

Advocacy for Refugees

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Refugees are a population distinct from other immigrants in that they have been forced to leave their homes and relocate in other countries out of fear of persecution based on race, religion, ethnicity, political opinion, or social group.¹ The United States admits more refugees for permanent resettlement than any other nation² and data from the North Carolina Refugee Health Program at the Department of Health and Human Services³ indicate that refugees are increasingly being resettled in North Carolina. In order to appropriately address the acute and long-term health issues of refugees arriving in North Carolina, physicians will be required to augment their current understanding of cultural competency to include topics of conflict-related violence and psychological evaluation.¹

Studies report that refugees experience higher risk of psychiatric conditions, including depression, suicide, post-traumatic stress disorder (PTSD), and substance abuse, all of which are directly related to their past trauma.³ Given that 5-10% of refugees who have come forward with their stories have experienced physical and psychological abuse, the need for mental health evaluation and treatment is crucial to healing.³⁻⁵ This information is particularly salient to discussions of societal well-being, as children exposed to torture are vulnerable to destructive habits and abuse as adults,^{6,7} as well as to neuropsychiatric disorders caused by brain injury and malnutrition.⁸

The current cultural competency curricula being used in many medical schools do not sufficiently train doctors to meet the health needs of their refugee patients.⁹ Gavagan and colleagues recommend coverage of the following four points in a clinical evaluation, depending on the refugee's area of origin: (1) nutritional status, including children's growth and development; (2) mental health, focusing on PTSD, anxiety, physical abuse, and substance abuse; (3) infectious diseases; and (4) preventive screening.¹⁰

The strategies for implementing more comprehensive and culturally competent care require changes at the national policy level as well as the organizational and individual levels.

On the policy level, an augmented curriculum that stresses recognition of refugees' unique needs should be universally disseminated, implemented, and tested.¹¹ There are institutions, such as Harvard and the University of Washington,³ that advocate for the use of a more thorough evaluation of medical history and psychological state, one that inquires about the person's life story, medical history, path to host country, infectious diseases, traditional medicine, substance use, sexual history, and trauma history. This comprehensive evaluation, in addition to Harvard's Trauma Questionnaire, gives the provider

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a more thorough picture of the influences of violence and trauma on the patient's current and future health.¹²

On the organizational level, health care settings should facilitate multidisciplinary teams that include health care providers, social workers, lawyers, and interpreters for refugee patients.⁵ Lay health advisors and other community members can also help to bridge cultural barriers between providers and refugee patients. Furthermore, an interpreter familiar with the patient's culture can help with appropriate

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assessments,³ dispelling negative myths about treatment and overcoming attitudinal barriers.¹³

Finally, providers must become more familiar with the populations they are serving. They should exhibit background knowledge and a genuine interest in the patient's culture and experience.^{5,11,14} Health professionals should also keep in mind that the visit in which the evaluation is performed may be the patient's first physical or mental assessment of any kind. Extra sensitivity and caution is warranted, as well as mindfulness of the possibility that previous encounters with health professionals may have been in contexts of torture.⁸ Several visits may be necessary before a trusting relationship can be established.⁸

In an age where international conflict is increasing, providers in states that host growing numbers of refugee populations should strategize ways to bring refugee populations in for care, ensure that refugees' perspectives are represented when redesigning and disseminating a more comprehensive curriculum, use interpreters in patient treatment, involve lay community members for refugee outreach, and couple with policymakers to garner the political and financial support to

make these changes happen. These challenges will require not only an ethical commitment from health care providers but also a financial investment. As it stands, physicians often cite barriers such as a lack of time to be able to fully assess their patients and the hardships of caring for under- or uninsured patients.

Over the years several strategies have been developed to address the need for specific attention on refugee populations. There are programs in medical schools such as at State University of New York at Buffalo, for example, that allow students to gain cultural competency first-hand by working directly with refugee populations.¹⁵ A formal program may not be necessary for health professionals to gain an insider perspective. The increase in refugee and immigrant populations provides a greater possibility for collaboration and sharing of intercultural perspectives. Providers may choose to gather with other health professionals to discuss the impact of globalization on their practices, to travel, or to seek background information relative to the patient's experience before the visit. **NCMJ**

REFERENCES

- 1 Henderson SW. New approaches to health care for displaced populations. *JAMA*. 2001;285(9):1212.
- 2 Educational resources: fact or fiction answers. USA for UNHCR website. <http://www.usaforunhcr.org/usaforunhcr/dynamic.cfm?ID=73>. Accessed January 29, 2009.
- 3 Adams KM, Gardiner LD, Assefi N. Healthcare challenges from the developing world: post-immigration refugee medicine. *Br Med J*. 2004;328(7455):1548-1552.
- 4 Pincock S. Exposing the horror of torture. *Lancet*. 2003;362(9394):1462-1463.
- 5 Moreno A, Piwowarczyk L, Grodin MA. Human rights violations and refugee health. *JAMA*. 2001;285(9):1215.
- 6 McCloskey LA, Southwick K. Psychosocial problems in refugee children exposed to war. *Pediatrics*. 1996;97(3):394-397.
- 7 Psychological woes haunt Burmese refugees. The Irrawaddy website. http://www.irrawaddy.org/article.php?art_id=7678. Accessed December 1, 2008.
- 8 Davidson N, Skull S, Chaney G, et al. Comprehensive health assessment for newly arrived refugee children in Australia. *J Paediatr Child Health*. 2004;40(9-10):562-568.
- 9 Champaneria MC, Axtell S. Cultural competence training in US medical schools. *JAMA*. 2004;291(17):2142.
- 10 Gavagan T, Brodyaga L. Medical care for immigrants and refugees. *Am Fam Physician*. 1998;57:1061-1072.
- 11 Mollica RF. Assessment of trauma in primary care. *JAMA*. 2001;285(9):1213.
- 12 Mollica RF, Caspi-Yavin Y, Bollini P, Truong T, Tor S, Lavelle J. The Harvard Trauma Questionnaire: validating a cross-cultural instrument for measuring torture, trauma, and posttraumatic stress disorder in Indochinese refugees. *J Nerv Ment Dis*. 1992;180(2):111-116.
- 13 Musser-Granski J, Carrillo DF. The use of bilingual, bicultural paraprofessionals in mental health services: issues for hiring, training, and supervision. *Community Ment Health J*. 1997;33(1):51-60.
- 14 Bateman C, Baker T, Hoornenborg E, Ericsson U. Bringing global issues to medical teaching. *Lancet*. 2001;358(9292):1539-1542.
- 15 Griswold KS, Kernan JB, Servoss TJ, Saad FG, Wagner CM, Zayas, LE. Refugee health and medical student training. *Med Educ*. 2006;40:697-703.