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Global Health at Home:
Primary Care Considerations for Individuals Arriving to the United States With Refugee Status

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Objectives

- Understand that primary care clinicians are uniquely suited to care for refugees.
- Review the global refugee crisis and refugee resettlement process including the Centers for Disease Control and Prevention's (CDC's) domestic screening guidelines
- Discuss common primary care issues for individuals arriving with refugee status
- Understand primary care's critical role in taking care of individuals with refugee status
- Case studies to illustrate common issues in refugee care

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What does it mean to be a refugee?

- A refugee is someone who has been forced to flee his or her country because of persecution, war, or violence.
- A refugee has a well-founded fear of persecution for reasons of race, religion, nationality, political opinion or membership in a particular social group.
  - Refugees often cannot return home or are afraid to do so.
  - War, including ethnic, tribal and religious violence is the leading cause of refugees fleeing their countries.

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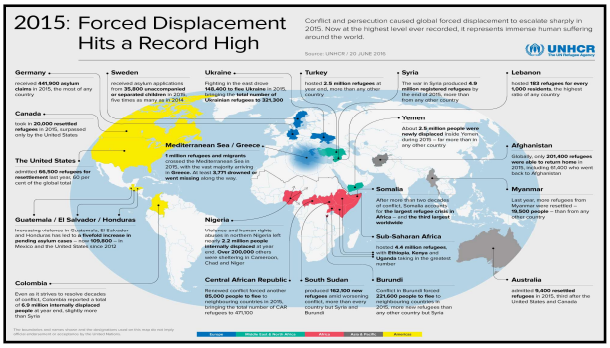

How does the process work?

- 1% of individuals with refugee status are resettled by official sponsorship in other countries as a form of foreign aid.
  - In current crisis climate, many countries are hosting unofficially resettled refugees
- Historically, up until 2016, the US has resettled approximately 70,000 refugees per year; decreased to 50,000 in 2017
  - 60% of all those resettled through sponsorship
  - Idaho receives ~750-1,000 of these individuals per year
  - Most resettle in Boise; some in Twin Falls

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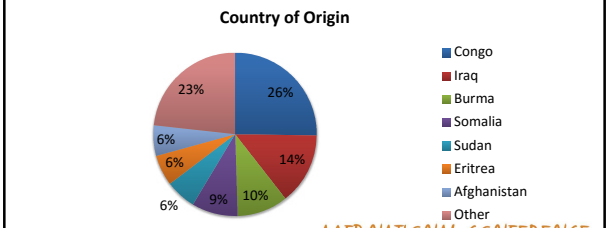
Idaho Arrivals 2015



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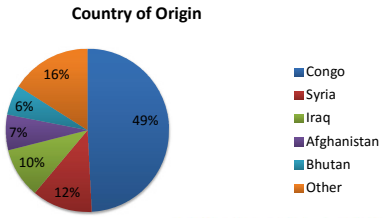
Idaho Arrivals 2016



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FAMILY MEDICINE RESIDENCY OF IDAHO

- FQHC comprised of seven clinics and a family medicine residency training program
- Our Emerald Clinic provides all domestic screening exams for people arriving with refugee status in Boise, Idaho
  - Primary care and specialized ID care (HIV, TB, viral hepatitis) also available
- In 2016, received 818 newly resettled refugees
  - Populations include refugees from:
    - Burundi
    - Central African Republic
    - Congo
    - Eritrea
    - Ethiopia
    - Kenya
    - Somalia
    - Sudan
    - Burma
    - Afghanistan
    - Russia
    - Ukraine
    - Mexico
    - Bhutan
    - Iran
    - Iraq
    - Pakistan
    - Syria

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SCREENING

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Refugee Screening Program

- Screening includes:
  - Medical screen
  - Mental Health screen
  - Immunizations
  - Transition to PCP
- First visit with nursing
  - Blood draw
  - First immunizations,
  - Orientation to clinic/process
- Second visit is with provider
  - Infectious disease screening
  - Lab results
  - Presumptive anti- parasitic therapy
  - Triage immediate medical and mental health concerns
  - Review health history (IOM, EDN paperwork)
  - Recommendations for PCP

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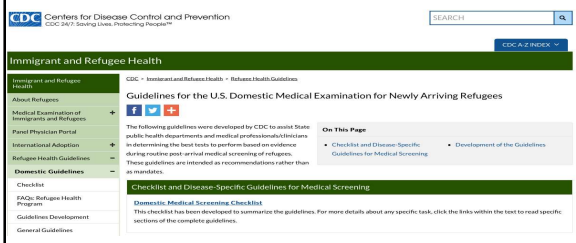

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What do we check?

- Labs
  - For 17yo and older
    - Hep B (sAb, sAg, total cAb)& Hep A serology
    - HIV, treponemal Ab, T spot
    - CBC with differential
    - HCG (13-45 yo)
    - Glucose
    - UA
    - Strongyloides & Schistosomiasis IgG for Africans
  - 13-16yo
    - HBsAg, HIV, RPR, CBC with differential, T spot, lead, HCG, glucose, UA
  - 5-12 yo
    - lead, CBC w/ diff, HBsAg, T spot
  - 6 mo-5 yo
    - PPD, lead, CBC w/diff, HBsAg, HIV
- Immunization Titers (17yo and older only)
  - MMR, Varicella, Polio
  - Younger kids – get vaccinated for all unless they bring records with them
- Mental health screen (RHS-15)
  - Developmental screen for kids

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Presumptive Treatment

Table 1. Recommended medication regimen for presumptive treatment of parasitic infections

Refugee Population	Regimens by Pathogen		
	Soil-transmitted helminths: Albendazole	Strongyloidiasis: Ivermectin or high-dose albendazole	Schistosomiasis: Praziquantel[1]
Adults			
Asia, Middle East, and North Africa, Latin America and Caribbean	400 mg orally for 1 day	Ivermectin, 200 µg/kg/day orally once a day for 2 days	Not recommended
Sub-Saharan Africa, non-*Loa loa*-endemic area	400 mg orally for 1 day	Ivermectin, 200 µg/kg/day once a day for 2 days	Praziquantel[1], 40 mg/kg (may be divided and given in two doses for better tolerance).
Sub-Saharan Africa, *Loa loa*-endemic area	400 mg orally for 1 day	Only use ivermectin (200 µg/kg/day once a day for 2 days) if *Loa loa* infection has been ruled out. May use high dose albendazole (400 mg twice a day for 7 days)) if *Loa loa* infection cannot be ruled out. For more	Praziquantel, 40 mg/kg (may be divided and given in two doses for better tolerance).

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Presumptive Tx – con't

		information see screening and diagnostic tests for strongyloidiasis below.	
Pregnant women			
Asia, the Middle East/North Africa, Latin America and Caribbean	Not recommended	Not recommended	Not recommended
Sub-Saharan Africa	Not recommended	Not recommended	Praziquantel, 40 mg/kg (may be divided and given in two doses for better tolerance).
Children			
Asia, the Middle East/North Africa, Latin America and Caribbean	12-23 months of age: 200 mg orally for 1 day. Presumptive therapy is not recommended for any infant less than 12 months of age.	Ivermectin, 200 µg/kg/day orally once a day for 2 days Should not be used presumptively if <15 kg or from Loa loa-endemic country.	Not recommended
Sub-Saharan Africa	12-23 months of age: 200 mg orally for 1 day. Presumptive therapy is not recommended for any infant less than 12 months of age.	Ivermectin, 200 µg/kg/day orally once a day for 2 days Should not be used presumptively if <15 kg or from Loa loa-endemic country.	Children under <4 years of age should not receive presumptive treatment with praziquantel. Only for children from sub-Saharan Africa

Although WHO states ivermectin and albendazole may be given concurrently, it is recommended that ivermectin be taken on an empty stomach and albendazole with fatty foods.

Praziquantel, if not co-administered, should be administered at least one day prior to either ivermectin or albendazole. Praziquantel should be taken with liquids during a meal.

All sub-Saharan African countries are considered endemic for schistosomiasis except Lesotho.

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Screening Pearls

- First contact with the medical system in the US
  - Giving lab results
  - Teaching the system, pharmacy, expectations
- Opportunity to establish rapport
- Can triage – don't have to address all at one visit
- Often first time of diagnosis for some chronic issues
- Close follow up is key

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PRIMARY CARE

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Importance of Primary Care

- Continuity is key!
- Ask questions, be gender sensitive whenever possible, provide trauma-informed care
  - Establish trust
  - Nonverbal communication- smile, express welcome & interest
  - Reinforce counseling
  - Define interpreter preferences
  - Ask about adjustment, sleep, pain syndromes
  - Do not make assumptions, but realize cultural context and remember refugees are coming from instability, persecution, displacement, violence, trauma, loss

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Our approach for continuity challenges in a residency program

- Team based care
  - Three consistent providers, case manager, social work/behavioral health, referrals coordinator, on site interpreters
  - Access
  - Frequent visits
  - PCMH /shared care model
  - Intensive services especially in first year

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Working with interpreters

- Very important skill!
  - Speak directly to the patient
    - Acknowledge the interpreter as a professional
    - Introduce yourself
  - Choose your words to be concise and simple
    - Speak slowly rather than loudly
    - Speak in short segments of information
  - Give permission to interject culturally appropriate communication
    - Many concepts have no equivalent in other languages
  - If not working – step back and review dynamics
    - Encourage interpreter to ask questions or alert you to misunderstandings
    - Avoid patronizing the patient
  - Be patient!

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Primary Care Considerations: Infectious Disease

- TB
- HIV
- STI
- Malaria
- Viral hepatitis – especially hepatitis B
- Neglected tropical diseases
  - Schistosomiasis/strongyloides
  - Soil transmitted helminthes
- Skin
  - Fungal very common
  - Leishimaniasis

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Primary Care Considerations: Undifferentiated Chronic Disease

- HTN
- Cardiomyopathies
- DM
- Chronic pain
- TBI
- Developmental concerns
- Genetic syndromes
- Cancer
- Limb deformities from trauma or other

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Primary Care Considerations: Mental Health

- Chronic PTSD
  - Repeated exposure to war and trauma
- Depression/anxiety
- Agoraphobia
- Previously undiagnosed bipolar, schizophrenia
- Psychosis occurring in process of resettlement stress

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POPULATION SPECIFIC CONSIDERATIONS AND CASES

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+ Medical Update

Case #1

- 3yoF, arrived in US with refugee status from Uganda (family from DRC) 6 weeks ago
- In for acute visit with c/o on and off fevers for 1 week
  - Subjective
  - Mostly at night
  - Decreased appetite, runny nose, sneezing
  - No sore throat, n/v, abd pain, or dysuria
- No significant PMH
  - Received coartem, prazi, ivermectin, and albendazole pre-dept
- Exam
  - Vitals: HR 124, BP 108/68, RR 24, O2 98% RA, Temp 98.9F
  - Exam normal other than rhinorrhea/nasal congestion
- DDx?

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Case #1 - con't

- Labs
  - CBC: WBC 5.0, Hgb 10.2, Plts 132K
  - UA: no blood, no protein, SG <1.005, 25 LE, 2 WBCs, no nitrites
- Presumptive dx?
  - Malaria
- Add'l labs done
  - Parasite smear - +P. malariae, 0.2% parasitemia
  - G6PD - normal
- Treatment?
  - Malarone x 3 days

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Malaria Pearls

- Always suspect it!
- Diagnosis
  - Blood smear
  - RDT
  - PCR (not useful for acute setting)
- Need to know:
  - Any severe features?
    - AMS, Hgb <7, renal failure, ARDS, hypotension, DIC, spontaneous bleeding, acidosis, hemoglobinuria, jaundice, generalized convulsions, parasitemia >5%
  - Species- Faciparum or not?
  - % parasitemia
- CDC Malaria Hotline – 770-488-7788

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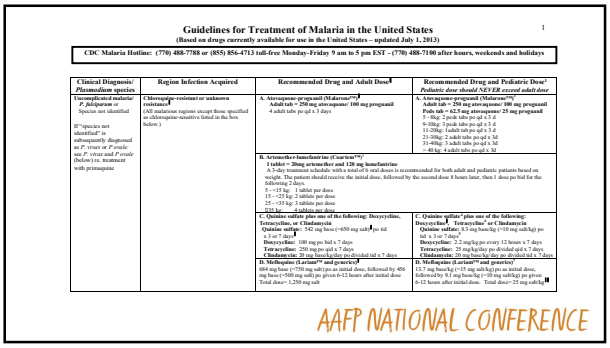

Guidelines for Treatment of Malaria in the United States
(Based on drugs currently available for use in the United States – updated July 1, 2013)

CDC Malaria Hotline: (770) 488-7788 or (855) 856-4713 toll-free Monday-Friday 9 am to 5 pm EST - (770) 488-7100 after hours, weekends and holidays

Clinical Diagnosis/ *Plasmodium* species	Region Infection Acquired	Recommended Drug and Adult Dose[1]	Recommended Drug and Pediatric Dose[2] *Pediatric dose should NEVER exceed adult dose*
Uncomplicated malaria/ *P. falciparum* or Species not identified If "species not identified" is subsequently diagnosed as *P. vivax* or *P ovale* then *P. vivax* and *P ovale* Dalow) rec. treatment with primaquine	Chloroquine-resistant or unknown resistance[3] (All malarious regions except those specified as chloroquine-sensitive listed in the box below.)	**A. Atovaquone-proguanil (Malarone™)[4]** **Adult tab = 250 mg atovaquone/ 100 mg proguanil** 4 adult tabs po qd x 3 days	**A. Atovaquone-proguanil (Malarone™)[4]** **Adult tab = 250 mg atovaquone/ 100 mg proguanil** **Peds tab = 62.5 mg atovaquone/ 25 mg proguanil** 5 - 8kg: 2 peds tabs po qd x 3 d 9-10kg: 3 peds tabs po qd x 3 d 11-20kg: 1 adult tab po qd x 3 d 21-30kg: 2 adult tabs po qd x 3d 31-40kg: 3 adult tabs po qd x 3d > 40 kg: 4 adult tabs po qd x 3d
		B. Artemether-lumefantrine (Coartem™)[5] **1 tablet = 20mg artemether and 120 mg lumefantrine** A 3-day treatment schedule with a total of 6 oral doses is recommended for both adult and pediatric patients based on weight. The patient should receive the initial dose, followed by the second dose 8 hours later, then 1 dose po bid for the following 2 days. 5 – <15 kg: 1 tablet per dose 15 – <25 kg: 2 tablets per dose 25 – <35 kg: 3 tablets per dose ≥35 kg: 4 tablets per dose	
		C. Quinine sulfate[6] plus one of the following: Doxycycline, Tetracycline, or Clindamycin **Quinine sulfate:** 542 mg base (=650 mg salt)[7] po tid x 3 or 7 days[8] **Doxycycline:** 100 mg po bid x 7 days **Tetracycline:** 250 mg po qid x 7 days **Clindamycin:** 20 mg base/kg/day po divided tid x 7 days	**C. Quinine sulfate[6] plus one of the following: Doxycycline[9], Tetracycline[9] or Clindamycin** **Quinine sulfate:** 8.3 mg base/kg (=10 mg salt/kg) po tid x 3 or 7 days[8] **Doxycycline:** 2.2 mg/kg po every 12 hours x 7 days **Tetracycline:** 25 mg/kg/day po divided qid x 7 days **Clindamycin:** 20 mg base/kg/day po divided tid x 7 days
		D. Mefloquine (Lariam™ and generics)[9] 684 mg base (=750 mg salt) po as initial dose, followed by 456 mg base (=500 mg salt) po given 6-12 hours after initial dose Total dose= 1,250 mg salt	**D. Mefloquine (Lariam™ and generics)[9]** 13.7 mg base/kg (=15 mg salt/kg) po as initial dose, followed by 9.1 mg base/kg (=10 mg salt/kg) po given 6-12 hours after initial dose. Total dose= 25 mg salt/kg

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Guidelines for Treatment of Malaria in the United States 2
(Based on drugs currently available for use in the United States – updated July 1, 2013)

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Uncomplicated malaria/ ***P. falciparum*** or ***Species not identified***	**Chloroquine-sensitive** (Central America west of Panama Canal; Haiti; the Dominican Republic; and most of the Middle East)	**Chloroquine phosphate (Aralen[USA] and generics)[a]** 600 mg base (=1,000 mg salt) po immediately, followed by 300 mg base (=500 mg salt) po at 6, 24, and 48 hours Total dose: 1,500 mg base (=2,500 mg salt) **OR** **Hydroxychloroquine (Plaquenil[USA] and generics)** 620 mg base (=800 mg salt) po immediately, followed by 310 mg base (=400 mg salt) po at 6, 24, and 48 hours Total dose: 1,860 mg base (=2,400 mg salt)	**Chloroquine phosphate (Aralen[USA] and generics)[a]** 10 mg base/kg po immediately, followed by 5 mg base/kg po at 6, 24, and 48 hours Total dose: 25 mg base/kg **OR** **Hydroxychloroquine (Plaquenil[USA] and generics)** 10 mg base/kg po immediately, followed by 5 mg base/kg po at 6, 24, and 48 hours Total dose: 25 mg base/kg
Uncomplicated malaria/ ***P. malariae or P. knowlesi***	**All regions**	**Chloroquine phosphate:**[a] Treatment as above **OR** **Hydroxychloroquine:** Treatment as above	**Chloroquine phosphate:**[a] Treatment as above **OR** **Hydroxychloroquine:** Treatment as above
Uncomplicated malaria/ ***P. vivax*** or ***P. ovale***	**All regions** Note: for suspected chloroquine-resistant *P. vivax*, see row below	**Chloroquine phosphate[a] plus Primaquine phosphate[c]** **Chloroquine phosphate:** Treatment as above **Primaquine phosphate:** 30 mg base po qd x 14 days **OR** **Hydroxychloroquine plus Primaquine phosphate[b]** **Hydroxychloroquine:** Treatment as above **Primaquine phosphate:** Treatment as above	**Chloroquine phosphate[a] plus Primaquine phosphate[c]** **Chloroquine phosphate:** Treatment as above **Primaquine:** 0.5mg base/kg po qd x 14 days **OR** **Hydroxychloroquine plus Primaquine phosphate[b]** **Hydroxychloroquine:** Treatment as above **Primaquine phosphate:** 0.5mg base/kg po qd x 14 days
Uncomplicated malaria/ ***P. vivax***	**Chloroquine-resistant[d]** (Papua New Guinea and Indonesia)	**A. Quinine sulfate plus either Doxycycline or Tetracycline plus Primaquine phosphate** **Quinine sulfate:** Treatment as above **Doxycycline or Tetracycline:** Treatment as above **Primaquine phosphate:** Treatment as above **B. Atovaquone-proguanil plus Primaquine phosphate[c]** **Atovaquone-proguanil:** Treatment as above **Primaquine phosphate:** Treatment as above **C. Mefloquine plus Primaquine phosphate[c]** **Mefloquine:** Treatment as above **Primaquine phosphate:** Treatment as above	**A. Quinine sulfate plus either Doxycycline[e] or Tetracycline[f] plus Primaquine phosphate[c]** **Quinine sulfate:** Treatment as above **Doxycycline or Tetracycline:** Treatment as above **Primaquine phosphate:** Treatment as above **B. Atovaquone-proguanil[g] plus Primaquine phosphate[c]** **Atovaquone-proguanil:** Treatment as above **Primaquine phosphate:** Treatment as above **C. Mefloquine plus Primaquine phosphate[c]** **Mefloquine:** Treatment as above **Primaquine phosphate:** Treatment as above
Uncomplicated malaria: alternative for pregnant women[h,i,j,k,l,m]	**Chloroquine-sensitive** (see uncomplicated malaria sections above for chloroquine-sensitive species by region)	**Chloroquine phosphate:** Treatment as above **OR** **Hydroxychloroquine:** Treatment as above	Not applicable
	Chloroquine-resistant (see uncomplicated malaria sections above for regions with chloroquine-resistant *P. falciparum* and *P. vivax*)	**Quinine sulfate plus Clindamycin** **Quinine sulfate:** Treatment as above **Clindamycin:** Treatment as above **OR** **Mefloquine:** Treatment as above	Not applicable

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Guidelines for Treatment of Malaria in the United States 3
(Based on drugs currently available for use in the United States – updated July 1, 2013)

CDC Malaria Hotline: (770) 488-7788 or (855) 856-4713 toll-free Monday-Friday 9 am to 5 pm EST - (770) 488-7100 after hours, weekends and holidays

Severe malaria[n,o,p,q,r]	**All regions**	**Quinidine gluconate[s] plus one of the following: Doxycycline, Tetracycline, or Clindamycin** **Quinidine gluconate:** 6.25 mg base/kg (=10 mg salt/kg) loading dose IV over 1-2 hrs, then 0.0125 mg base/kg/min (=0.02 mg salt/kg/min) continuous infusion for at least 24 hours. An alternative regimen is 15 mg base/kg (=20 mg salt/kg) loading dose IV infused over 4 hours, followed by 7.5 mg base/kg (=10 mg salt/kg) IV every 8 hours, 4 hours after beginning the loading dose (see package insert). Once parasite density <1% and patient can take oral medication, complete treatment with oral quinine, dose as above. Quinidine/quinine course = 7 days in Southeast Asia; = 3 days in Africa or South America. **Doxycycline:** Treatment as above. If patient not able to take oral medication, give 100 mg IV every 12 hours and then switch to oral doxycycline (dose as above) as soon as patient can take oral medication. For IV use, avoid rapid administration. Treatment course = 7 days. **Tetracycline:** Treatment as above **Clindamycin:** Treatment as above. If patient not able to take oral medication, give 10 mg base/kg loading dose IV followed by 5 mg base/kg IV every 8 hours. Switch to oral clindamycin (oral dose as above) as soon as patient can take oral medication. For IV use, avoid rapid administration. Treatment course = 7 days. ***Investigational new drug (contact CDC for information):*** **Artesunate followed by one of the following: Atovaquone-proguanil (Malarone[USA]), Clindamycin, or Mefloquine**	**Quinidine gluconate[s] plus one of the following: Doxycycline[t], Tetracycline[t], or Clindamycin** **Quinidine gluconate:** Same mg/kg dosing and recommendations as for adults. **Doxycycline:** Treatment as above. If patient not able to take oral medication, may give IV. For children <45 kg, give 2.2 mg/kg IV every 12 hours and then switch to oral doxycycline (dose as above) as soon as patient can take oral medications. For children ≥45 kg, use same dosing as for adults. For IV use, avoid rapid administration. Treatment course = 7 days. **Tetracycline:** Treatment as above **Clindamycin:** Treatment as above. If patient not able to take oral medication, give 10 mg base/kg loading dose IV followed by 5 mg base/kg IV every 8 hours. Switch to oral clindamycin (oral dose as above) as soon as patient can take oral medication. For IV use, avoid rapid administration. Treatment course = 7 days. ***Investigational new drug (contact CDC for information):*** **Artesunate followed by one of the following: Atovaquone-proguanil (Malarone[USA]), Clindamycin, or Mefloquine**

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MALARIA CASE SURVEILLANCE REPORT
Department of Health and Human Services, Centers for Disease Control and Prevention
Division of Parasitic Diseases (MS F-22), 4770 Buford Highway, N.E. Atlanta, Georgia 30341
Part I

State Case No: ..... CSID No..... Case No: .....

Patient name (last, first):

Date of symptom onset of this attack (mm/dd/yyyy): ____/____/____

Physician name (last, first):

Telephone Number: ( ) _____ – _____

Positive lab test result (*check all that apply*):
☐ Smear ☐ PCR ☐ RDT ☐ No test done/unknown

Species (check all that apply):
☐ Vivax ☐ Falciparum ☐ Malariae ☐ Ovale ☐ Not Determined
☐ Other species (specify) _____

Parasitemia (%): _____

Laboratory name:

Telephone Number: ( ) _____ – _____

Age: _____ **yrs. mos. wks. days** (circle one)
Date of Birth: ____/____/____
Is patient pregnant? ☐ Yes ☐ No
Height: _____ **ft. and** _____ **in.** Weight: _____ **lbs.**

Sex:
☐ Male
☐ Female
☐ Unknown

Ethnicity:
☐ Hispanic or Latino
☐ Not Hispanic or Latino

Race (select one or more):
☐ American Indian/Alaska Native
☐ Native Hawaiian/Other Pacific Islander
☐ Black or African American
☐ Asian ☐ White ☐ Unknown

State/territory reporting this case: _____
County: _____

Patient admitted to hospital: ☐ Yes ☐ No ☐ Unknown
Hospital: _____
Date: ____/____/_____ Hospital record No.: _____

Specimens being sent to CDC? ☐ Yes ☐ No ☐ Unknown
If yes: ☐ Smears ☐ Whole Blood ☐ Other: _____

Has the patient traveled or lived outside the U.S. during the past 2 years? ☐ Yes ☐ No If yes, specify:
Country: 1. _____ 2. _____ 3. _____

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Case #2

- 2.5yoM, arrived in the US with refugee status from DRC via Tanzania, 10 months ago. Coming in for WCC.
- Parents deny any concerns about health, growth, development, hearing, vision or speech. They comment on poor appetite since arrival in the US.
- Height 34.5inches, weight 24lbs
  - Well appearing on exam
  - Meeting developmental milestones
- DDx?

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Case #2 – con't

- Lab results:
  - CBC – WBC 9,8, Hgb 12.4, Plts clumped
  - HBsAg neg, HIV neg
  - Lead <1.9
  - Schisto/strongy IgGs neg
- Stool studies
  - Negative culture
  - Giardia antigen positive
  - O&P – rare Giardia lamblia cysts and trophozoites, rare Entamoeba coli cysts and trophozoites
- Treatment?
  - Giardiasis
    - Tinidazole 50mg/kg single dose for kids >3. Albendazole 400mg x 5 days, Metronidazole 5-10mg/kg TID for 7 days, or nitazoxanide 100mg BID for 3 days for kids <3
  - Entamoeba coli
    - Nonpathogenic – no tx needed

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Democratic Republic of Congo

- Parasitic infections, including Malaria
- Mental Health
- Gender and sexual based violence

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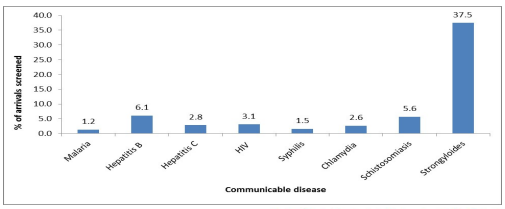
Communicable diseases found in Congolese refugees during domestic medical examinations in 6 states from 2010–2013 (n=2,355)*

Source: Refugee health screening data from health departments in Colorado, California, Illinois, Texas, New York and Indiana



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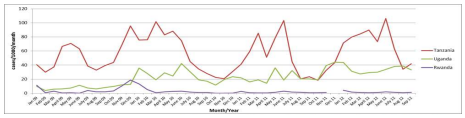
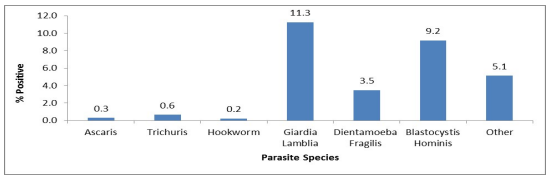
Parasitic Infections

- Strongyloides =parasitic nematode
  - known to persist > 50 years in host
  - hyperinfection- when parasite infiltrates organs has > 50% mortality rate
- Schistosomiasis= uxorious worm
  - can last 10-30 years, 2nd to malaria as far as impact
- Malaria



Parasites found in stool ova and parasite examination in Congolese refugees from 2010–2013 (n=1,347)



Parasites represented in the Other category include Chilomastix mesnili, Endolimax nana, Entamoeba coli, Entamoeba hartmanni, and Iodamoeba buetshlii

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Mental Health/PTSD from DRC

- 41% of the adult population=major depressive disorder (MDD)
- 50% for PTSD
- After extrapolation of this study data
  - 3.25 million adults meet criteria for PTSD
  - 2.63 million meet criteria for MDD
  - ~1.04 million have attempted suicide.

This was a population based study conducted in eastern DRC

Available at: http://www.lawrynesearch.com/553.

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Accessing Services for Congolese

- People from DRC have high degree of mental health issues after arrival in US, - including depression, anxiety disorder, substance abuse, and domestic violence.
- 2 challenges identified after arrival in US for accessing help
  - interpretation needs
  - client's refusal of services.
- Group psychotherapy was found to be more effective at reducing PTSD, depression and anxiety symptoms, while improving overall functioning
- Trust built between patient and caregiver allow open discussion.

Above information was based on report surveying 43 local resettlement agencies serving refugees from DRC in US.

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Gender Based Sexual Violence

- One study estimated that 48 women are raped every hour in DRC, which is a little over 1,150 women a day.
  - In addition 50 % of rape victims are found to have no access to medical care
  - Complications include fistula, pregnancy, infertility, genital mutilation, HIV/AIDS and other sexually transmitted diseases
- In another study, rates of reported sexual violence were 40% among women, and 24% among men.

8.Peterman A, Palermo T, Bredenkamp C. Estimates and determinants of sexual violence against women in the Democratic Republic of Congo. Am J Public Health 2011;101:1060-7.

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Do's & Don't /Gender Based Violence

Do
- Use same gender interpreters and staff when possible
- Identify who patient trusts
- Build a trusting relationship over time
- Realize what is at stake
  - Ostracized from spouse, family, community

Don't
- Ask directly about rape
- Ask questions about paternity of children
- Ask questions regarding sexual health with other family members in room
- Try to fit the person sitting in front of you into a checklist you are trying to get through

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Case #3

- 46yoM, arrived in the US with refugee status from Iraq, coming in for first primary care visit. Reports difficulty sleeping.
  - PMH
    - Kidney stone 2 years ago
    - Uses inhaler occasionally, ?dx of asthma
  - Vitals – Weight 104.5kg, HR 87, BP 154/98, RR 14, O2 94% RA
  - Labs
    - WBC 5.6, Hgb 16.8, Plts 287
    - UA trace protein
    - Gluc 130
    - T spot negative
    - HIV, HBsAg negative
    - RHS-15 positive
- What do you want to know?
- Considerations for additional w/up/treatment?

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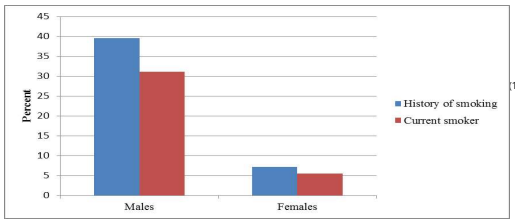
Iraq

- Most Common
  - Hypertension
    - 33% >15 yo (N13,299)
    - 10% aware of diagnosis
  - DM
  - Smoking
  - PTSD
  - Obesity
    - 38% overweight
    - 34% obese
- Other Considerations
  - G6PD
  - Thalassemia

Self-reported tobacco use among Iraqi refugees during visa medical examinations at panel physician sites, 2008-2013 (N=63,322)



(18)

- Source: CDC's Electronic Disease Notification system (EDN) (18)

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PTSD

The International Rescue Committee has remarked that the population from Iraq arrive with more emotional issues than many other refugees

- International Rescue Committee. The Health of Refugees from Iraq. 2009. http://www.rescue.org/iraqi-refugees

2012 CDC survey of Iraqi refugees who had lived in the United States 8-36 months
- 50% anxiety
- 49% depression
- 31% need PTSD assessment

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From Iraq but been to Syria?

Study done of Iraqis in Syria
-89.5% depression, 81.6% anxiety, 67% PTSD
WHY? Reported experiences….
-77% bombardments, shelling, rockets
-80% shooting
-75% knew someone killed
-60% interrogation/harassment
-What symptoms of PTSD should you look for?

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Interpreter Input- Iraq

- Ramadan awareness
- Culturally, in the US health information is much more direct
- Gender sensitivity
  - Female provider touching male patient ? Ask permission/ wear gloves?

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Case #4

- 47yoF, arrived in the US with refugee status from Bhutan via Nepal, coming in for follow up visit.
  - Hx congenital hip dysplasia, vision impairment, decreased hearing, and HTN
- Screening labs notable for Hgb 10.3, MCV 74.6
- Pt reports all over body pain, including HAs and chest pains, and poor appetite. Otherwise feels well.
- Additional work-up you'd like?
  - B12 level 286
  - Hgb electrophoresis - Hgb S/E disease

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Bhutan

- Anemia
- Vitamin B12 deficiency
- Mental Health

Anemia In Bhutanese

Texas study numbers found anemia in refugees from Bhutan as follows. These numbers are reflective of worldwide anemia statistics from WHO.

- 19% in women of reproductive age
- 28% in pregnant women
- 20% children < 15 yo
- 20% adults 65 yo

- 2007 study in Nepal found anemia in 13.6% mothers and 43.3% of children aged 6-59 months.

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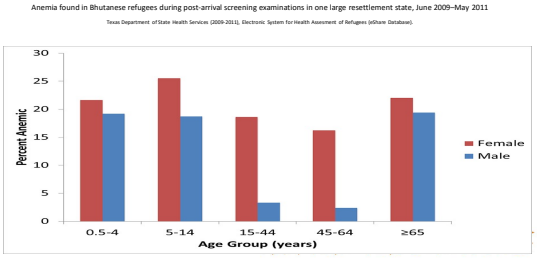
Anemia in Bhutanese



Causes of Anemia

- Most common cause= iron deficiency
- Parasites
- Malaria
- Vitamin B 12 deficiency
- TB
- Hemoglobinopathies
- Chronic disease

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Vitamin B12 deficiency

- Prevalence in Bhutanese refugees is estimated at 30-60%(CDC study 2008-2011)
- Per CDC, it is recommended that Bhutanese refugees be given nutritional advice and advised on supplemental vitamin B12 upon arrival in the U.S.
- Also Note-Vitamin B2 (riboflavin) deficiency –look for angular stomatitis in adolescents, has also been identified in this population.

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Bhutan- PTSD/Suicide

- Some refugees may have been tortured prior to fleeing Bhutan.
- People with symptoms of PTSD were more likely to report suicidal ideation than those without PTSD.
- Post arrival difficulties most associated with suicidal ideation were
  - Anxiety/depression
  - family conflict
  - unable to find work

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Suicide Rates

- The global suicide rate is 16 per 100,000
- The U.S. rate for the general population is 12.4.
- The rate for Bhutanese refugees settled in the US is 20.3
- The rate in Bhutanese refugee camps in Nepal is 20.7

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Case #5

- 19yoF, arrived in the US with refugee status from Somalia via Kenya, with hx Down Syndrome.
- Class B1 for TB due to abnormal CXR overseas
  - CXR read – "bilateral apical infiltrates, right upper/midzone peripheral fibrotic streak"
  - Sputum smear and culture negative x 3 overseas
- T spot positive on screening labs
- What do you want to know?
  - Pt asymptomatic, reports no cough, fever, weight loss, or night sweats

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Case #5 – con't

- US CXR – "moderate diffuse coarse bilateral reticular opacities. Cannot exclude underlying bronchiectasis. No cavitary lesions."
- Sputum
  - Smear neg x 3, NAAT neg
  - After 4 weeks, 1/3 cultures grew MTB, pansensitive isolate
- Now what?

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TB Pearls

- Always think about it! Pulm vs extra-pulm
- IGRA often preferable to TST
- Low threshold for sputum collection
- Treat LTBI when you can
- Develop relationship with your local health department

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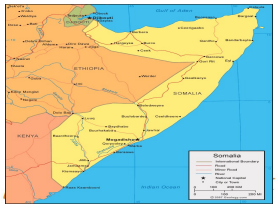
Somalia

- Depression, Anxiety, PTSD
- Infectious Diseases
- Hypertension
- Diabetes
- FGM



Nin madaxa laga haayo, meeli uma fiyooba:

"If a person has a sickness or pain in their head, no other parts will work"

(Somali idiom trasnslated ;Palinkas et al., 2003)

- Study found 80 % with depression, anxiety, PTSD
- More associated psychosis than other refugee populations
- Distinct somatic complaints.
- Anxiety more associated with Khat use
- Always consider possible history of head injury

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Somali- PTSD

- Use metaphors when you can- example of stepping out in to street and almost getting hit by car for PTSD
- Listen, take time- it may take several visits of listening to physical complaints before open up and connect to past trauma-may prefer primary provider than formal services due to cultural stigma of mental illness.
- *Shaki*- worrier
- *Murung*- mild depression
- *Waali*- crazy
- Many terms for spirit possession

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Interpreter Input- Somalia

- Careful about direct health information or words you use
- Try to explain the context first
- Often when a diagnosis is made – they immediately make their own associations with the diagnosis- and do not hear what else is said

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Case #6

- 54yoM, arrived in the US with refugee status from Myanmar via Thailand. Also spent time in Cambodia and India prior to US arrival.
- Screening labs:
  - CBC- WBC 8.0, Hgb 13.9, Plts 197
  - Gluc 97
  - UA with trace blood and 6 RBCs
  - T spot positive
  - HIV neg, HBsAg neg
- Additional w/up?
  - Cr 0.86, LFTs normal
  - Urine O&P neg
  - Schisto IgG positive
- Now what?

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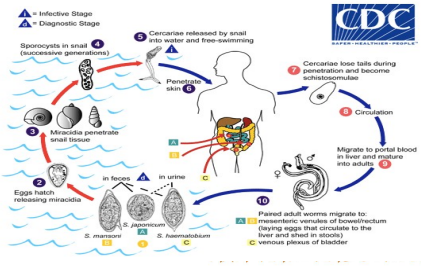
Schistosomiasis



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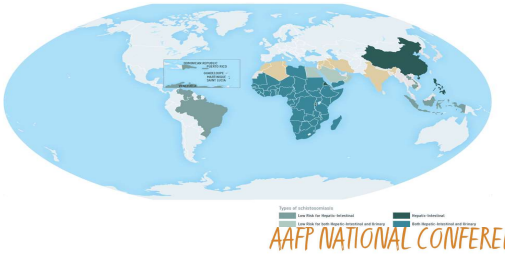
Worldwide Distribution of Schisto



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Schistosomiasis – con't

- Diagnosis can be tricky
  - Stool/urine O&P
  - IgGs show infection at some point
  - Incubation period 14-84 days; many asymptomatic
- Treatment
  - Praziquantel 40mg/kg in 2 divided doses for 1 day
    - 60mg/kg in 3 divided doses for 1 day if S. japonicum or S. mekongi
  - Effective against adult worms
    - May need second course of tx

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Myanmar

Western

- Parasitic infection, including malaria
- Hepatitis B
- Anxiety
- Nutrition
- Smoking
- Domestic Violence

Eastern

- Hot & Cold Fluctuations
- Healthy Blood
- "Food is Medicine, Medicine is Food"
- Betel Nut
- Expected to be stoic regarding mental illness

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Interpreter Input - Myanmar

- Culturally, they do not discuss sexual health
- Provide opportunity for patient to provide information- for example…
- Instead of
  - "Are you taking any medication?"
- Try
  - "Tell me about any medication you take or treatment you use when you feel sick."

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Summary

- There are health conditions specific to the refugee populations we serve
  - Infectious disease, chronic disease
- Trauma is pervasive in refugee populations
  - Trauma awareness is needed
  - Efforts to be gender sensitive are essential
- Consider what is most appropriate culturally
- Despite political pressures or national climate – care for the patient in front of you. He or she needs your help, your compassion, and your smile!

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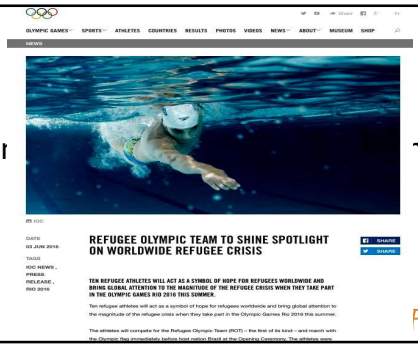

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Q&A

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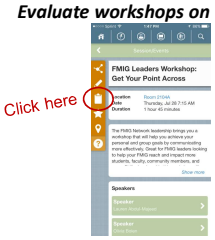
Evaluate workshops on the NC app



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