions
- Interaction of culture and healthcare
- Challenges of medication compliance
- Strategies for improving care and medication compliance
- Conclusion and discussion




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## Who is a refugee?

A person who is outside his or her country of nationality or habitual residence; has a well-founded fear of persecution because of his or her race, religion, nationality, membership of a particular social group or political opinion; and is unable or unwilling to avail himself or herself of the protection of that country, or to return there, for fear of persecution” -UN 1951 refugee convention

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## Numbers, Origins and Destinations

- 15.4 million refugees worldwide in 2010
  - Additional 26 million displaced persons (UNHCR)
- 75% of refugees in 2010 resided in a country neighboring their own
- 80% were hosted by developing nations

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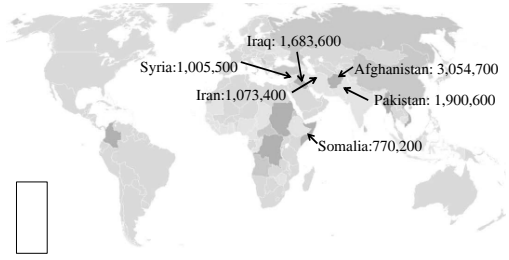
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## Top countries of Origin and Asylum for Refugees in 2010



Country	Number of Refugees
Afghanistan	3,054,700
Pakistan	1,900,600
Iraq	1,683,600
Iran	1,073,400
Syria	1,005,500
Somalia	770,200

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## Life as a Refugee



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## Loss and Trauma

- Loss of home, land, and possessions
- Death of family members and friends, and separation from family.
- Traumatic physical injuries such as gunshot wounds, amputation of limbs, rape, and torture.
- Up to 35% refugees world-wide may have experienced physical or psychological torture [4].



"About 1,400 Tamil refugees are dying every week at the giant Manik Farm internment camp"

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## Refugee Camps: Inadequate Healthcare

•Baidoa refugee camp:  
3,897/10,000 individuals died in  
232 days, and 74% of children  
under 5 died in seven months  
[MMWR Dec 1992]

•11,000-14,000 refugees per  
primary health clinic in camps  
surveyed in 2006 [11]

•Most deaths due to diarrheal  
disease, acute respiratory  
infections, measles, malaria, and  
other infectious diseases



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## Refugee Camps: Overcrowding and unsanitary conditions

- 30% of refugee camps do not have appropriate latrines and waste disposal facilities [14]
- Dadbaab refugee camp: designed to house 90,000 people, houses 261,000, as many as 30 people living in a 12X13 meter space [13]



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## Refugee Camps: Limited Access to food, water, education

- 50% of refugees do not receive minimum water allowance set by UNHCR (5 gallons/day) [11]
- Food ration standards met in some camps, fall short in others
- At least 30% of youth not enrolled in school



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## Refugee Camps: Limited Mobility and Rights

- Most host countries do not allow refugees freedom of movement to leave the camp
- Many refugees are forced to rely solely on humanitarian aid, setting up a cycle of dependence.



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## Protracted Refugee Situations

- "One in which refugees find themselves in a long-lasting and intractable state of limbo. Their lives may not be at risk, but their basic rights and essential economic, social and psychological needs remain unfulfilled after years in exile. A refugee in this situation is often unable to break free from enforced reliance on external assistance." (17)

15 million refugees in a protracted situation in 2010

- The number of protracted situations has increased from 9 years in 1975 to 17 years at the end of 2010

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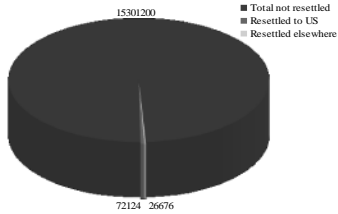
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## Durable Solutions for Refugees

- Repatriation to country of origin- benefits the most refugees
- Integration into country of asylum- variable
- Resettlement to a third nation- 1% of the world's refugees
  - US tops number of citizenships granted in last 10 years

Refugee Numbers and Resettlement



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## Resettlement to the United States

The United States has resettled almost 3 million refugees since 1975 (20).

The United States has resettled more refugees than any other country, with more than half of the refugees resettled each year.

- Of 98,800 refugees resettled in 2010, 73% were resettled in the US
- Top countries of origin in 2010: Myanmar, Iraq, Burundi, Somalia, and Democratic Republic of Congo.

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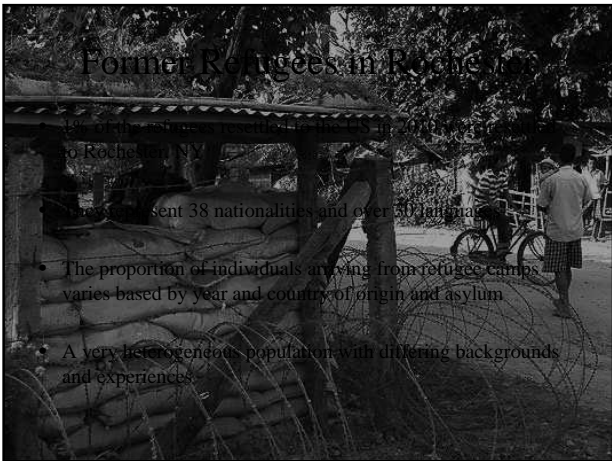
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**Refugees Resettled to Rochester, NY 1/2008-12/2010**

Country of Origin	Numbers	Country of Origin	Numbers
Afghanistan	18	Iraq	158
Belarus	2	Korea, N.	4
Bhutan	761	Kyrgyzstan	6
Burma	537	Liberia	19
Burundi	55	Nepal	1
China	1	Rwanda	5
Congo	57	Somalia	169
Cuba	170	Sudan	16
Dem.	3	Turkey	5
Eritrea	19	Ukraine	22
Ethiopia	3	Vietnam	3
Georgian	1	Zaire	12
Iran	7	<b>Total</b>	<b>2054</b>

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## Challenges of Resettlement

- Dealing with past trauma
- Low socioeconomic status
- Culture Shock
- Language barrier
- Transportation
- Healthcare
- Housing




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## Common Health Problems in Refugees

- Infectious disease:
  - tuberculosis: 6.9% active TB in Somali patients
  - hepatitis B: 8-30%
  - parasitic infections
  - H. pylori
- Mental health [39]:
  - post-traumatic stress disorder (PTSD): 9% in adults, 11% in children- much higher than in general US population
  - major depressive disorder (MDD): 5% in adults
  - anxiety: 4% in adults

Percent 5+ yo with Depression	
Somalia	3.0%
Afghanistan	34.8%
Iraq	42.3%

US depression prevalence = 6.7%

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## Common Health Problems in Refugees

- Pain: back pain, neck pain, abdominal pain, whole body pain, headaches
- OB/GYN: pelvic pain, fistulas, female circumcision
- Dental caries (61%) and malocclusion (78%)
- Iron deficient anemia
- Dermatologic: Tinea, eczema, etc.
- Chronic conditions: diabetes mellitus type 2, hypertension, dyslipidemia, vitamin D deficiency, asthma

Presentations are highly variable based on country of origin, age, gender, flight experiences, resettlement experience, and other factors

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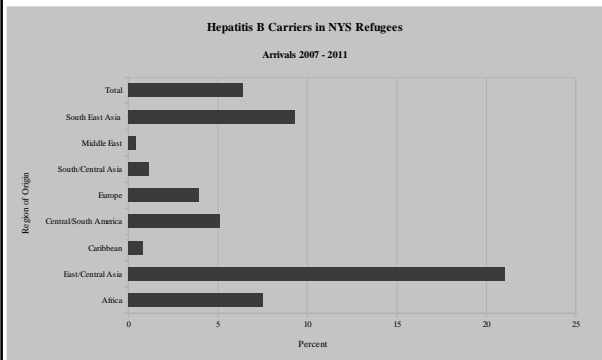
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## NY State Data



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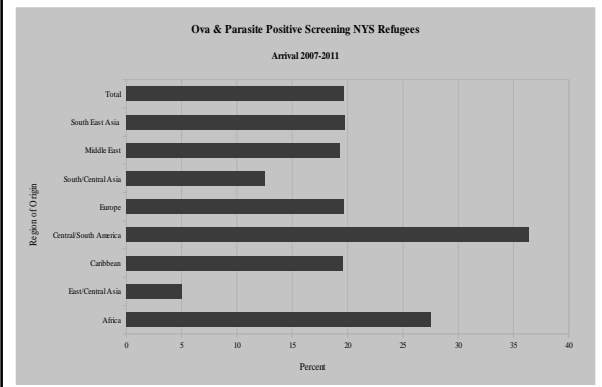
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## NY State Data



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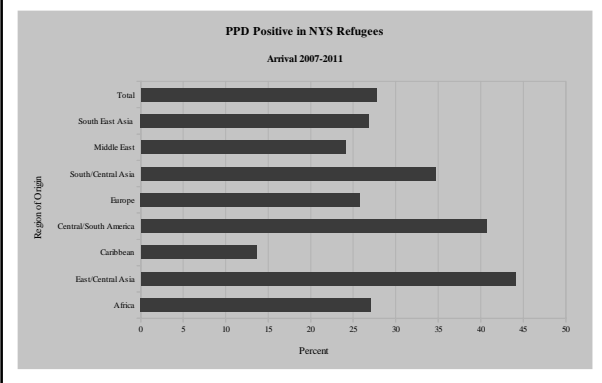
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## NY State Data



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## Clinical Case

- Liberian woman, DOB of 01/01/78, brings her 3 children, needs interpreter
- First born child died shortly after birth, another child died at 2-3 years of age from measles and diarrhea. Husband killed by government soldiers in front of family, her oldest son taken by rebels.
- Fled her home in rural Liberia in 1996. Spent the last 14 years in a refugee camp in Ivory Coast
- Past medical history: Malaria, worms, G6P600?3
- TB clinic paperwork shows PPD+, CXR=old scarring, on INH
- Patient complains of headache, abdominal pain, rash on feet, tooth pain, trouble seeing, malaria.

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### Physical exam:

- Thin, appears tired, flat affect when not engaged, facial scars
- Ht – 5 ft, Wt – 87 lbs, BP – 97/55, HR- 92, T – 37.1
- HEENT: Left TM perfed and wet, pterigium both eyes to iris border, deviated nasal septum, multiple teeth missing and dental caries.
- Neck: + goitre, shotty lymph nodes
- Pulm & cardiac essentially normal
- Abd: thin, +BS, soft, NT, + hard stool LLQ, no mass, liver down 2 cm, spleen firm but normal size.
- Skin: Multiple 1 cm linear scars on lower back, hyperpigmented ankles, feet - thickened cracked scaling, with white between toes

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Many refugees are from developing countries, have multiple health problems, years of untreated pathology and routine and exotic potential health problems

### Potential Diagnoses So Far

- |                        |   |
|------------------------|---|
| • Malaria              | • Perfed TM with chronic otitis externa |
| • Abdominal pain       | • Pterigium                             |
| • Malnutrition         | • Deviated nasal septum                 |
| • Visual problems      | • Dental problems                       |
| • PPD+                 | • Goitre                                |
| • PTSD/Depression      | • Tinea pedis                           |
| • Headache             | • Hepatomegaly                          |
| • Intestinal parasites |   |

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Treatment:

- Stool Ova & Parasite Screen:
  - E. histolytica – Flagyl and Paromomycin
  - Hookworm – Mebendazole or Albendazole
  - Hymenolopis nana (dwarf tapeworm) - Praziquantel
  - Blastocystis hominis, Entameba coli – generally non pathogenic
- Urinalysis:
  - E. coli – tx with antibiotic of choice
  - Schistosoma hematobium – Praziquantel
- Anemia: Iron sulfate

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## Clinical Case 2

- 47 year old Nigerian woman, in the US for 7 years, spent 3 years in a refugee camp in Benin
- Works, takes care of 7 children, dealing with domestic violence
- Medical problems at arrival: anemia, hookworm, dysmenorrhea, migraines
- Medical problems recent visit: Obesity, hypertension, migraines, dysmenorrhea, back pain, GERD, depression, allergic rhinitis
- Medication: atenolol, ranitidine, ibuprofen, loratadine, meloxicam, counseling
- Blood pressure in clinic fluctuates, as do weight and other symptoms

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Multiple clinic visits to address symptoms and how to take medications properly:

- Patient not interested in weight loss
- Patient forgets to bring in medications
- Patient can't remember which medication she takes
- Patient brings in medications and physician goes over what each medication is and how to take it
- Patient comes in again, does not remember what each medication does, is taking medicines at random at onset of symptoms until she feels something is working....

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## Health and Culture

- Poor outcomes with refugees are most often due to language barrier and cultural misunderstandings
- Effective clinical interventions require:
  - Understanding of life before, during, and after refugee status
  - Assessment of intellectual function, prior education & literacy (in any language)
  - Knowledge of patient's cultural beliefs
  - Patience and compassion

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## Culture: Defining Health

- Obesity as an ideal in some African countries
- No experience with or understanding of preventive health care
- Different beliefs about dietary intake, physical activity, environmental hazards



"If its not broke, then don't fix it"

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## Culture: Defining Illness

- No concept of Western theories of disease processes
- Illness due to magic, witchcraft or no logical cause
- Limited or no exposure to medical care, especially in patients from rural/undeveloped areas
- Somatization is common, especially in individuals with past trauma
- Non-traditional symptoms/manifestations

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### Culture, Role and position of women

- Women subservient to men
- Men control fertility
- Arranged marriage is common
- Belief that fertility rate controlled by gods
- In country of origin, if you have 6+ children, maybe two will remain to care for you when old
- Women placed under great stress to maintain household, take care of children, and work

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### Cultural Stuff

- Family honor is most important, individual is not
  - Person being hurt often accepts the situation
  - Divorce rare, would shame family, so wife lives in awful situation
- Cross racial and social hierarchy often accepted in the culture
- Women may be seen as second class citizens
  - Example: stabbing of sister, and community approval
- Intra-family partner violence (husband to wife) accepted and expected
  - Wife expected to stand and take the punishment
- Child abuse, corporal punishment
- Intra-family marriages, Father with many daughters
- Most challenging when father comes to US, 10-15 years after rest of family → widens cultural gap

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### Inter-generational Challenges

- Children adapt first (often become the functioning boss outside the home)
- Older people often never adapt
- Lack of male head of household
- Adolescence: often worse parent/child problems than US
- Young adult/adolescent supporting extended family
- Traditional adults vs Americanized young
  - Young person can be lost between 2 worlds
- Arranged marriages (examples)
- Parenting styles
- Schooling
  - How can children excel when no parents help with homework?

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## Culture: Patient-Provider Relationship

- Fear and mistrust of medical professionals
- Provider's role: "You are the doctor, why can't you fix what is wrong with me?"
- Appropriate verbal communication and eye contact
- Appropriate physical distance and contact
- Interacting with Muslim women (for men)
  - Men should not look directly at a strict Muslim woman
  - Men should not touch a strict Muslim woman, this includes handshakes

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## Language Barrier

- Most former refugees will speak little to no English at arrival
- Some individuals from Sudan, Nepal, etc may speak some English at arrival
- Most individuals from Somalia, Burma, Afghanistan, etc will not speak any English at arrival
- Even after years in US, less likely to learn English if: older, less educated, large local population, origin from underclass

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## Simple English

- Speak slowly – not loudly
- Use simple sentence structures – we often use complex sentence structures to get across subtle points. For people who do not speak English well, this complexity totally obscures even the simple meaning. 80% accurate is usually better than missing the point entirely.
- Use simple words, even if the meaning may seem less clear to you
- Example:
  - "We need to do a pap smear to screen for cervical cancer"
    - "We look inside where baby come from. Make sure no bad sickness inside"
- Don't be fooled by refugee smiling and nodding their head

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## Overcoming Language Barrier: Interpreters

- ADA requires interpreters be provided if needed. Insurers do not pay for interpreters in NYS
- Ideal interpreting allows patient and provider to look at each other while words interpreted on the fly – often not possible
- Some words/phrases are difficult to translate
- A good interpreter can help provider be culturally sensitive
- Phone interpretation can be expensive
- Partial language skills can at times be more dangerous

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## Medication Compliance

- Use of complementary and alternative medicine
- Limited understanding of chronic conditions
- Different prior experiences with medication
- No understanding of the refill process



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## Medications

- Cannot read
- Use daily meds as PRN
  - SSRI taken only when feel down
  - OrthoEvra applied only during sexual activity
- Lies of omission, or active misdirection
- Limited mental capacity
- Fear of medicines
  - Too many medicines
  - Become dependent on medicines
  - Western medicines too strong
  - Too many side effects
- Medicines as magic, do not understand need for timely administration



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### Conclusion

- Always listen to the patient and their family. Let them tell you their story and their experiences. Ask them about their beliefs and values.
- Let the patient guide you in understanding their preferences.
- Never judge someone and let patients know that they have been through or are going through a hard time.
- Be creative and go the extra step to assist the patient.
- I encourage the group to discover solutions.

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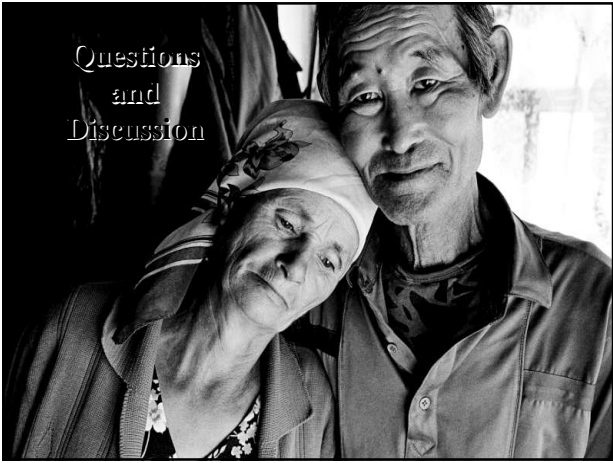
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### Questions and Discussion

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### Resources

- [www.Healthyroadsmedia.org](http://www.Healthyroadsmedia.org)
- [www.ethnomed.org](http://www.ethnomed.org)
- [www.nlm.nih.gov/medlineplus/languages/medicines.html](http://www.nlm.nih.gov/medlineplus/languages/medicines.html)
- [www.healthtranslations.com](http://www.healthtranslations.com)

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## References

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- Just some thoughts
- I might change around how the pharmacy stuff is presented (if you are not already doing this). Offer that here are some things others have suggested. This group could probably come up with some solutions and then standardize across the area. Maybe we can talk about options. "I realize many pharmacists are too busy to breathe let alone address the needs of 'difficult' patients. However, I suspect you are like me and it is when a personal connection is made with a patient and we help that patient, that makes our job worthwhile. For many of you, you desire more than dispensing medications, you went into the profession to help others.
- Need more personal stories and examples of some of the challenges that happen when working with refugees.
- I like backdrop photos, but some people find overwhelming. I like to create slides with information at various levels. I find it interesting seeing photos while listening to speaker's stories.
- We should discuss generational divide/gap and how rapidly it grows. Kids learn language first and acculturate first. This changes dynamics of family. E.g. 14 yo male now rules house by controlling flow of information in and out of house, to/from parents.
- Highlight many single/widowed women in a very male dominant culture. Causes troubles between boys/young men and their mother.
- Possibly delve more into aculturation stuff: early adopters, non-adopters, etc.
- Would some pharmacists consider locating or creating common medication instructions in various languages?

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- Intra-family marriages; Father with many daughters
- Work ethic
- Most challenging when father comes to US a few years after rest of family
  - widens cultural gap

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## Observations

- Cultural assimilation vs segregation vs integration
  - Older refugees often maintain their traditional ways (segregation)
  - Younger children often go native (assimilation). Often cannot even speak language of parents
  - In-between ages and some adults achieve integration.
- The larger the cultural difference between country of origin and the US, the larger and more robust the local community, the less likely US culture will be adopted.
- Refugees that integrate are more successful and self sufficient
  - higher employment rates and less depression.
- Refugees often support family still overseas

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