Primary Care for Refugees

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Over the past decade, at least 600,000 refugees from more than 60 different countries have been resettled in the United States. The personal history of a refugee is often marked by physical and emotional trauma. Although refugees come from many different countries and cultures, their shared pattern of experiences allows for some generalizations to be made about their health care needs and challenges. Before being accepted for resettlement in the United States, all refugees must pass an overseas medical screening examination, the purpose of which is to identify conditions that could result in ineligibility for admission to the United States. Primary care physicians have the opportunity to care for members of this unique population once they resettle. Refugees present to primary care physicians with a variety of health problems, including musculoskeletal and pain issues, mental and social health problems, infectious diseases, and longstanding undiagnosed chronic illnesses. Important infectious diseases to consider in the symptomatic patient include tuberculosis, parasites, and malaria. Health maintenance and immunizations should also be addressed. Language barriers, cross-cultural medicine issues, and low levels of health literacy provide additional challenges to caring for this population. The purpose of this article is to provide primary care physicians with a guide to some of the common issues that arise when caring for refugee patients. (*Am Fam Physician.* **2011;83(4):429-436.** **Copyright © 2011 American Academy of Family Physicians.**)

Throughout history, persons have been forced to flee their homes because of war, famine, or persecution. In 1951, in an effort to protect European refugees in the aftermath of World War II, the United Nations developed an official definition of "refugee," which has since been called the Geneva convention. A 1967 United Nations Protocol removed the geographic and time boundaries from the original definition. Today, the United Nations defines a refugee as anyone who:

> …owing to well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion, is outside the country of his nationality and is unable or, owing to such fear, is unwilling to avail himself of the protection of that country.[1]

Over the past decade, at least 600,000 refugees from more than 60 different countries have been resettled in the United States.[2] *Table 1* lists the top 10 countries of origin for refugees arriving in the United States from 2000 to 2009, and *Table 2* shows the distribution of those refugees resettled in each state or territory.[2]

A refugee's personal history is often marked by trauma, torture, loss of family and friends, and the trials of resettlement in a new country and orientation to a new culture. Although refugees come from many different countries and cultures, their shared pattern of experiences allows for some generalizations to be made about their health care needs and challenges. The purpose of this article is to provide primary care physicians with a guide to some of the common issues that arise when caring for refugees.

Table 1. Top 10 Countries of Origin for Refugees Resettled in the United States from 2000 to 2009

Country	*Number of refugees*	*Country*	*Number of refugees*
Cuba	119,129	Iraq	40,868
Former Soviet Union	87,621	Iran	38,140
Somalia	60,003	Liberia	26,046
Former Yugoslavia	46,868	Sudan	21,985
Burma	46,235	Vietnam	20,274

Information from reference 2.

Initial Medical Screening Examination

Before being accepted for resettlement into the United States, all refugees must pass the overseas medical screening examination performed by panel physicians under the technical oversight of the Centers for Disease Control and Prevention (CDC), with

the goal of detecting class A and B conditions[3] *(Table 3[4])*. The CDC further recommends, but does not mandate, an initial domestic screening examination, the purpose of which is to further identify medical conditions that pose a public health risk or that might interfere with successful resettlement.[5] Several documents on the CDC Web site provide guidance as to the components of an initial history, physical examination, and laboratory assessment (http://www.cdc.gov/immigrantrefugeehealth/guidelines/domestic/domestic-guidelines.html).[6] Each state develops its own protocol for completing the initial medical examination, which often is performed by a combination of local health department and private physicians.

Table 2. Top Three Refugee Countries of Origin by U.S. State or Territory

State/territory	*Refugees resettled, 2000 to 2009*	*Top three countries of origin*
Florida	108,261	Cuba, Haiti, former Yugoslavia
California	75,167	Iran, former Soviet Union, Iraq
Texas	39,494	Burma, Cuba, Somalia
New York	38,785	Former Soviet Union, Burma, Liberia
Minnesota	31,458	Somalia, Laos, Ethiopia
Washington	29,412	Former Soviet Union, Somalia, Burma
Arizona	21,896	Iraq, Somalia, Burma
Georgia	20,562	Somalia, former Yugoslavia, Burma
Illinois	18,750	Former Yugoslavia, Iraq, former Soviet Union
Michigan	17,768	Iraq, former Yugoslavia, Cuba
Pennsylvania	17,440	Former Soviet Union, Liberia, former Yugoslavia
North Carolina	14,065	Vietnam, Burma, former Soviet Union
Virginia	13,982	Somalia, Iraq, former Yugoslavia
Ohio	13,817	Somalia, former Soviet Union, former Yugoslavia
Massachusetts	12,794	Former Soviet Union, Somalia, Iraq
Missouri	11,597	Former Yugoslavia, Somalia, former Soviet Union
Oregon	10,761	Former Soviet Union, Somalia, Cuba
Kentucky	10,725	Cuba, former Yugoslavia, Burma
Colorado	9,363	Former Soviet Union, Somalia, Burma
New Jersey	9,059	Cuba, Liberia, former Soviet Union
Tennessee	8,662	Somalia, Sudan, Iraq
Maryland	8,293	Sierra Leone, former Soviet Union, Burma
Utah	8,009	Somalia, former Yugoslavia, Burma
Indiana	7,132	Burma, Thailand, former Yugoslavia
Wisconsin	6,830	Laos, former Yugoslavia, Burma
Idaho	6,317	Former Yugoslavia, former Soviet Union, Afghanistan
Iowa	6,146	Former Yugoslavia, Sudan, Burma
Connecticut	5,186	Former Yugoslavia, Somalia, former Soviet Union
Nevada	4,689	Cuba, former Yugoslavia, Iran
Nebraska	4,597	Sudan, Burma, former Yugoslavia
New Hampshire	4,112	Former Yugoslavia, Bhutan, Somalia
North Dakota	2,853	Former Yugoslavia, Somalia, Bhutan
South Dakota	2,736	Somalia, Sudan, former Yugoslavia

continued

Table 2. Top Three Refugee Countries of Origin by U.S. State or Territory
(continued)

State/territory	*Refugees resettled, 2000 to 2009*	*Top three countries of origin*
Louisiana	2,585	Cuba, former Yugoslavia, Vietnam
Vermont	2,093	Former Yugoslavia, Somalia, Bhutan
Rhode Island	1,961	Liberia, former Soviet Union, Burundi
Kansas	1,754	Burma, Somalia, Vietnam
New Mexico	1,690	Cuba, Iraq, Vietnam
Maine	1,580	Somalia, Sudan, former Yugoslavia
Oklahoma	1,209	Burma, former Soviet Union, Vietnam
Alabama	1,105	Iraq, Cuba, former Soviet Union
South Carolina	1,043	Former Soviet Union, Burma, Somalia
District of Columbia	794	Ethiopia, Sierra Leone, Iraq
Alaska	459	Former Soviet Union, Laos, Bhutan
Delaware	241	Liberia, Sierra Leone, Afghanistan
Puerto Rico	234	Cuba, Vietnam, Colombia/Haiti
Mississippi	218	Sudan, Somalia, Afghanistan
Hawaii	154	Vietnam, Burma, former Soviet Union
Arkansas	105	Laos, Vietnam, Cuba
Montana	85	Former Soviet Union, Iraq, Cuba
West Virginia	54	Iraq, Vietnam, Burma
Guam	5	Vietnam
Wyoming	3	Former Soviet Union
Total	**618,090**	

Information from reference 2.

Table 3. Components of the Refugee Initial Overseas Medical Examination, Including Class A and Class B Conditions

Examination components

- Full medical history (i.e., current medical conditions and medications, previous hospitalizations, social history, and complete review of systems)
- Physical examination including, at a minimum: examination of the eyes, ears, nose, throat, extremities, heart, lungs, abdomen, lymph nodes, skin, and external genitalia
- Mental status examination including, at a minimum: assessment of intelligence, thought, cognition (comprehension), judgment, affect (and mood), and behavior
- Laboratory syphilis screen
- Tuberculosis screen
- Appropriate immunizations

Class A conditions: a physical or mental disorder (including a communicable disease of public health significance or drug abuse/addiction) that renders a person ineligible for admission or adjustment of status

- Active or infectious tuberculosis
- Untreated syphilis
- Untreated chancroid
- Untreated gonorrhea
- Untreated granuloma inguinale
- Untreated lymphogranuloma venereum
- Hansen disease
- Addiction to or abuse of a specific substance* without harmful behavior and/or any physical or mental disorder with harmful behavior or history of such behavior, along with likelihood that behavior will recur

Class B conditions: significant health problems affecting ability to care for oneself or attend school or work, or that require extensive treatment or possible institutionalization

- Inactive or noninfectious tuberculosis
- Treated syphilis
- Other sexually transmitted infections
- Pregnancy
- Treated, tuberculoid, borderline, or paucibacillary Hansen disease
- Sustained, full remission of abuse of specific substances* and/or any physical or mental disorder (excluding addiction to or abuse of specific substances, but including other substance-related disorders) without harmful behavior or with a history of such behavior considered unlikely to recur

*—*Amphetamines, cannabis, cocaine, hallucinogens, inhalants, opioids, phencyclidines, sedative-hypnotics, and anxiolytics.*

Information from reference 4.

Common Presenting Problems

Refugees present to primary care physicians with a variety of health problems. The most common are musculoskeletal and pain issues, mental and social health problems, infectious diseases, and longstanding undiagnosed chronic conditions *(Table 4)*.

MUSCULOSKELETAL AND PAIN ISSUES

Many refugees seek medical attention for musculoskeletal pain, most commonly of the neck and lower back.[7-9] Contributing factors (e.g., past physical trauma), current employment in jobs involving physical labor (e.g., housekeeping, factory work), and difficult living conditions (e.g., sleeping on floors or couches) must be considered in the assessment and treatment plan.

Chronic headaches are another common pain issue, as is ill-defined, whole body pain. Pain in the abdomen and pelvis is more common in women.[7-9] Organic causes for abdominal, pelvic, and whole body pain are often difficult to identify despite extensive workups, which should include assessment for *Helicobacter pylori*, intestinal parasites, and vitamin D deficiency, and imaging as indicated.[10-12]

MENTAL AND SOCIAL HEALTH

It is not surprising that refugees, given their often traumatic pasts, have higher rates of depression, anxiety, and posttraumatic stress disorders than the general population.[8,13-15] Postmigration resettlement stressors, such as social isolation, financial problems, generational acculturation differences, culture shock, employment difficulty, disability issues, and housing issues, also adversely affect refugees' mental and physical health.[10,13,14,16-18]

The relative contribution of pre- versus postmigration stress to the development and maintenance of mental health disorders is unknown. Many experts emphasize the importance of addressing refugees' postmigration resettlement challenges (e.g., housing, employment, social isolation) rather than directing therapies at healing past traumas.[13,16-18] When possible, these patients should be referred to local community agencies that can assist them with their social needs.

INFECTIOUS DISEASES

Although many physicians think of infectious diseases when dealing with refugees, other diagnoses such as musculoskeletal pain and mental health issues are actually more prevalent.[7] Because refugees are such a tightly controlled population, with pre- and postmigration screening for and prophylactic treatment of infectious diseases, they account for less international spread of infectious diseases than international travelers and other migrant populations.[3]

That said, infectious diseases, particularly tuberculosis, should remain high on the list of possible diagnoses when evaluating symptomatic refugees.[3] *Table 5* lists some of the recommended infectious disease screening and diagnostic tests.[3,19,20]

Patients presenting with abdominal symptoms, hematuria, or failure to thrive should be assessed for parasites[19,21] *(Table 5*[3,19,20]*)*. At times, the only sign of a parasitic infection may be an asymptomatic eosinophilia. Although collection and analysis of multiple stool samples are a common way to assess for the presence of parasites, negative results do not rule out parasitic infection, and serologic testing for antibodies may be necessary. If such infection is suspected, consultation with an infectious disease expert can be helpful.[19,21]

Table 4. Common Presenting Health Problems and Conditions Among Refugee Patients

Mental health	Undiagnosed chronic conditions
Adjustment disorder	Anemia
Depression/anxiety	Asthma
Posttraumatic stress disorder	Chronic obstructive pulmonary disease
Social isolation	Diabetes mellitus
Pain	Dyslipidemia
Abdominal pain	Hypertension
Back pain	Vitamin D deficiency
Female pelvic pain	
Headache	
Neck pain	

NOTE: *See Table 5 for common infectious disease–related problems.*

Table 5. Recommended Infectious Disease Screening and Diagnostic Tests for Refugees

Infectious agent	*Test*	*Comments*
Parasites*†		
Ascaris lumbricoides (roundworm)	Three stool ova and parasites tests, collected on three different mornings	—
Entamoeba histolytica	Three stool ova and parasites tests, collected on three different mornings	—
Filariasis	Three stool ova and parasites tests, collected on three different mornings	—
Giardia lamblia	Three stool ova and parasites tests, collected on three different mornings	—
Hookworm	Three stool ova and parasites tests, collected on three different mornings	—
Plasmodium species	Three thick and thin blood smears done over six to 12 hours, preferably during a fever spike	Consider in refugees from malaria-endemic areas with fever, thrombocytopenia, splenomegaly, or anemia
Schistosoma species	Three stool ova and parasites tests, collected on three different mornings	Consider with hematuria; infection is a risk factor for bladder cancer
Strongyloides species	Three stool ova and parasites tests, collected on three different mornings	Untreated strongyloidiasis puts patients at risk of disseminated strongyloidiasis if they become immunocompromised
Taenia species (tapeworm)	Three stool ova and parasites tests, collected on three different mornings	—
Trichuris trichiura (whipworm)	Three stool ova and parasites tests, collected on three different mornings	—
Sexually transmitted infections		
Gonorrhea/ chlamydia	Urine or cervical gonorrhea/chlamydia	—
Hepatitis B	Hepatitis B core antibody, hepatitis B surface antibody, hepatitis B surface antigen	Screen all refugees coming from areas in which hepatitis B is endemic
HIV	HIV-1 and HIV-2	—
Syphilis	Rapid plasma reagin, VDRL	—
Other		
Helicobacter pylori	Fecal antigen preferable over serology[20]	—
Tuberculosis	Purified protein derivative/Mantoux test, Quantiferon-G, chest radiography	All refugees should be screened for tuberculosis because it is one of most common infectious diseases in refugees[3]; consider renal tuberculosis in patients with hematuria

HIV = human immunodeficiency virus; VDRL = Venereal Disease Research Laboratories.

**—Suspect parasites with eosinophilia.*

†—Negative stool sample results do not always rule out parasitic infections; therefore, serologic testing for antibodies may be necessary.

Information from references 3, 19, and 20.

Malaria remains endemic in sub-Saharan Africa, south Asia, Asia, and some areas of the Middle East. Refugees from endemic areas presenting with fatigue, pallor, hematologic abnormalities, and possibly an enlarged spleen should be evaluated for malaria.[19]

UNDIAGNOSED COMMON CHRONIC CONDITIONS

In addition to the special health considerations described above, refugees have the same common chronic conditions as nonrefugee patients, such as diabetes mellitus,

Table 6. CDC-Mandated Immunizations for Refugees Requesting Adjustment of Status

Vaccine	Age: Birth to 1 month	2 to 11 months	12 months to 6 years	7 to 10 years	11 to 17 years	18 to 64 years	65 years and older
DTP/DTaP/DT	No	Yes		No			
Td/Tdap	No			Yes, 7 years and older (for Td); 10 to 64 years (for Tdap)			
IPV	No	Yes				No	
MMR	No		Yes, if born after 1957			No	
Rotavirus	No	Yes, 6 weeks to 8 months	No				
Hib	No	Yes, 2 to 59 months		No			
Hepatitis A	No		Yes, 12 to 23 months	No			
Hepatitis B	Yes, through 18 years					No	
Meningococcal (MCV4)	No				Yes, 11 to 18 years	No	
Varicella	No		Yes				
Pneumococcal	No	Yes, 2 to 59 months (for PCV)		No			Yes (for PPV)
Influenza	No	Yes, 6 months through 18 years (each influenza season)				No	Yes, 50 years and older (each influenza season)

CDC = Centers for Disease Control and Prevention; DT = pediatric formulation diphtheria and tetanus toxoids; DTaP = diphtheria and tetanus toxoids and acellular pertussis vaccine; DTP = diphtheria and tetanus toxoids and pertussis vaccine; Hib = Haemophilus influenzae *type b conjugate vaccine; IPV = inactivated poliovirus vaccine (killed); MCV = meningococcal conjugate vaccine; MMR = combined measles, mumps, and rubella vaccine; PCV = pneumococcal conjugate vaccine; PPV = pneumococcal polysaccharide vaccine; Td = adult formulation tetanus and diphtheria toxoids; Tdap = adolescent and adult formulation tetanus and diphtheria toxoids and acellular pertussis vaccine (Boostrix for persons 10 to 18 years of age; Adacel for persons 11 to 64 years of age).*

Adapted from Centers for Disease Control and Prevention. Vaccination requirements for adjustment of status for U.S. permanent residence: technical instructions for civil surgeons. December 14, 2009. http://www.cdc.gov/immigrantrefugeehealth/pdf/2009-vaccination-technical-instructions.pdf. Accessed April 14, 2010.

hypertension, hyperlipidemia, and asthma.[9] Depending on the health care available to refugees in their country of origin or their host country (where refugees sometimes spend up to 20 years in refugee camps before coming to the United States), these conditions may or may not have been diagnosed and managed before these patients arrived in the United States.

Health Maintenance and Immunizations

Health care maintenance screening guidelines, such as cervical cancer screening, mammography, and colonoscopy, should be used with refugee patients, just as with nonrefugee patients. In addition, refugees often present for an appointment only to request necessary immunizations. The U.S. Immigration and Naturalization Service has determined that vaccinations are not mandatory for refugees on entry to the United States. However, they become mandatory one year after arrival, when these persons are applying for adjustment of status to legal permanent resident. *Table 6* lists the CDC-mandated immunizations for all immigrants and refugees requesting adjustment of status for U.S. permanent residence.[22]

SORT: KEY RECOMMENDATIONS FOR PRACTICE

Clinical recommendation	*Evidence rating*	*References*
Physicians should focus on addressing refugees' postmigration resettlement challenges (e.g., housing, employment, social isolation) rather than directing therapies at healing past traumas.	C	10, 13, 14, 18
Refugees presenting with abdominal symptoms, hematuria, or failure to thrive should be assessed for parasites.	C	19, 21
Refugees from malaria-endemic areas presenting with fatigue, pallor, hematologic abnormalities, and possibly an enlarged spleen should be evaluated for malaria.	C	19
Physicians who accept federal payers should provide language translation services for refugees who need them, as required by federal law.	C	23

A = consistent, good-quality patient-oriented evidence; B = inconsistent or limited-quality patient-oriented evidence; C = consensus, disease-oriented evidence, usual practice, expert opinion, or case series. For information about the SORT evidence rating system, go to http://www.aafp.org/afpsort.xml.

Special Challenges

LANGUAGE BARRIERS

Use of qualified translators is essential to caring for refugee patients. Refugees are not required to bring their own translator to an appointment, and federal law mandates that physicians who accept patients with federal payers must provide language translation to all of their patients who require it.[23] In most cases, insurance plans will pay for the translation services, but it is the responsibility of the physician's office to make arrangements for the provision of those services.

CROSS-CULTURAL MEDICINE

Western notions of body, health, and illness are often different from those of other cultures, as are perceived roles of patients, physicians, and medications. For example, some Somalis expect physicians to know what is wrong with them without needing to ask any questions, and may also expect medications and a cure.[24] A previous article in *American Family Physician* summarized some of the common beliefs of certain large refugee groups (http://www.aafp.org/afp/2005/1201/p2267.html). Familiarizing oneself with some general principles of a refugee's culture can be useful, but care must be taken not to stereotype persons within any group. An alternative and possibly more feasible approach may be to adopt and practice "cultural humility," exploring similarities and differences between oneself and each patient encountered, rather than learning the details of each culture.[25]

HEALTH SYSTEM LITERACY

Refugees' health literacy levels are typically very low. For example, many refugees do not understand the concept of medication refills. Often, they will finish a bottle of medication that is intended to be refilled and used long-term, thinking the treatment is complete, or think they need to return to the physician's office for more medication. Many also do not understand the distinction between primary care and other subspecialties. As a result, they may not schedule or keep an appointment with a subspecialist referral, but rather return to their primary care physician, whom they view as "their doctor."

Lack of transportation or ability to schedule the appointment with the subspecialist further contributes to poor compliance with subspecialist referrals.[26] The notion of set appointment times may also be unfamiliar to refugees, because many experienced previous systems in which they just showed up and waited their turn to see the physician.

Finally, many refugees do not understand the U.S. health insurance process. In states

in which Medicaid requires reapplication on a biannual or annual basis, many refugees have a lapse in insurance coverage because they missed the reapplication deadline. A previous article on medical care for refugees and immigrants in *American Family Physician* provides some further insight into additional challenges refugees may face (http://www.aafp.org/afp/980301ap/gavagan.html).

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