

Refugee Reports

A News Service of Immigration and Refugee Services of America

VOLUME 25, NUMBER 2

MARCH/APRIL 2004



Health Challenges for Refugees and Immigrants

by Ariel Burgess

This issue of Refugee Reports will focus on refugee health in the United States, beginning with Ariel Burgess's article about the general healthcare challenges facing refugees and immigrants. John Poon provides a case study of Afghan refugees trying to gain access to necessary health services, while José Quiroga, M.D., discusses the physical and mental health needs of torture victims. Several reports feature the important mental health issues facing newcomers as well as refugee-specific information about vaccinations and civil surgeons. Finally, this issue includes recent health-related updates and further resources on refugee health issues.

The growing number of immigrants and refugees in the United States presents enormous challenges to western bio-medical practice. While there are multiple challenges for every potential patient, people of foreign-born background encounter unique barriers when attempting to benefit from health care; these include difficulties in cross-cultural communication, disparate health practice beliefs, and limited cultural awareness on the part of the provider. While there is an effort to acknowledge and address linguistic and cultural barriers, learning by trial-and-error remains the most common form of education on the current American medical system.

In the absence of linguistically and culturally accessible care, refugees and immigrants may have difficulty

developing trust in, and respect for, physicians and western medicine. Without some means of communicating medical history, current needs, and personal health practices and beliefs, this population is prone to medical mistakes. Possible errors include patient-provider miscommunication, resulting in possible misdiagnosis; patients' non-compliance due to incomprehension of instructions; and patients' inappropriate usage of medical services, such as dependence on emergency room treatment. The patient can leave the visit confused, possibly misdiagnosed, and with little confidence in the care provided and the medical system in general. From this initial negative experience, feelings of alienation and mistrust continue to grow and may prevent the patient from seeking out future medical care.

Cultural sensitivity is often as crucial as competent interpretation in cross-cultural medical treatment. Providers must consider cultural factors when they:

- Take a medical history and physical exam. Cultural values inform the patients' definition of health, view of the body and its functions, and perception of problem and cause.
- Inquire about traditional treatments practiced. Alternative approaches exist in various cultures to routine matters like fever reduction, hygiene, and beautification, and a wide range of prac-

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tices and customs surround major life events like child birth and death.

- Assess care needs. This often requires the provider to view illness in a broad social context, rather than as an individual concern; differentiating between cure and treatment; sharing knowledge of health and wellness information; and involving the patients' family and community in care and medical decisions.

National Standards and Mandates

National mandates and standards have been developed to address the most immediate and necessary need of foreign-born individuals—language interpretation. The national standards of Culturally and Linguistically Appropriate Services in Health Care (CLAS) are requisite guidelines for providing health care to diverse populations. In 2000, the CLAS standards were listed in the Federal Register and are a template for large health care organizations and individual providers to reduce cultural and linguistic obstacles to treatment. Four of the fourteen standards are (unfunded) federal mandates, incorporating the Office of Civil Rights' charge for interpretation and translation of materials by any health service provider receiving federal funds. These mandates state that:

- Language-assistance services should be provided at no cost to the patient, at all points of contact, in a timely manner, and during all hours of operation;
- Verbal and written notices informing patients of their right to receive language assistance should be provided;
- Unless requested by the patient, family members or friends should not serve as interpreters; and,
- Patient-related materials and signage must be provided in the commonly encountered patient language group(s).

The remaining standards are recommended guidelines and are not mandated. They address the establishment of culturally competent care (standards 1-3) and organizational supports for cultural competence (standards 8-14). Information on the CLAS standards is

available on-line at <http://www.omhrc.gov/CLAS>.

As the CLAS standards and the Office of Civil Rights mandates are implemented, patient education becomes the missing link for quality medical care. Through federal regulations, cultural-awareness trainings, and advocacy on behalf of refugees, providers become more aware of diversity in practicing medicine. All three components—language access, cultural awareness, and education of both provider and patient—dispel myths, rumors, misunderstandings, and mistrust among the patient and the provider. Additionally, with early and continued education about the American medical model, clients are more likely to seek appropriate care and to have reduced

feelings of mistrust and alienation. In most medical settings, refugees have access to linguistic and cultural interpretation only after engagement within the medical system. In order to further reduce access barriers, accurate information must be provided before engagement. It is acknowledged that this is very difficult to accomplish without

adequate funding, resources and effort, especially when a client arrives requiring immediate medical care.

New Life, New Health Care Issues

As more refugees arrive from countries lacking sophisticated medical care, many have little, if any, prior experience with western medicine. War, conflict, and political barriers also impact a refugee's access to routine medical care. Refugees' expectations of westernized medical care may be unrealistic: while waiting to come to America, many refugees develop an idealized image of a system that will take care of all their needs, spiritual and physical. This myth is rudely dispelled when they encounter the bureaucratic maze of service fees, scheduled appointments, and insurance options that characterize medical care in the United States.

Patients must understand the system in order to express their needs and understand the reasoning behind medical procedures. After an initial health screening (which all refugees receive within 30 days of arrival) refugee clients may be referred to a health care provider for treatment. A resettlement caseworker usually accompanies refugees to these first appointments, but can rarely accompany and interpret for the client at each follow-up appointment. At this point, refugees often find them-

The patient can leave the visit confused, possibly misdiagnosed, and with little confidence in the care provided and the medical system in general.

selves trying to deal with medical problems, immersed in a complex, alien bureaucracy with no idea where to turn for explanations. At this stage, education (translated, if possible) on the following topics would help:

- Medical care in the United States: primary care, specialty care; health care enrollment; clinics, hospitals, private offices; co-pays and deductibles; the health, wellness, and prevention model
- Health benefits and eligibility: managed care; Medicaid; Medicare; disability and special needs
- Engagement with medical services: interpretation and transportation services; appointment wait time; appropriate use of the Emergency Room.

Education Models

Resettlement agency staff and other community resources, such as community providers and nursing students, can play a critical role by providing medical access information in small group settings. One model that the International Institute of St. Louis has found to be successful in conveying health, wellness, and prevention information, including healthcare access issues, is the "house party" concept. Clients are recruited to "host" a party with their friends. A nurse practitioner, with the help of an established curriculum including health-related topics, commonly facilitates. One party guest serves as interpreter. Because the setting is more personal and intimate, guests are actively engaged in the dialogue and sharing of information. Service providers also gain from the setting through direct client interaction and strengthening of the client-provider relationship.

It is ironic that advances, breakthroughs, and technological improvements often create additional barriers to patient care. As each new life-saving technique is discovered and perfected, the multifaceted medical system becomes a bit more confusing and confounding to even the average English-speaking patient. The role of service providers as the ambassadors to health care for the not-so-typical patient deserves attention and support.

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Recent Developments

Case Study: Working from Within the Culture

by John Poon

Editor's Note: For confidentiality reasons, the names of individuals in this story have been changed.

Sosan, originally from Afghanistan, came to the United States in the fall of 2000 with her son Ali after ten years in a refugee camp in Pakistan. She was 48 years old and her son was 18. She had been a single mother since the birth of her only child; Soviet soldiers abducted Sosan's husband in 1982 while she was pregnant and, to this day, she does not know her husband's fate. Although Sosan

has had to assume that he is dead, she is unable to put this devastating event behind her. When the sadness and frustration become overwhelming, she often resorts to hitting herself, a practice that is reportedly common among Afghan women.

When her husband was taken away in 1982, Sosan had been working as a schoolteacher

for two years, having graduated from college several years earlier. Despite her depression, she persevered in this work and even obtained a high-level position. Both mother and son lived in Kabul throughout the Soviet occupation and the civil wars that followed. With the rise of the Taliban in 1990, they left Afghanistan for Pakistan. In the refugee camp, Sosan was able to make use of her teaching experience by working as a health care educator.

As with all new refugee arrivals to the U.S., Sosan and Ali were faced with starting a new life in an unfamiliar country where they did not speak the language. She chose to settle in West Sacramento (in Northern California) because a cousin lived there. When the cousin moved away, Sosan and her son were left to fend for themselves. Neither knew how to drive, and their isolation grew as they maintained distance from the other Afghans in the community because of suspicions stemming from the political unrest in their home country.

Refugees' expectations of westernized medical care may be unrealistic: while waiting to come to America, many refugees develop an idealized image of a system that will take care of all their needs, spiritual and physical.

Sosan's depression and inability to concentrate made it difficult for her to learn English. Her son Ali learned the language through interactions with co-workers. However, being somewhat headstrong, he resisted enrolling in school and has not learned to read or write. Sosan is able to get by with the little English that she picked up in an ESL class available to all new arrivals. However, her inability to concentrate made progress difficult. This family unit's limited English proficiency has compromised their access to health care.

After the expiration of their refugee benefits, Sosan found a part-time job slicing meat at a sandwich shop kitchen. Ali was the primary breadwinner, but could find occasional work as a manual laborer. Illiteracy kept him in entry-level positions. Medicaid coverage for mother and son continued while Ali remained under 21 years of age.

Seeking Care

Sosan has experienced increasing levels of neck and upper back pain since shortly after her husband's disappearance. Her habit of hitting herself when experiencing extreme sadness and frustration exacerbates this condition. Her health deteriorated through vicious cycles of psychological and physical trauma.

In October 2002, Sosan was referred to a mental health clinic after seeking medical help for her neck and back pain. She was diagnosed with depression and post-traumatic stress disorder. At the time, a Farsi-speaking staff person from another unit provided the sole interpretation. Because there was no interpreter available on a consistent basis, Sosan's mental health treatment was limited to the prescription of psychotropic medication.

In the meantime, the medical clinic also referred Sosan to a specialist. In January 2003, she was diagnosed with Carpal Tunnel syndrome. Surgery was recommended and she was advised that California State Disability Insurance (SDI) would provide her with financial benefits while she recuperated. However, Sosan did not completely understand this advice, as the cousin who interpreted for her did not understand the SDI system. Sosan was fearful of undergoing surgery at the outset, and when Ali injured his back at work in March, she chose to continue working in order to ensure some income for the family. She also requested more hours on the job even though her work activity aggravated her Carpal Tunnel syndrome.

In April 2003, in anticipation of losing her Medicaid coverage when her son turned 21 in June, Sosan ap-

plied for disability Medicaid based on her mental health diagnoses of depression and PTSD. However, Sosan did not respond to follow-up letters and appointments because there was no one proficient in English and knowledgeable about the system to guide her through the disability qualification process. Her application was denied in October and her health insurance coverage ended. Sosan had fallen through a large crack in the system.

Fortunately, Najia, an interpreter, began work with the mental health clinic in August of 2003. Najia had been in this country for twelve years and understood the system because of her own earlier experience as a client. She, too, had lived in a refugee camp in Pakistan. Najia and Sosan's paths finally crossed in this country, as the two met when the former acted as an interpreter for Sosan at her quarterly medication evaluation session. Although Sosan was wary of the other Afghans in the community, she developed an instant trust in Najia, who offered her a ride back home. The two maintained regular phone contact from then on. In the course of three weeks, Najia learned of Sosan's full story and referred Sosan to the much-needed case management services.

Sosan is reportedly feeling much better these days. The SDI system was explained to her, and she is now considering having the surgery for her Carpal Tunnel syndrome. Her manager at work has assured her of a job when she recovers, and she will qualify for benefits in the meantime. As for Medicaid coverage, her long-term disability application will be re-activated and, pending the result, Sosan may become eligible for disability Medicaid. She and her son have qualified for the county's indigent health insurance program. All this has helped to alleviate Sosan's depression because she has come to realize that she is no longer on her own in her new country.

Sosan had walked to the clinic which was about 2 miles from her home; this was difficult for her because of the pain in her neck and back. What worked in this situation was that the interpreter, Najia, was operating spontaneously from "within culture." While she may have crossed professional boundaries in offering the client a ride home, she believed that it was the proper thing to do. When the refugee experience has been seared into one's soul, it is immensely difficult not to offer a ride to the one who is next.

While Sosan and Najia's paths to America seem more obviously similar to us, working from within culture can be a lesson for anyone who works with this population. The work can take root only when we come to recognize that we are all refugees.

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Torture Survivors: Unique Health & Mental Health Issues

by José Quiroga, MD & S. Megan Berthold, Ph. D., LCSW

Refugees are forced to move by events beyond their control. They escape regions or countries where genocide, civil and international war, military dictatorship, or gross violations of human rights, such as torture, have occurred. The violence not only results in the suffering of individuals but is also a form of social trauma that disrupts interpersonal relationships and is often used as a method of instilling fear in the society, to prevent dissent and further strengthen the position of those in power.

In the Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, The United Nations, in 1984, adopted the following definition of torture:

"For the purpose of this Convention, the term torture means any act by which severe pain or suffering, whether physical or mental, is intentionally inflicted on a person for such purpose as obtaining from him or a third person information or a confession, punishing him for an act he or a third person has committed, or is suspected of having committed, or intimidating or coercing him or a third person, or for any reason based on discrimination of any kind, when such pain or suffering is inflicted by, or at the instigation of, or with the consent or acquiescence of, a public official or other person acting in an official capacity. It does not include pain or suffering arising only from, inherent in, or incidental to lawful sanctions." (U.N., 1984)

The legal definition applied only to nations and restricted the definition to government-sponsored torture. The most recent worldwide survey on torture conducted by Amnesty International found that 150 (77 percent) countries among the 195 investigated practiced torture between 1997 and 2000. Half of these countries practiced systematic torture and victims died as a consequence of torture in forty percent of the countries (AI, 2000). The prevalence of torture among refugees varies in relation to the country and communities selected, but

most experts estimate between 30 and 35 percent (Gurr & Quiroga, 2001).

Medical Consequences of Torture

Torture inflicts severe psychological and physical pain on its victims. The skin and muscular-skeletal system form the first defense to blunt trauma, burns, electricity, and cuts. Skin lesions such as bruises and lacerations, and bone lesions, such as fracture, are frequently found in torture survivors. If the survivors are examined immediately after torture, these types of fresh lesions are easily observed.

The abdominal wall is the weakest part of the body. The rupture of the liver and spleen, with resulting severe internal bleeding, is often the cause of death in cases of brutal and indiscriminate physical torture. Head trauma can produce brain hemorrhage resulting in traumatic stroke, and also brain edema and dementia. Natural orifices such as the vagina and rectum are frequently the targets of sexual assault. Rape and sodomy with a foreign object are also frequent. Given the widespread epidemic of HIV and AIDS, torture survivors who are raped are increasingly at risk of contracting the HIV virus.

If the survivors are examined weeks, months, or years after torture, 30 percent do not have physical evidence of their torture. Most of the survivors have some evidence, however, such as skin scars, orthopedic or neurological deficits, or evidence of a bone fracture. The most important chronic medical sequela in torture survivors is pain, mostly headaches, and/or muscular-skeletal, chest and abdominal pain. Survivors also frequently complain of palpitations and anxiety.

Psychological Consequences of Torture

The uncertainty about their future, the stress of adjusting to a new society, numerous losses, and the focus on their traumatic past may contribute to feelings of low self-esteem, hopelessness, and depression among refugee torture survivors. In addition to depression, torture survivors have high rates of post-traumatic stress disorder (PTSD) and other anxiety conditions, as well as other conditions also found in traumatized refugees. Some experience panic attacks or dissociative episodes. Others turn to alcohol and other substances to cope with their symptoms.

Torture survivors often have significantly greater rates of symptomatology than other groups of traumatized individuals. A study of Turkish torture survivors, for example, reported a PTSD prevalence rate of 85

percent (Paker et al., 1992). A recent analysis of clients at the Program for Torture Victims in Los Angeles, California, revealed a similar prevalence rate of 88 percent. By contrast, studies of U.S. Vietnam War veterans found a PTSD prevalence rate of 30-38% (Reeler, 1995). The prevalence in the U.S. population between ages 18 and 54 suffering these disorders in any one-year period is 5.3% for Major Depressive Disorder and 3.6% for PTSD (APA, 1994). In a study of children and adolescents in the former Yugoslavia exposed to war-related traumas, those who had been tortured had the most severe PTSD and comorbid depression (UNICEF, 1995, as cited in Pynoos et al., 2001).

It is common for torture survivors and other refugees who suffer from PTSD to experience a chronic fluctuating course of their symptoms over time. For example, long lasting post-traumatic stress reactions spanning many years were found in longitudinal studies of Cambodian child survivors of the Khmer Rouge regime (Kinzie et al., 1989; Sabin, et al., 1996). Individuals who may have been in partial or full remission can go through periods of exacerbation or re-emergence of their symptoms in the face of new traumas or stresses, or when exposed to things that remind them of their trauma many years after the original trauma. Those survivors whose relatives are killed, tortured, or threatened due to their connection with them often experience intense self-blame and complicated grief as a result.

While some torture survivors arrive in the United States as refugees, the majority are asylum seekers who lack legal status, do not have any form of health insurance, are unemployed (without income or assets), without legal authorization to work, and fall below the U.S. poverty level.

Medical Needs of Torture Survivors

Torture survivors need comprehensive medical evaluations and care, including trauma and medical history, complete medical examinations, and a work-up of the medical problems found. Laboratory tests, x-rays and other procedures may be indicated for diagnostic purposes. In addition, consultation with specialists and follow-up of chronic medical conditions are often needed, such as when the survivor does not have other alternatives for medical care. Some may need optometry examination and glasses.

Women who have been raped need a complete gynecological examination, preferably done by a female physician (depending on cultural considerations). This examination includes a pap smear, cervical culture, syphilis, and HIV testing. In addition, a breast examination and mammogram may also be needed. They also frequently need access to free medications.

Forensic medical evaluations are recommended for torture survivors requesting political asylum, along with the preparation of medical affidavits and expert medical testimony in immigration court depending on the findings.

Psychological Needs of Torture Survivors

Survivors of torture frequently have multiple psychological needs that go beyond the scope of this article. Some of the most prominent needs include: reconnection to a sense of meaning and purpose in life, a focus on working through the significant losses and trauma they have experienced, and establishing a sense of safety.

Torture survivors often do not have legal status in the new country, and frequently must apply for asylum if they wish to remain. The asylum process can be intensely re-traumatizing for those subjected to torture. One of

the hallmarks of PTSD is the attempt to avoid thinking, talking or writing about one's traumatic experiences. The mere act of filling out an asylum application requires an individual to recall and write in detail about their experiences of persecution. When these experiences include sexual torture, they are required to reveal details about experiences that are considered deeply shameful.

Clinicians working with asylum seekers can play a valuable role in preparing them psychologically to fill out their asylum application, and in testifying in their asylum interview or in immigration court. In addition, forensic psychological evaluations and expert psychological testimony in immigration court are frequently needed. Obtaining asylum goes a long way toward establishing a foundation of safety and security that facilitates the healing process.

Medical Approach to Rehabilitation of Torture Victims

The objective of a medical program for refugees in general, and torture survivors in particular, is to assure that their health status is compatible with their achievement of self-sufficiency.

It can be very helpful to collaborate with a cultural consultant or indigenous healer, while empowering the survivor as the expert

In our experience, 30-40 percent of torture survivors have significant medical problems that require medical work-up and treatment that they cannot afford. Additionally, 40-70 percent of torture survivors require psychiatric medications because of significant PTSD or depression symptoms, and 3-5 percent are so sick that they require inpatient care. Seventy percent need a forensic medical evaluation. Collaboration and linkage with local free medical clinics, and recruitment of physicians to provide pro-bono medical services can facilitate the provision of appropriate medical services to survivors, particularly if specialized training and consultation is provided to these practitioners.

Psychological Approach to the Rehabilitation of Torture Victims

It should not be assumed that a Western approach to treatment will work with torture survivors from other cultures, particularly given that more than 90 percent are not familiar with Western psychotherapeutic concepts (Elsass, 1997). Indeed, they may have never heard of a therapist before; similar professionals may not exist in their homeland, or it may be considered highly stigmatizing to seek professional psychiatric help. Furthermore, it may be considered taboo or shameful to discuss one's problems with someone who is outside the family, or who is not a respected elder or spiritual leader, particularly when the problems involve sensitive issues such as sexual torture.

Maintaining confidentiality and providing a context of safety and trust are essential for any effective therapeutic work with torture survivors, and care must be taken to avoid or minimize re-traumatizing them. It is essential that one adapt one's approach to be culturally attuned and appropriate, while challenging one's own prejudices, assumptions, and attitudes. It is important to be familiar with the traditional approaches to healing in the culture of the survivor, as well as assessing to what extent he/she believes in these approaches. It can be very helpful to collaborate with a cultural consultant or indigenous healer, while empowering the survivor as the expert. Practitioners typically increase their effectiveness when they seek to understand the worldview and system of meaning

of the person, and their explanation for their distress. Otherwise, they may not engender the trust of their client.

Helping survivors develop or plan meaningful rites, rituals, and prayers in keeping with their spiritual beliefs in the absence of their traditional support systems may facilitate the grieving process. Involving others in this process may be healing for those from communal cultures or cultures where the healing process is public. Culturally competent community-based interventions and efforts to build and sustain capacity in traumatized refugee communities can be very beneficial, such as those developed by the Transcultural Psychosocial Organization (TPO) in 15 countries in Africa, Asia, and Europe (Eisenbruch, de Jong, & van de Put, 2004).

Practitioners are encouraged to work to restore social connections that may have been lost when the survivor left their country, as well as restore agency and meaning to the survivor's life. An overall approach that focuses on "undoing" the trauma (Deutsch, 2003), including counteracting the messages of the perpetrator or torturer, validating the client's experience and reality, and acknowledging their courage, achievements, strengths and resilience is suggested.

An interdisciplinary approach to working with torture survivors, involving a wide range of primary care medical, psychiatric, psychological interventions, as well as case management interventions to reduce other stressors and address their basic needs is recommended. The approach should be tailored to the particular survivor. A variety of therapeutic approaches have been employed with torture survivors, often in combination, including in part: cognitive-behavioral therapy, existential therapy, psychoeducation, developmental

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psychodynamic psychotherapy, physical rehabilitation, psychotropic medication, educational assistance, family therapy, supportive group therapy including peer-support and socialization opportunities, giving testimony, art therapy, music therapy, writing, story telling, sand-play therapy, drama, dance, the use of rituals, and other creative approaches. The effectiveness of these different treatment approaches need further study (Jaranson, et al., 2001).

Overall, clinicians must be well grounded in the principles of cross-cultural interventions and in trauma theory, and remain creative and flexible in their use of therapeutic interventions. Ultimately, the therapeutic services need to be tailored to the particular survivor and safeguards must be installed to ensure that no harm is done. For example, respecting a survivor's own pace in addressing their torture is highly recommended, as cultural and individual differences have been found in traumatized refugees' need to directly focus on and work through their traumas. Compared to Indo-Chinese refugees, those from South America were found to be more receptive to recounting their trauma histories (Morris & Silove, 1992).

A long-term approach to treatment with severely traumatized refugees is recommended (Boehnlein & Kinzie, 1996; Jaranson et al., 2001). Kinzie stresses that the key therapeutic ingredient is the relationship between the client and the clinician that develops over time. A long-term approach may be particularly relevant for torture survivors who frequently have had their trust in others shattered, and may experience recurrent or chronic episodes of psychological distress.

Survivors of torture experienced a severe form of human-perpetrated trauma that may destroy their belief in the larger social contract. In many countries, impunity is rampant in situations of state-sponsored torture. Societal and legal interventions aimed at fighting impunity can be helpful for those who may struggle with issues of human accountability (Clark, Pynoos, & Goebel, 1996).

While working with survivors of torture can be challenging, such work can be enormously meaningful as well, and can contribute to the larger human rights effort against state-sponsored torture.

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Field Notes

Highlighting Recent Arrival Health Issues: Liberians, Hmong, Somali Bantu

Health Issues of Liberians

The Office of Global Health Affairs of the National Institutes of Health has prepared a background report on potential health issues for Liberian Refugees. This report is summarized here, but the full report is available at <http://www.globalhealth.gov>.

With little access to health services for over a decade, Liberia's Disability Adjusted Life Expectancy (DALE) has dropped to 34 years. Given their limited access to health care, it is important to note that the immunization rate for this population is likely to be very low.

Liberians make a distinction between the physical basis of illness (i.e. bacterial infection, virus, etc.) and the "reason" they have the illness. Many Liberians, as well as many other Africans, believe that illnesses are the result of being cursed, targeted by evil spirits, sorcery, or taboo violation. In many cases, Western forms of treatment will be combined with indigenous cures. Typical traditional treatments for illnesses can include the ingestion or topical application of herbal remedies, scarification or application of chalk and paint over symptomatic areas, and tying the wrists, neck or abdomen with ropes. It is recommended that physicians be sensitive to this practice and ask the patient or family members what other forms of treatment they are receiving in order to determine if they might be dangerous or counteractive with their treatment plan.

Special health issues for Liberians include:

- Sickle cell anemia
- Chronic conditions such as severe hypertension and diabetes
- Amputations
- Malnutrition, including chronic malnutrition, and micronutrient deficiency
- Infectious diseases such as chickenpox, dengue fever, hepatitis (A,B,C,D)
- HIV/AIDS
- Malaria

- Measles
- Shigellosis or bacillary dysentery
- Syphilis
- Trachoma
- Tuberculosis
- Typhoid or paratyphoid fever
- Yellow fever
- Parasites such as ascariasis, enterobiasis or pinworm infection, filariasis, giardia, guinea worm, leishmaniasis, schistosoma, strongyloidiasis, trichuriasis
- Oral health care
- Reproductive health as related to pregnancy, female genital cutting
- Mental health

The report highlights the link between migration, resettlement, and health burdens in the following ways:

- Pre-migration: exposure to infectious & parasitic diseases, physical & psychological trauma
- During flight & refugee camps: malnutrition, exposure to the elements, exposure to infectious & parasitic diseases, physical & psychological trauma
- Post-migration/Resettlement: increasing susceptibility to chronic diseases, problems & stressors of resettlement (racism, unemployment, ESL, crime, etc.)

Health Issues of Hmong

In December 2003, the United States announced plans to resettle up to 15,000 Hmong refugees from Laos registered with the Government of Thailand and living in a self-constructed village in Wat Tham Krabok, a Buddhist temple 90 miles northeast of Bangkok. To help the St. Paul, Minnesota, community prepare for this influx of refugees, St. Paul Mayor Randy Kelly led a delegation of city, county, and community experts on a visit to the Wat. The delegation -- which included representatives of a local hospital, the school system, resettlement agencies, and a number of Hmong Americans -- spent March 3-11, 2004, in the village. The delegation's report is available on the website of the Minnesota Council of Nonprofits at <http://www.mncn.org/hmongbriefing.htm>.

The assessment team noted that many of the Hmong, particularly those with financial resources from work in Thailand or from relatives abroad, have had access to the Thai medical system and understand the medical model. However, malnutrition may well have put the children at risk for developmental delays that will need to be examined upon arrival in the United States. Chronic illness, disabilities, maternal and child health, and mental health are the primary concerns noted by the delegation, which suggested the medical community in the Twin Cities collaborate to standardize protocols and recalibrate practices for the medical and mental health screening of new arrivals.

To meet the health needs of these newly arrived refugees, the delegation recommended:

- The medical community makes conscious efforts to establish trust with the new refugees to counter some mistrust of previous medical care available to them.
- Professionals acknowledge the high incidence of depression and anxiety in this group (much of which is situational and attributable to the Hmong life situation, physical health issues, as well as the powerlessness they feel over whether they will be allowed to resettle to the United States).
- Practitioners understand that after an initial sense of hopefulness and euphoria over the opportunity to resettle in the United States, it is normal for the reality of how difficult this transition is to erode the refugees' morale. Connecting and maintaining communication with new arrivals will be important to combating isolation and promoting successful adjustment.



Photo Credit: USCR/M. Emery

- Resettlement agencies ensure that they are prepared to provide physical and mental health screening for all new arrivals in a timely manner. The medical community should collaborate on establishing best practices in physical and mental health screening, and these recommendations should be shared widely. Innovative social adjustment programs should be supported, particularly those which deal with mental health issues, maternal and child health issues, and disabled populations.
- Medical communities prepare for an influx of refugees with chronic illness and disability, including children with birth defects, the hearing-impaired, elderly with war wounds, and chronic illness such as diabetes and hypertension. Maternal and child health issues are expected to be significant, with a high incidence of teenage marriage and pregnancy. Tuberculosis will likely be the major infectious disease requiring follow-up, but detailed data from the International Organization for Migration (IOM) and Centers for Disease Control (CDC) screening is not yet available. Immunization coverage, particularly for younger patients, may be more complete than for previous refugee groups, but adequate records may be lacking, and adults may have inadequate vaccination coverage. New arrival screening protocols should consider including serologic screening for common vaccine preventable illnesses. Mental health issues may be very significant, with a high incidence of major depression, PTSD, anxiety, and suicidal ideation.

This delegation also recommends that immediate action be taken in the camp as follows:

- Hmong-American public health and mental health professionals should be immediately placed in the camp to work with the refugees. The assessment team is concerned about the high degree of major depression, PTSD, and severe anxiety seen in their surveys. Specifically, they are concerned with the potential for suicide being unusually high in the village. These professionals could help refugees cope with the severe stress exacerbated by the U.S. resettlement processing and the deep concerns people are feeling over the potential rupture

of families resulting from resettlement. They know from experience that information in the Hmong language is able to alleviate the situational stress causing at least some of the current depression and anxiety.

- The communities should immediately establish a public health and primary care infrastructure at Wat Tham Krabok that provides free care. This is best accomplished through the use of international or non-governmental organizations, many of which have been working with the Hmong in Thailand for decades. The sick are not going to the existing camp clinic or Thai hospital because of a lack of money and a lack of trust in the care provided there. The team is particularly concerned that patients with tuberculosis are not receiving true directly observed therapy. People are suffering unnecessary death and disability because of the lack of access to health care. Establishing a system now that provides adequate free care is the ethical thing to do, will result in less immediate morbidity, and will result in fewer people coming to the United States with poorly controlled medical problems.

The Hmong Health Information Project, <http://www.hmonghealth.org>, has created a listserv to discuss issues related to Hmong health. The list includes announcements of educational programs related to Hmong health; information related to the health status of the Hmong people; updates to the Hmong Health website; announcements of books and audiovisual resources related to Hmong health; and questions and discussion related to Hmong health promotion and education. To subscribe, email hmonghealth@uic.edu.

Health Issues of Somali Bantu

The Office of Global Health Affairs of the National Institutes of Health reports that past experiences with refugees coming from the Kakuma camp in Kenya indicate a risk of undiagnosed health conditions and problems upon resettlement in the United States. Reports from the State Department and from organizations working with the Somali Bantu in Kakuma indicate that, in general, the Somali Bantu have lower levels of health than others in the camp, primarily due to lower nutritional levels. Nutritional surveys have found that the Somali Bantu have slightly higher levels of acute malnutrition

than other groups in this camp. This, in turn, may cause a number of other illnesses as outlined in the document of the Office of Global Health, available online at <http://www.globalhealth.gov>.

IOM Migrant Health Services examined a total of 7,244 Somali Bantus, ranging in age from 0 to 73. The following medical conditions were found:

- Hypertension: The IOM medical staff noted that the rate of hypertension is very high, especially above the age of 45 (30.5 per cent). Among the 35-44 age range it was around 12.7 percent.
- HIV: The rate of HIV is 0.1 percent (or only 7 cases) out of the total number examined. This test was done for all refugees above the age of 15, except in cases whereby the parents are found to be positive. Then tests are done on the whole family. The prevalence rate is about 0.2 percent among the 15-34 year old range.
- Syphilis: This rate is 1.1 percent among the same age group (15-34) and above 2 percent for those aged 35 and above.
- Tuberculosis: There is a definite correlation between HIV and TB. The rate is 2 percent among the same group age (15-24), and from 25-34 it is up to 5.8 per cent. Overall TB rate is 2.5 per cent across all age groups.
- Malnutrition: For children under the age of 4, it is 19.3 percent.
- Umbilical Hernia: 8.4 per cent found in children under 4 years of age.

The positive news is that 85.5 per cent were determined to be in good health and have no apparent diseases, defects or disabilities.

The Global Health Report lists the special health issues for Somali Bantus as follows:

- Malnutrition including acute or severe malnutrition, chronic malnutrition, micronutrient deficiency
- Infectious diseases such as dengue fever, hepatitis, Hepatitis (A,B,C, D)
- HIV/AIDS
- Malaria
- Measles
- Shigellosis or bacillary dysentery
- Syphilis
- Trachoma
- Tuberculosis

- Typhoid and paratyphoid fever
- Parasites such as ascariasis, blastocystic hominis, dog tapeworm, enterobiasis or pinworm infection, filariasis, giardia, guinea worm, leishmaniasis, schistosoma, strongyloidiasis, tichuriasis
- Oral health care
- Mental health (see below)

There are cultural issues that need to be addressed with the Somali Bantu as well. Many believe that some illnesses are the result of being cursed or targeted by evil spirits and, therefore, do not seek medical attention, but go to a traditional healer who performs ceremonies and rituals to remove the curse or cast out the spirit. Beyond rituals, traditional treatments for illnesses often include burning, cutting or lacerations. This includes applying hot metal nails to the forehead, chest, face and other body parts. It is also common that the milk teeth of infants are pulled to heal diarrhea during teething.

The Somali Bantu have a very high fertility rate that affects the health of the mother and children. Fre-



Photo Credit: K. Bahry

quent pregnancies affect the mother's nutritional status, leaving them more susceptible to disease. Due to the mother's low nutritional status during pregnancy, infants have an increased risk of low birth weights. Few of the Somali Bantu have been exposed to modern birth control methods and teen pregnancy is common.

The Somali Bantu practice female genital cutting; they are aware that it is an illegal practice in the United States and there is some evidence that they are having the procedure preformed on their daughters prior to their departure as they cannot be punished *ex post facto*. Those who recently had the procedure preformed are at risk for infection due to poor sanitary conditions.

As with many other refugee populations, the Somali Bantu have a substantial mental health burden secondary to their pre-migration experience, migratory experience, life in refugee camps, and subsequent resettlement. Resettlement mental health concerns can be linked to their history of slavery and, after slavery, marginalization within Somalia. These experiences may have significant negative effects on their sense of worth and general self-esteem. It has also been reported that many Bantu witnessed friends and relatives being killed in bandit attacks. The report suggests that resettlement professional and health care providers should understand the following:

- The Bantu struggle with after-effects of violence and psychological and physical trauma;
- The intergenerational culture of inferiority and second class status;
- Their complex historical, cultural, religious and political backgrounds;
- Their high risk factors for anxiety-related disorders and depressions;
- Potential contentious relations between Bantu and the Somali population in the U.S.;
- The general prevalence of certain psychiatric disorders in the U.S.;
- The Bantu psychological and spiritual assets that should be identified and strengthened;
- Their traditional explanations for mental health problems and traditional systems for mental health interventions.

Social Adjustment and Mental Health of Refugees

Refugees are among the United States' strongest, most courageous, and most resilient residents. They have suffered losses beyond the imagination of most Americans and have overcome challenges and boundaries that are not often in our daily perception. By the time they arrive on our shores to meet an entirely new set of challenges, they have already lost homes and loved ones, their sense of safety and, often, their self-esteem. Their identities change in a new country; they may have had professional careers in their former countries while, in their new homeland, they may need to take entry-level jobs in order to support themselves. All aspects of their new lives may seem strange to them and the adjustment process takes considerable time—time in which they are trying to rebuild their lives, settle into new communities, and find employment in order to support themselves and their families and even to pay back the loans they received for their airfares to the United States. And many arrive without the ability to speak English even though they may speak several other languages.

Agencies across the country are working hard to serve their refugee clients – to find them suitable housing and furnishings, to help them with employment, ESL classes, getting their children into schools, teaching them about their benefits, and helping them integrate into the community in which they live. This is, indeed, a fulltime and sometimes overwhelming job.

With the ratification of the Torture Victims Relief Act of 1998 (PL. 105-320), signed into law in October 1998, the U.S. Congress enacted the "Torture Victims Relief Reauthorization Act of 1999" initially allocating 7.5 million dollars to funding torture treatment centers throughout the country, followed by an allocation of 10 million dollars for the fiscal year 2001 and 2002. While this sum is widely regarded by experts as inadequate to address the challenges of the torture survivors in the United States, it is a step in the right direction. In 2001, the National Consortium of Torture Treatment Programs (NCTTP) was incorporated to advance the knowledge, technical capacities and resources devoted to care of survivors of torture and to act collectively for the purpose of preventing torture worldwide. As of April 2004, there were over 35 member organizations in 21 states. By defi-

dition, these torture treatment centers serve a specific group of clients who meet the criteria of torture victims. Their staffs are trained and prepared to work with these clients in providing for the recovery of those who have suffered in their pursuit of democracy and basic human rights.

There are refugees who purposely face the challenges of resettlement in this country as they move ahead towards education, employment, and adjustment into their new communities. There are many factors entering into this adjustment such as the degree of their trauma prior to arrival in the United States, their support system once they arrive, and their general personality and approach when facing adversity. These are the lucky ones.

It should not be overlooked, however, that there are many individuals and families that fall between these two groups: those who were not tortured by the criteria of the United Nations definition but, still, have experienced trauma without psychological support and whose recovery needs more time and help, thereby making it more difficult to face the new challenges of life in their adopted country. The support that these individuals receive in the United States can make the difference between integration and alienation/marginalization. The signs aren't always evident when a refugee first arrives on our shores. He/she often feels excitement, relief, enthusiasm, a sense of safety, and fascination mixed with some bewilderment and confusion. As reality sets in, he/she becomes more aware of challenges and may feel some disappointment at unmet expectations, anger and fear mixed with a preoccupation with losses and memories of traumatic events. Confusion and frustration and feelings of being overwhelmed may occur at this stage. It is during this time that individuals may move in different directions, depending on their individual personalities, family stability, physical and psychological health and the degree of support available.

One path is for the individual(s) to take initiative and move ahead with ESL classes, training, jobs, etc. and to develop a support network with a determination to succeed. New roles and identities are developed as they begin to accept losses and to heal from their past trauma. This path leads to good psychological and social adjustment, self-sufficiency and self-confidence, well-

defined roles and identity, sense of power and control, language competence, and a well-functioning family and social support system.

Other individuals may take another path, one of alienation as they withdraw and become more isolated and apathetic as they lament the loss of former roles and experience more despair and sadness. Their physical and mental health may suffer at this stage. The result of this path often results in a lack of independence, unemployment, legal involvement, family dysfunction and disintegration, and a minimal social support system.

Taking the latter path does not mean that the individual is mentally ill but, rather, is having difficulty dealing with the challenges that have and are facing him/her and needs some additional assistance. Mental illnesses are disorders of the brain that disrupt a person's thinking, feeling, moods, and ability to relate to others. Just as diabetes is a disorder of the pancreas, mental illnesses are disorders of the brain that often result in a diminished capacity for coping with the ordinary demands of life. If one shows signs of mental illness, he/she should be referred to a culturally sensitive psychiatrist who could, preferably, provide a combination of pharmaceutical treatment and talking therapy.

There are refugee programs in the United States that provide a broad continuum of mental health services to clients, including psychosocial assessments, advocacy, home visits, case management, counseling, psychopharmacology, and asylum evaluations. There are many agencies that encourage all of their staff to consider social adjustment issues from intake throughout the refugee experience with the given agency. Often ESL teachers or employment counselors are in a good position to observe clients over a longer period of time and to note difficulties that may arise which would benefit from additional social services and counseling. The expressive arts can also provide significant healing, especially if they relate to the culture of the refugees involved. Many agencies talk to refugees about the paths they may find themselves on and the emotional difficulties that they may face as time goes by. There is, unfortunately, a stigma to mental health issues and refugees should be approached very carefully on this subject. They may say that they are feeling particularly anxious or that their hearts beat very

There are refugees who purposely face the challenges of resettlement in this country as they move ahead towards education, employment, and adjustment into their new communities.

rapidly; they may talk about nightmares and thoughts of suicide; they may exhibit domestic violence or substance abuse. If social adjustment and mental health issues can be incorporated into the thinking of all individuals working with refugees, all will be better served.

It is important to remember that self-care of refugee workers is another issue that should be recognized and honored. Hearing stories of horror experienced by others can bring trauma to the listener...which can be intensified over time until the individual helping the refugee also needs help him/herself.

Steps can be taken to alleviate the suffering of refugees and to help them on the path of integration into our communities. Such steps can prevent more serious problems that may arise as time goes by – traditionally between six months and two years after arrival. Meeting the mental health needs of the American population is a challenge in itself: the Interim Report from the President's New Freedom Commission on Mental Health calls for "dramatic reform" to address major barriers including fragmented service delivery, lack of support programs, and failure to provide effective services for children and older adults.

The Commission further highlights the importance of intervening early to prevent mental health problems, its recognition of the important role that schools can play in provision of mental health services, and its acknowledgement of the need to expand model wraparound-services to children who are at risk of more serious problems if their needs are not recognized and treated. Any steps taken for prevention of mental health problems in refugees will be rewarded many times over by their adjustment and success in their newly adopted communities. For further information and resources, go to: http://www.refugeesusa.org/who/prog_info_sp.cfm.

BCIS Designated Civil Surgeons

"Civil Surgeons" are physicians designed by the Bureau of Citizenship and Immigration Services (BCIS) to provide medical examinations and vaccinations for individuals seeking to change their status from that of refugee, asylee, or non-immigrant status to permanent status. According to the BCIS, Civil Surgeons receive special and on-going immigration oriented medical training and policy updates and a medical examination performed by a doctor NOT approved by BCIS will not

be recognized. The payment of fees of medical exams and vaccinations administered by Civil Surgeons are not covered by insurance and must be paid in cash by the person seeking these services.

Doctors interested in being registered as Designated Civil Surgeons should submit the following information to the BCIS office in their district (there are 33 Immigration District Offices in the U.S., each of which covers part of a state or territory, an entire state, or many states):

- A letter to the District Director requesting consideration
- A copy of a current medical license
- A current resume that shows 4 years of professional experience, not including a residency program
- Proof of citizenship
- Two signature cards showing name typed and signature below

The vaccination requirements for refugees, asylees, immigrants, people with non-immigrant visas and individuals seeking change of status are determined by Section 341 of the Illegal Immigration Reform Act of 1996. This Act requires that all persons seeking to adjust their residence to permanent status in the United States and those who apply for immigrant visas to enter the United States after September 30, 1996 must receive vaccinations for specific diseases. Immigrants are required to have all the vaccinations specified in the reform act. The absence of such vaccinations constitutes grounds for the denial of admittance to the United States. A designated civil surgeon must administer the necessary vaccinations to satisfy the requirements of this Act.

People who enter the United States as immigrants (permanent status) or with refugee status are required to have a medical exam/screening before entering the United States. People who enter the United States on temporary visas (students, business, travel or asylees) are not required to have the medical examination before entering the United States. Refugees or persons with temporary status who wish to "change their status" to permanent/immigrant status must undergo the medical screening mandated by DQ. This screening must be done by a Designated Civil Surgeon (one of three thousand in the United States). These regulations mandate that refugees must undergo TWO medical examinations: 1) overseas in order to enter the United States 2) domestically when they seek to change their status. They are

Fact Sheet: Required Vaccinations for Refugees, Asylees, Immigrants, People with Non-Immigrant Visas and Those Seeking Change of Status

Legislation

The vaccination requirements for refugees, asylees, immigrants, people with non-immigrant visas and individuals seeking change of status are determined by Section 341 of the Illegal Immigration Reform Act of 1996. This Act requires that all persons seeking to adjust their residence to permanent status in the United States and those who apply for immigrant visas to enter the United States after September 30, 1996 must receive vaccinations for specific diseases. The diseases required for vaccination are: mumps, measles, rubella, polio, tetanus, diphtheria toxoids, pertussis, influenza type B, hepatitis B, and any other diseases recommended by the CDC. Current ACIP recommendations are varicella, haemophilus influenzae type B, and pneumococcal vaccines.

Refugees

Refugees are not required to have the vaccinations specified in the Reform Act of 1996. However, if refugees apply for permanent status after one year in the United States then they are subject to the vaccination requirements in the Reform Act. Designated civil surgeons administer the vaccinations necessary to fulfill the requirement.

Asylees

Asylees are not required to have the vaccinations specified in the Reform Act of 1996. However, asylees who apply for permanent status after one year of residence in the United States are subject to the vaccination requirements in the Reform Act. A designated civil surgeon must administer the necessary vaccinations to satisfy the requirements of this Act. Unlike refugees, asylees must undergo intensive medical examination if they wish to apply for permanent status in the United States due to the absence of a medical screening before their admittance to the U.S.

Immigrants

Immigrants are required to have all the vaccinations specified in the reform act. The absence of such vaccinations constitutes grounds for the denial of admittance to the United States.

Non-immigrant visas (students, business, travelers)

People entering the U.S. with non-immigrant (temporary) visas are not subject to the vaccinations specified in the Act. However, if they desire to change their status to permanent they would be subject to the requirements of the Act.

Exceptions

While people falling under the refugee, asylee, or non-immigrant status are not subject to the requirements of the act because of their entry status, they may still be subject to vaccination requirements because of their school attendance or organizational affiliation. Schools, places of employment, or other organizational structures may require their students, employees, or affiliates to have certain vaccinations. Refugees, asylees, and non-immigrants who seek to partake in an institutional affiliation with such vaccination requirements are not exempt because of their status.

People Seeking Change of Status

People seeking to change their status from refugee, asylee, or non-immigrant status to permanent status are subject to the requirements of the reform act. Civil surgeons administer the vaccinations in preparation for change in status. In order to locate a civil surgeon in your area call BCIS National Customer Service Center at: 1-800-375-5283. Choose #2 (Medical Examination) when given a list of options, and be prepared to provide your zip code. More information is available at <http://www.bcis.gov>.

Special Note: As of April 2004, immunizations are given prior to departure for those refugees processed through Accra, Nairobi, and Bangkok. In time, this will be the common practice for all refugees. Resettlement agencies should make note of the immunization cards so that these vaccinations will not be duplicated when they arrive in the United States.

the only “status” group that must undergo two exams. In some instances, people entering the United States with temporary visas may be subject to medical exams “at the discretion of the consular officer overseas or immigration officer at the U.S. port of entry, if there is reason to suspect that an inadmissible health-related condition exists.”

The purpose of the medical examination is to identify, for the DOS and BCIS, applicants with inadmissible health-related conditions. The Division of Global Migration and Quarantine is responsible for determining which health conditions are inadmissible and hence the guidelines for the medical exams. These guidelines are given to the Department of State and the Bureau of Citizenship and Immigration Services which then supervise their implementation by civil surgeons and panel physicians (these are the physicians who do medical screenings internationally). The health-related grounds for the denial of admittance or change of status in the United States include those aliens who have a communicable disease of public health significance, who fail to present documentation of having received vaccination against vaccine-preventable diseases, who have or have had a physical or mental disorder with associated harmful behavior, and who are drug abusers or addicts. In some instances waivers may be issued that will allow people to enter the United States or change their status in the United States who have “inadmissible” conditions. For further information, contact: <http://www.cdc.gov/ncidod/dq/health.htm>.

Updates

• **Buffalo’s “Refugee Health and Cultural Awareness Training Program:”** a program where everyone wins. Medical students and residents rarely have the opportunity to learn about the experiences of refugees and immigrants before meeting them in the emergency room of a hospital. Thanks to a grant from the New York State Department of Health, the University of Buffalo (New York) School of Medicine and Biomedical Sciences, the Jericho Road Family Practice, the Kaleida Health’s Columbus Health Center, the International Institute of Buffalo, and Journey’s End Resettlement Services have implemented a highly successful program whereby students medically evaluate refugees in a very unique atmosphere.

This innovative educational program is aimed at increasing the cultural competency of students while improving access to preventive and primary care services for refugees. Physicians, students, refugees, interpreters, and resettlement experts meet in a concentrated cultural-immersion experience at evening clinical sessions that serve only refugee patients; to date, the refugees have come from Rwanda, Sudan, Somalia, Ethiopia, Congo, Kosovo, Bosnia, Cuba, as well as a number of Asian countries. Prior to seeing the refugees, the students attend an orientation discussion presented by the staff of one of the resettlement agencies, a cultural/medical anthropologist, a physician, and a case worker from either the International Institute of Buffalo or Journey’s End who is informed about the medical, psychosocial, financial, cultural, gender and legal issues of the refugees to be seen. They are briefed on what type of psychosocial problems the refugees might present with, such as traumatic stressors such as torture, mutilation, religious persecution, murder of family members, or loss of home and possessions. They also learn about the medical problems common to the refugees’ homeland. There is also instruction about the issues of translation and how it will be handled. Advice is shared as to the most culturally appropriate way of working with the refugees to encourage an open sharing of information and knowledge.

After the orientation, students spend several hours in clinic where they practice their interviewing and listening skills. Afterwards, they meet with the refugees, interpreters, resettlement experts, and others where they take the medical and experiential histories and conduct physical examinations. The students are taught how to review the patient’s story and objective findings and to make an assessment and plan for the patient’s continuing medical and psychosocial care, which may include referral to health care centers collaborating with the program. At the close of the clinic session, the students re-group for a debriefing session conducted in a focus-group format. The students talk about all aspects of their clinical sessions as well as their own emotions brought forth and the cultural lessons learned during this process. The data is recorded and qualitatively analyzed by the program’s medical/cultural anthropologist. *For further information, contact: May Shogan at the International Institute of Buffalo at MShogan@IIBuff.org.*

• **Since the inception of the Office of Refugee Resettlement’s national initiative to assist with the placement of**

HIV+ refugees, over 700 HIV positive refugees and their accompanying family members from Africa, Southeast Asia, Columbia, Europe, and the Former Soviet Union have resettled in the U.S. Although there was a decline in the number of HIV+ refugee arrivals in FY 2002 & 2003, in FY 2004 as the overall number of refugee arrivals increases, it is expected that more HIV+ clients will arrive this year than the last two years combined. Unfortunately due to the decrease in funding of the ORR HIV medical case management program, local resettlement agencies with little or no experience serving refugees living with HIV/AIDS will now be expected to handle these medical cases.

Obviously, serving special medical clients presents challenges to refugee resettlement agencies; however, challenges should not be seen as obstacles that cannot be overcome. According to the U.S. Office of Global Health Affairs commissioned report, "Assessment of Care for HIV positive Refugee Family Reunification Cases," some resettlement agencies have implemented HIV case management services that have facilitated refugee clients' access to medical care and a wide range of HIV related services. Resettlement agencies were able to implement effective services because of their organizational preparation and collaboration with AIDS service organizations. How agencies should prepare to receive these cases is important.

Organizational capacity to serve refugees with HIV should begin with an assessment of agency staff's knowledge and understanding of AIDS issues. Agencies should provide training for staff, board of directors and/or volunteers on a wide range of AIDS issues including AIDS prevention, confidentiality, privacy, and identifying local AIDS resources. In preparing for the resettlement of HIV positive refugees, all refugee agencies should develop linkages with local AIDS service organizations to assist in the resettlement process. AIDS service organizations can provide primary medical care, case management, prevention education and other support services such as dental services, housing services and medications.

IRSA provides technical assistance to help local resettlement agencies create partnerships with AIDS organizations and enhance organizational capacity to provide services for HIV positive refugees. Any local or national refugee voluntary agencies or AIDS service provider may request assistance for the following services: Referral and identification of local AIDS services resources and informational resources, including treat-

ment guidelines and bilingual AIDS prevention materials for clients. *For more information about the IRSA HIV Technical Assistance Program, contact, IRSA at 202-797-2105 or brochelle@irsa-uscr.org.*

- **Undocumented Alien Emergency Medical Assistance Amendments of 2004 Defeated.** The Congressional bill (HR 3722) introduced by Congressman Rohrabacher (R-CA) as an amendment to section 1011 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 was defeated by a vote of 331 to 88. This bill proposed that hospitals be required to check the citizenship status, immigration status, address in the United States, and information on the identity of the patient's employer prior to providing treatment. Hospitals administrators themselves were strongly opposed to this bill on the grounds that they did not believe that hospital workers should take on the role of enforcement officers and because of the ultimate risk this legislation could pose to public safety. In arguments for the bill, Congressman Rohrabacher stated: "Americans and legal residents who lack health insurance will be sent to the back of the line when seeking help for a medical emergency because the hospitals will naturally give primary service to those illegal immigrants whose tab is being picked up by the Federal taxpayers. This is a travesty." Congresswoman Solis (D-CA) spoke strongly against the bill by saying that, "This bill goes in the wrong direction because it asks for our hospitals to become enforcers of immigration law."

Migration from Latin America to Europe: Trends and Policy Challenges

Synopsis: Latin American migration to Europe has increased dramatically during the last few years. Countries in Southern Europe which have close historical and cultural ties to Latin America have been most affected. This Migration Research Series study analyzes current trends, causes and policy challenges of recent LAC flow to Europe.

Arab Migration in a Globalized World

Synopsis: The Regional Conference on Arab Migration in a Globalized World brought together representatives of governments and of international organizations, as well as academics and practitioners to discuss migration-related issues in the Arab world and how they exist in relation to the particular conditions of the countries and peoples of the region. In tracing migratory trajectories and figures

of economics development, the authors provide substantial empirical evidence behind their policy suggestions aimed at the countries of origin and destination involved in this population exchange. Number of Pages: 254

Orders may be sent to:

International Organization for Migration
Publications Unit

17 route des Morillons, 1211 Geneva

E-mail: publications@iom.int

Hmong Refugees: Health Training Resources, The Minnesota Department of Health's Refugee Health website: <http://www.health.state.mn.us/divs/idepc/refugee/index.html> includes a wide range of information for service and health care providers. Information specific to the Hmong population has recently been added and will be particularly valuable to refugee service providers working with new Hmong refugee arrivals.

Resources

"Advances in Contemporary Transcultural Nursing," a special issue of *Contemporary Nurse Journal*, Volume 15, issue 3, October 2003, Sidney, Australia. Available on line at http://www.contemporarynurse.com/vol15_3.htm. This special issue contains articles related to education, research, and clinical work as well as sections on culture and health, cardiovascular health, and mental health.

Connections, IRSA's mental health newsletters, address many issues faced by refugee workers and refugees, such as mental health interpretation, the healing arts, resources and contacts from a refugee mental health conference, available at: http://www.refugeesusa.org/help_ref/help_ref_connections.cfm.

Health Care Experiences - 2002 National Survey of Latinos Survey Brief, by the Kaiser Family Foundation, examines Latinos experiences with health care in the United States. Topics discussed include coverage, accessing health care services, and communicating with health care providers. This report is available online at <http://www.kff.org/kaiserpolls/7055.cfm>.

Health Worker Shortages and the Potential of Immigration Policy, by Rob Paral, examines the important role of immigrant doctors and nurses – many of whom have received their training abroad – in the U.S. health industry, using new Census Bureau data as well as information from numerous interviews with health industry experts. This report is available online at <http://www.aifl.org/ipc/ipf031104.asp>.

Human Trafficking: Health Consequences from Vital Voices website: http://www.vitalvoices.org/programs/anti-trafficking/Health_and_Trafficking_Eng.pdf.

Immigrants and Health Report, Greater Twin Cities United Way, April 2004. Report is designed to promote a better understanding of the multiplicity of issues immigrants and refugees face related to infectious diseases, mental health issues, chronic illnesses, and health insurance coverage that are vital to newcomers' integration into the community. Report can be downloaded from <http://www.unitedwaytwincities.org/Immigrantreport.cfm> or by calling the Research and Planning Department of the Greater Twin Cities United way at 612-340-7560.

In the Right Words: Addressing Language and Culture in Providing Health Care. Grantmakers in Health, August 2003. Available on line at <http://www.gih.org>. This publication describes the consequences of language barriers on healthcare outcomes, provides an overview of relevant laws and policies, and highlights strategies for improving language access.

Lessons from the Field: Issues and Resources in Refugee Mental Health, IRSA, discusses refugee health and well-being, refugee adaptation in the resettlement process, potential mental health issues for refugees, working with refugees, self-care for the care-taker, etc. Available on line at: http://www.refugeesusa.org/help_ref/lessons_field_manual.pdf.

Que Es La Depression? The National Mental Health Association available in packets of 50 for \$30.00. <http://www.nmha.org/bookstore>. This pamphlet reaches out to the Latino/Hispanic community to educate about depression.

Race, Ethnicity, and Health: No. 20, by Kenneth Finegold and Laura Wherry, uses data from the 1997, 1999, and 2002 rounds of the National Survey of America's Families to examine changes in health insurance coverage and health status by race and ethnicity. The data reflect the effects of sharp economic fluctuations and recent changes in health policy. This report is available online at http://www.urban.org/media/snapshots3_no20.pdf.

Racial and Ethnic Disparities in Women's Health Coverage and Access to Care, by the Kaiser Family Foundation, uses data from the 2001 Kaiser Women's Health Survey, a nationally representative survey of nearly 4,000 women between the ages of 18 to 64. The issue brief explores racial and ethnic disparities in health care among women. It provides new information on the differences in health status, health insurance coverage, and selected measures of access to care across three racial/ethnic groups of women: African American, Latina, and white. This report is available online at <http://www.kff.org/womenshealth/7018.cfm>.

Rapid Assessment of Mental Health Needs of Refugees, Displaced and Other Populations Affected by Conflict and Post-Conflict Situations: A Tool for Community-Oriented Assessment. Issued by the World Health Organization, developed in collaboration with the International Federation of Red Cross and Red Crescent Societies and the Disaster Mental Health Institute, the University of South Dakota, and authored by Ms. Mary Petevi, Dr. Jean Pierre Revel, and Dr. Gerard A. Jacobs. Geneva, 2001. Can be downloaded at <http://www.who.int/disasters/repo/7405.pdf>.

The Refugee Health Listserv from the Substance Abuse, Mental Health Services Administration (SAMHSA) is a useful tool for ongoing updates and information from the Refugee Health Program at SAMHSA. The List was established as part of the Office of Refugee Resettlement's Refugee Health Promotion & Disease Prevention Initiative (RHPDPI). The List provides information and updates on the RHPDPI, information on refugee health/mental health issues, and discussion of related topics. The Listserv may be accessed at: <http://list.nih.gov>, click on "Browse," click on R and look for Refugee Health. There you will find instructions for subscribing.

Somali and Oromo Refugees: Correlates of Torture and Trauma History by James M. Jaranson, M.D., MPH, et al in American Journal of Public Health, April 2004 reports on a study of 1134 Somali and Ethiopian (Oromo) refugees in Minnesota to determine torture prevalence and associated problems. Reprints can be requested from Marline Spring, Ph.D., Division of Epidemiology, School of Public Health, University of Minnesota, 1300 S. Second St. Suite 300, Minneapolis, NB 55454 (sprin006@umn.edu).

Stress and Trauma Handbook – Strategies for Flourishing in Demanding Environments. Edited by John Fawcett for World Vision Publications, 2004. The authors help the reader understand what stresses are unique to our working environment, whether in the office or in the field, and show how individuals and organizations can overcome these difficulties to continue meeting the needs of those we serve. The book shows how to create an environment that promotes development and strong emotional health through strong relationships, knowledge, skills, and professional activities.

The Seven Beliefs: A Step by Step Guide to Help: Latinas Recognize and Overcome Depression. Belisa Lozano-Vranich, Psy.D., and Jorge Petit, M.D. This book opens doors for healing in a poignant, powerful way and shows Latinas that confronting and overcoming depression is possible if they look at each aspect of their lives, step by step.

Worlds Apart: Films on Cross-Cultural Care - four short films & accompanying study guide, produced with partial support from The Commonwealth Fund, explore the issues of cross-cultural health care. Many researchers have documented the shortcomings of the patient-physician communication process, concerns that become far greater when patients are minorities, don't understand English well, or come from cultural traditions with which most American doctors are unfamiliar. These films are available online at:

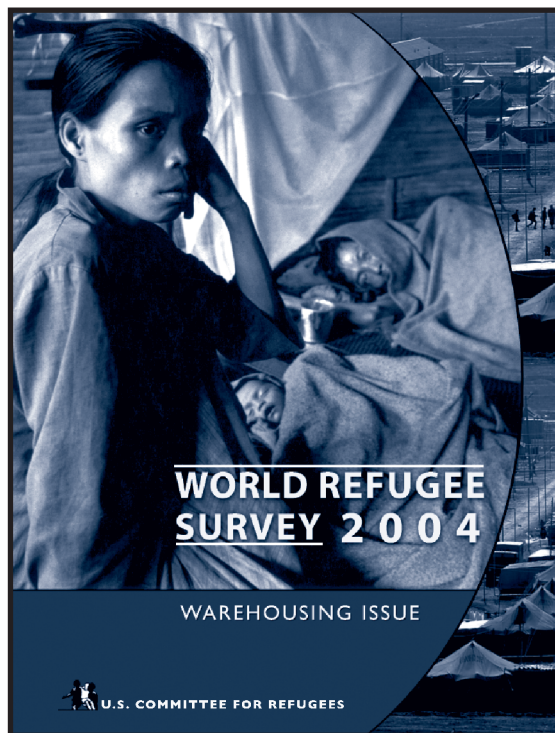
<http://www.cmwf.org/programs/minority/worldsapart020504.asp>.

The World Refugee Survey 2004

IRSA's U.S. Committee for Refugees has published the *World Refugee Survey 2004*. The 110-page report reviews refugee conditions in 145 countries worldwide and has 14 pages of comprehensive statistics. Also included is a CD-ROM which offers the entire *Survey* plus individual country updates. The *2004 Survey* focuses on the theme of refugee warehousing and features full-length articles on refugees in Lebanon, Syria, Thailand, Pakistan, Nepal, the Sovereign Base Areas of Cyprus, and several African countries.

The *World Refugee Survey 2004* documents the state of refugee protection, human rights, and adherence to international law in an era when refugees are spending increasingly more time as refugees unable to exercise basic rights waiting in constant limbo.

The *2004 Survey* costs \$25 (reduced rates for bulk orders). To order, e-mail Raci Say at rsay@irsa-uscr.org or visit <http://www.refugees.org>.



REFUGEE REPORTS (USPS-001-465) is published monthly for:

\$60.00 one-year subscription

\$100.00 two-year subscription

Overseas postage is an additional \$50.00.

Single copies of back issues: \$5.00

Periodicals postage paid at Washington, D.C. and additional mailing offices.

POSTMASTER: Send address changes to Refugee Reports, IRSA 1717 Massachusetts Ave., NW, Suite 200, Washington, DC 20036.

Editorial comments and communications regarding subscriptions should be sent to:

Refugee Reports

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Washington, D.C. 20036

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Refugee Reports

A News Service of Immigration and Refugee Services of America

1717 Massachusetts Ave., NW, #200

Washington, DC 20036-2003

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