Refugee health

Epidemiological paradox
The refugee experience

• Each individual experience is very particular:
• Within their countries there are significant differences: language, dialect, culture, religious backgrounds, exposure to traumatic events, etc
• Some refugees never have seen their “country of origin”
• The refugee camp is not a camp
Screening

- Tuberculosis
- HIV
- Hepatitis B and C
- Parasitic infections
- STDs: Syphilis, gonorrhea, chlamydia, Herpes, genital warts
- Malaria
Tuberculosis Screening

• In individuals 5 and older: Quantiferon test
• In children under 5 we test with PPD
• Active TB is uncommon
• Latent Tuberculosis infection is currently treated with rifampin for 4 months
HIV

• All individuals diagnosed with HIV infection were from African countries, predominantly the Democratic Republic of Congo
Infectious Hepatitis

• Hepatitis B is the most prevalent condition
• Most likely the transmission is sexually or vertical during delivery
• Hepatitis C screening is using the antibody reflexed to PCR
• We are currently treating Hep C in the primary care setting
• We don’t test for hep A
Parasitic infections

• We don’t do universal testing
• We test patients with symptoms and significant eosinophilia
STD

• We test syphilis serology for children 2 and older
• GC and chlamydia is tested for women having PAPs
• We do physical exam including genital exam to all males and females that are older than 18 or are sexually active
Screening

- Blood count
- Lead screening
- Micronutrient screening
- Cancer screening
- Chronic disease screening
- Mental health screening: Depression, Anxiety, PTSD
Barriers

• Cultural competence
• Language Access: Use trained interpreters
• Health disparities: Access, financial disincentives, diversify health care workforce
• Navigation of healthcare system
• Social Services: Cash and medical assistance, employment
• Mental health
Mental Health

• Screening and treatment of mental health problems is suboptimal: multiple reasons but especially lack of evidence –based interventions
• Higher rates of depression and anxiety
• Higher rates of suicide
• Somatization and health care utilization
• PTSD
• Substance abuse
• Prevalence is related to trauma exposure and post-migration socio-economic factors
Suicide prevention

• Improve sense of belonging and meaning
• Community building
• Gatekeeper model: Those who are in contact with refugee regularly can be trained to identify and refer people at risk
• Treat people with mood disorder, people with previous suicidal attempt and those who are having suicidal ideation
PTSD


• Psychological states: Humiliation, anger, revenge/hatred and hopelessness/despair

• Emotional States: “emotional firestorm”

• Physical illnesses: HTN, cardiovascular disease, diabetes, premature death

• Avoid over-medicalizing mental health
PTSD

- How to help to have purpose of life in the USA-Fargo
- Financial problems, social isolation
- Pain is always real: Avoid unnecessary testing/imaging. No correlation between anatomy and chronic pain
- When using meds focus on practical benefits: sleep, energy, reduced nightmares
- Legal concerns:
Practical Points

• Learn about their particular refugee experience.
• Greet in their language: even if you sound funny
• Use medically trained interpreters
• Give bad news face to face
• For mental health diagnosis: Use symptoms
• Develop clinical guidelines and best practice orders
• Use community health workers: Time for certification?