12

Refugee Health

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Overview—Refugee Problems

During the 20th century more than 15 million refugees have relocated to the United States. During the decade from 1986 to 1996 there have been 25 to 30 million displaced persons in the world during any given month. Some of these have become immigrants to the United States, some have returned to their homes, and many are still waiting for permanent relocation. Throughout the 1990s there have been large refugee camps in Asia, Europe, and Africa. Each area has its own unique problems.

The majority of refugee groups throughout the world have evolved from political upheavals and ethnic struggles within their countries of origin. As a result, the refugees suffer not only from physical but also mental trauma. Being a refugee often has lifelong consequences for refugee families even when relocation is rapid, safe, and provides generously for material needs. In fact, most relocations are slow, involve a great deal of chaos, and are accompanied by poverty. In general, refugee settings lack adequate attention and programs for the most vulnerable—pregnant and nursing mothers, children, and the elderly. Although they should provide safety and a haven, refugee settings often contribute to continuing physical and mental risks for the most vulnerable. These have negative impacts for productivity, economics, and political stability that adversely affect the whole world.

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Examples of Refugee Camps

Refugee camps are grim places, in general. Housing is extremely crowded, sanitation is poor, there is a frequent risk of fire, and the noise level is high. In spite of this, refugee men often develop small businesses and are busy (Torjesen, Olness, & Torjesen, 1981). Women are usually very busy with the complexities of carrying food and water from distribution points, cooking, washing, and child care in refugee camps. There seems to be little doubt that women in many refugee settings have large numbers of children (Wulf, 1994). Centers for Disease Control researchers in a refugee camp in Thailand documented that the crude birth rate in 1980 was 55 per 1,000, a high rate (Toole & Waldman, 1988). Unfortunately, the high rates of pregnancy are at the expense of refugee women's already fragile health status. The World Health Organization (WHO) definition of high-risk criteria among pregnant women includes ages under 19 or over 40, women with no accompanying family, illiterate women, women with less than 2 years between births, women suffering acute chronic or medical conditions or infection, women with poor immunization status, or women being served by health providers who

S. Loue (ed.), *Handbook of Immigrant Health*

do not speak their language (United Nations High Commission for Refugees, 1993). Unfortunately, many refugee women fit this definition and the repercussions from high-risk pregnancies for both the women and their infants are negative. For example, the fetus may be at risk from maternal infections with tuberculosis, hepatitis, malaria, gonorrhea, chlamydia, HIV virus, syphilis, or several of these diseases.

Food rations in refugee camps are based mainly on total calorie intake rather than on a population's specific nutritional needs. In many societies women serve the male members of the family and their children before they eat themselves. It is likely that the majority of refugee women suffer from malnutrition, especially iron and calcium deficiencies.

Existing health services in most refugee settings overlook specific needs of women. This ranges from provision of sanitary supplies for menstruating women to provision of birth spacing services. When birth spacing services do exist, they are often insensitive to refugee beliefs, fears, and educational level. Health education regarding sexually transmitted diseases is usually inadequate for both men and women and nonexistent for adolescents. In both Asian and African countries there are beliefs that a man can cure AIDS by having sex with a virgin. This belief has jeopardized the lives of many young females, as young as 4 or 5 years, and caused transmission of HIV infection to them.

Labor and delivery is hazardous in refugee settings. Properly equipped facilities for complicated deliveries are not often available. Many women do not have supportive family members to help them during labor and delivery. Most refugee women will choose to give birth at home, often because they do not like being treated by health professionals who are not of their own gender or ethnic group.

Somali Refugees in Kenya (Wulf, 1994)

Overall conditions of the camps were described as relatively good in 1993. However, the heat, dust, flies, and refuse piles reinforced an unrelenting impression of hardship. Camps were divided into sections with leaders, and each section chose a male community health worker. They provided information about hygiene, sanitation, and malaria prevention. Community development workers, some of them female, were also trained to carry out community clean-ups, cooking demonstrations, or protection of the elderly. Every camp had market areas including availability of a kind of pink bubble gum used to sweeten the sharp flavor of khat, the dried green leaf chewed all day by older members. In spite of these relatively well-organized circumstances and reduction of serious malnutrition, there were still many infectious diseases in these camps. Tuberculosis remained common, for example. The birth rate was high and facilities for women at high risk during pregnancy were very limited. Women leaving the camps to gather firewood were frequently raped by roving bandits, young men from the camps, or members of the Kenyan army and police force assigned to protect the camps. Somali women who were raped were then abandoned by their husbands and husbands' families if they became pregnant.

Afghan Refugee Camp Near Hangu, Pakistan (1996)

These camps had existed for about 15 years and were well organized in terms of housing, activities of daily life, and health programs. General food distribution from United Nations agencies was no longer available. Families without an employed male had problems getting adequate food. Each camp had a Basic Health Unit (BHU), open several days of the week and staffed with both Afghan and Pakistani physicians and nurses. Each camp also had volunteer Community Health Workers (CHW) and Community Health Supervisors (CHS). In recent years Volunteer Female Health Workers (FHWs) have also been trained to provide prenatal monitoring and advice to pregnant women and to assist during home deliveries. Although purdah (the requirement that women

remain in their family compound) is practiced, exceptions are made to allow women to come to the BHUs where male and female clinics are separated. The BHUs charge refugees, except widows and orphans, for health services.

In general the CHW and FHW teaching, often done while patients wait to be seen, is excellent. For example, they provide discussions on control of mosquitos, flies, and preparation of oral rehydration solution made with wheat and sugar. FHWs have been able to change some traditional practices such as smearing cow dung on umbilical cords shortly after birth. As a female, I was allowed into Afghan homes to meet with women. I was not allowed to photograph women but I could photograph the cows tethered in the home compound. I observed training in preparation for delivery and actual delivery; training uses a box cut to simulate the birth canal. Women laughed when they told me how stupid they used to be about many things, such as smearing cow dung on the umbilical cord.

A major continuing problem in these camps was malnutrition of children. This seemed related to both lack of food and to chronic diarrhea that often affected toddlers. There were many children with evidence of developmental delays, genetic disorders, and cerebral palsy. Some of this may relate to frequent marriages among cousins. Birth rates were high in these camps and most couples were not interested in birth spacing, although there were a few new users of birth control each month. Most girls were not allowed to attend the refugee camp schools, and those who did attend might do so for only 2 or 3 years. Husbands did all family shopping and it was clear that the problem of malnutrition was more likely to be resolved by education of men than of women.

Refugee Camps in Zaire

In 1994 many Rwandans fled from Rwanda into Zaire and Tanzania in the largest mass movement of refugees ever recorded. As a result the refugee camps were incredibly crowded and infectious diseases were rampant during the initial months. Within a few weeks there were 10,000 unaccompanied minors identified, most of them infants or toddlers. Although most Rwandan children were in a normal state of nutrition at the time their families fled, a majority of preschoolers were malnourished within a month of arriving in the refugee camps. Women were also malnourished and many of the lactating women complained about their shortage of breast milk. Women also appeared anxious, depressed, and overwhelmed. In general, Rwandans prefer the privacy of the nuclear family and their usual huts are spread out over hills. Undoubtedly, the proximity of shelters (mostly branches and plastic sheeting from the United Nations) in the refugee camps was stressful for Rwandan women. Most of the women in the camps preferred to give birth in their hut rather than in the camp hospitals because they prefer the squatting position for delivery. This was not allowed in the hospitals.

Rwandan women leave school much earlier than men in order to take on domestic duties. In general, women do most of the work. The insistence on privacy and independence of individual households means that women are unlikely to share new skills or information with neighbors. This reduced the transfer of knowledge about birth spacing, sexually transmitted diseases, and other health matters. At the time of the large refugee exodus, studies indicated that 30% of pregnant women in Kigali were infected with HIV. It is likely that rampant transmission of HIV has continued in the refugee camps.

In November and December 1996 the majority of Rwandan refugees returned to Rwanda. It became apparent that many of the refugees, especially the women, children, and elderly, had been held hostage by Hutu militia who were well organized in the refugee camps and used them for staging their military plans. The return to Rwanda was rapid with little concern for children. Once again, many young children were separated from parents and identified as unaccompanied minors.

What Can We Learn from the Refugee Camp Examples?

Refugees from each of the camps described became immigrants to the United States. It is unlikely that most American health providers would recognize the physical and mental hazards that these immigrants had endured. For example, a 5-year-old child who had become an orphan in one of these settings may have had normal weight on arrival in the United States. Medical records for him may be scanty or nonexistent. But if he suffered severe malnutrition in his first 2 years in the refugee setting, he is likely to have permanent brain injury with learning disabilities that will manifest by age 9 or 10 (Galler, Shumsky, & Morgane, 1996). Former refugee women may continue to have depression. They may be suspicious of Western health providers. They may have chronic ongoing infections or problems resulting from their long period of malnutrition in the refugee camps. It is noteworthy that former refugees often do not discuss the circumstances of their flight or their experiences in the refugee camps. They may be afraid that the information will jeopardize their status in the United States or may simply wish to repress the experience. It is possible for American health care providers to get specific information about various refugee settings from U.N. agencies, from the International Rescue Committee on Refugee Women and Children, or from other nongovernmental agencies (International Federation of Red Cross and Red Crescent Societies, 1996).

Traumatization of Refugees

Traumatization of refugees is often an enduring, cumulative process that continues from the native country and into the country of exile (Kleber, Figley, & Gersons, 1995). The trauma includes political repression, detention, torture, terror, battlefield experiences, disappearance of relatives and friends, separation and loss of families and friends, and hardships during the flight or in the refugee camps. Health programs for refugees must take into account such traumatization.

Uprooting, being forced to leave one's familiar surroundings, involves three forms of loss (Van der Veer, 1995):

1. The loss of love and respect experiencd in the relationship with family and friends.
2. The loss of social status in the country of exile. Most refugees have to start at the bottom of society.
3. The loss of a familiar social environment that gave meaning to life.

Adults

Van der Veer (1995) has described the experiences of refugees in three phases including (1) increasing political repression, (2) major traumatic experiences associated with a variety of emotional reactions, and (3) the phase of exile. The last includes ongoing problems in cultural adjustment, language problems, social isolation, problems in finding work, and receiving bad news from the country of origin.

All health professionals who work with adult refugees need to be sensitive to the prior traumatization and how it is likely to cause both biologic and behavioral problems. It is also important to recognize that mental health interventions appropriate for Americans may not be appropriate for refugees from very different cultures. Americans value individualism and self-analysis. This is not true for many cultures (e.g., Lao or Vietnamese). The idea that symptoms will respond to talking with a stranger over time may make no sense to a refugee. The idea of expressing anger openly is abhorrent to Southeast Asian refugees. Health providers should have some knowledge about the adult refugee's beliefs concerning causes of illness. For example Mollica and Lavelle (1988) reported that Cambodian refugees who had been tortured believed this was done to them because of their karma. They felt responsible for their own suffering.

The need to communicate through interpreters may cause problems for health professionals and for the newly arrived refugee. The choice of an interpreter must take culture into account. Issues such as gender, social status, or prior relationships may make therapy difficult. Westermeyer (1989) noted that some interpreters may have experienced traumas similar to those of the patient. In order to avoid thinking about his or her own issues, the interpreter may evade certain topics, change the subject, or inform the therapist that the interview is too stressful for the refugee.

Because of prior experiences, refugees often have a feeling of being humiliated or powerless. They are likely to be easily offended by anything in the manner of a health professional or his coworkers that resembles indifference, humiliation, or abuse of power. A traumatized refugee requires time, patience, interest, and respect. The health professional should do his or her best to give the refugee a sense of control. It is very important to help adult refugees with ongoing problems related to their traumas, because doing so improves the mental health outlook for the entire family (Gany & DeBocanegra, 1996).

In spite of the liklihood that traumatized refugees often somatize their symptoms, it is important that American health professionals also recognize they may have serious biologic diseases that can cause vague symptoms or psychological problems. For example, vague intestinal complaints may be due to parasites. Intracerebral cysts from parasites may take years to manifest and symptoms may include seizures, headaches, or vague neurologic complaints. Flukes may cause hepatic disease with resultant nausea, anorexia, and weakness. Neuropsychological symptoms may be early signs of AIDS. It is recommended that the newly arrived immigrant from Africa or Asia have stool examinations, hepatitis assays, HIV testing, blood smears, and ultrasound or MRI examinations, depending on symptoms.

Delayed disorders associated with refugee trauma have been reported by Krell (1988). Psychiatric disorders have manifested decades later in adults who were Holocaust survivors or Japanese concentration camp internees as children.

Children

A defining characteristic of refugee status is loss. Children may lose their toys, clothing, homes, friends, siblings, parents, and grandparents. The loss of a parent is a major disaster for children, and outcomes depend on the developmental stage of the child at the time of the parent's death. The most vulnerable times are in the preschool years and in early adolesence. The risk for psychological morbidity is greater if the death is unanticipated or caused by violence as is the usual situation for a refugee child. Children exposed to war have many psychosocial problems (McCloskey & Southwick, 1996).

Refugee children also suffer long-term problems as a result of severe deprivation of food or medical care. Many refugee children are malnourished. When this occurs prior to age 3 years, there is a strong liklihood of permanent brain injury with cognitive and behavioral impairments that may not be manifest until the school years (Galler *et al.*, 1996).

About a third of children exposed to political violence and trauma have subsequent severe psychological problems. Many children seem to maintain resilience in the face of political violence. It is possible that this relates to habituation, intrinsic temperament, developmental stage when violence occurred, or quality and quantity of family support. However, good studies on long-term outcomes for children exposed to violence do not yet exist (Cairns & Dawes, 1996)

Much research has been done on coping ability. Children who cope well in adversity have been termed "stress resistant" or "resilient" (Garmezy, 1987; Rutter, 1985). Rutter noted that exposure to multiple stressors decreases a child'd ability to cope successfully. Garmezy identified protective factors as personality disposition of the child, a sup-

portive milieu, and an external support system in the community. Werner (1989) also noted that the ability to find emotional support in the community is an important characteristic of children who cope well. It is important to note that refugee children may have parents but that the parents may not be very available because of their own anxiety, grief, and insecurity. The strength of the community is very important for such children, and reestablishment of community in the new country may be problematic. Refugees may themselves be wary about establishing bonds in the community. Refugees tend to reinstitute preexisting ethnic, religious, and political divisions from the society of origin in their groupings in the new country. Racism may be a problem in the new community. Refugee families sometimes move several times within the first years in the United States and this further reduces the liklihood of establishing meaningful community bonds.

Developmental issues separate the refugee child from the refugee adult. Developmental changes may make children more vulnerable in some areas but more adjustable and flexible in others. They have the advantage over their parents in that they ensocialize and acculturate into American society in a way that their parents cannot. Sometimes a role reversal occurs due to more rapid acculturation among refugee children who then assume adult-type roles (e.g., translating for the parent, answering the phone). Parents may have problems adapting to American adolescent culture. Many refugee families may not be headed by a father. This was true for 23% of 37,844 Vietnamese households in the United States in 1976 (Kelly, 1977). Conflicts developed when adolescent sons believed they should dominate their solo-parent mothers.

A study of Cambodian refugee children took place after teachers in Portland, Oregon, observed that Cambodian students demonstrated sudden fear reactions. Psychiatric interviews were then conducted with 46 of the 52 Cambodian students (Kinzie *et al.,* 1986; Sack, Clarke, & Seeley, 1996). Six children had left Cambodia before Pol Pot and had no major traumas or symptoms. The remaining children had major trauma, including forced labor starvation and loss of family members. Seven saw their own family members killed. Half suffered PTSD by *DSM-III* (American Psychiatric Association, 1980) standards, and 53% had depressive disorders, most of them mild. There was no relationship between the symptoms and age, sex, or type of trauma. There was no evidence of social impairment in school or of antisocial behavior. Authors concluded that school provided a critical culture element in supporting these students during their adjustment to a new country. A follow-up of 27 of the 40 original subjects (Sack *et al.,* 1996) found that 13 had PTSD and 11 had more severe depressive disorders; 15 were still in school and 15 were supporting themselves. Again, no antisocial behavior was reported. The patients' suffering was subjective and private. It is likely that their symptoms will continue indefinitely.

Westermeyer (1991) has noted that refugee children are at increased risk for developing mental health problems include those without their families, children with brain damage from trauma or malnutrition, those in partial families, and those whose parents are psychiatrically or socially disabled (Westermeyer, 1991). Other areas of psychopathology among refugee children include identity conflicts, learning disabilities, mental retardation, major depressions, mania, eating disorders (usually obesity), conduct disorders, posttraumatic stress disorder (PTSD), substance abuse, and parental somatization of refugee children. With respect to the last diagnosis, refugee parents may displace their own anxiety onto normal children. Psychiatric assessment of the parent is indicated in this situation.

The resilience program for children developed by Grotberg (1995) and tested in many countries involves strategies for parents and children to facilitate coping. It is a practical program that may help refugee children while in refugee camps and after resettlement.

Health Problems of Child Refugees

The health problems of child refugees are biologic, psychological, and psychophysiological. Unfortunately, even in the best of refugee management circumstances, children are ill served. While in a refugee setting, a child may receive sufficient food, water, and housing but psychological issues related to the stress of being a child refugee are seldom addressed. Although the manner in which a child reacts acutely or over the long term depends on inherent temperament, available family support, and prior experiences, it is unlikely that any refugee child will escape fear, anxiety, or depression altogether.

In a refugee setting, children are especially vulnerable because of their small size, frequent malnutrition, lack of immunity to new infectious disease agents, and poor health care. Lack of sanitation, crowding, and stress contribute to frequent infectious illnesses among children. Sexual abuse occurs often in refugee camp settings and affects both girls and boys. If parents are present, they are likely to be depressed or preoccupied with problems of daily survival and not as comforting as they might be to their children in normal circumstances. Many refugee children have observed terrible events such as murders of family members, friends, or neighbors. They have lost their familiar and treasured homes, often abruptly. Preschoolers cannot comprehend the disruption, chaos, and agony of their elders.

All of the terrible refugee events are compounded by cross-cultural and language differences when these children arrive in the United States. They may have moved multiple times as refugees and they are likely to move several times after first arrival in the United States. The perception of instability and unpredictability of life continues. They lack language skills to explain their past experiences to relatives or sponsors; in any event, the new friends may themselves be disinterested or unable to relate to the past experiences of refugees.

Evaluation of a Refugee Child

Ideally, a medical evaluation should occur soon after the arrival of the child in the United States. While specific components of laboratory examinations may be eliminated, depending on the location of the refugee camp, all evaluations should assess development, behavior, and learning. Evaluation of learning may not be possible until the child has acquired English language skills but should not be forgotten. Special efforts should be made to help the child feel comfortable during the examination. The examiner should provide toys, allow the parent or a trusted adult to hold the child, and take time for an interpreter to explain each part of the examination to the child.

History

The initial evaluation should include a careful history, including the following:

1. Reason for refugee status, location of original family home, location of refugee camps, duration as a refugee, and stressors as a refugee. Describe a typical day as a refugee child.
2. Family status including list of those who perished in the disaster leading to movement of refugees, current family members available to the child, and health of remaining family members.
3. Nutrition prior to becoming a refugee and while in the refugee camp environment. What type of food was provided to the refugee child? How many meals per day?
4. Illnesses experienced in the refugee camp, history of any epidemics experienced by many in the refugee camp, and type of medical care received.
5. Immunization history.
6. Education history if relevant.
7. Birth history, early child development history, significant illnesses prior to becoming a refugee, family medical history.
8. History of recurrent fevers, worms, loose stools, jaundice, skin rashes,

seizures, wheezing, loss of hearing, visual problems, weight loss.

9. History of sleep problems, eating problems, fears, angry behavior, or other behavior problems that might reflect the refugee experience.
10. What medications is the child currently receiving? What indigenous herbs or medications have been given to the child recently?

Physical Examination

The examination should be thorough with sensitivity to the child's culture and perceptions. For example, if the child is from a Southeast Asian culture, it is not appropriate to touch the child on the head without requesting permission. Permission must also be requested before examining the ears with an otoscope. Special attention should be paid to height, weight, head circumference, and stigmata reflecting malnutrition or child abuse. A careful neuromotor assessment is important, especially for infants and toddlers. If the child is coming from an area endemic for malaria or hepatitis, it is important to palpate the liver and spleen. Skin must also be examined closely to rule out scabies and other parasites as well as to note evidence of indigenous treatment such as coining or cupping.

Laboratory Examinations

Depending on the history and part of world from which the child came, it is appropriate to request hepatitis B screening, HIV screening, VDRL or RPR, liver function tests, hemoglobin/hematocrit, sedimentation rate, urinalysis, stool for ova and parasites, blood lead level, and skin testing for tuberculosis.

Many of these children may not have had immunizations such as rubella, mumps, hemophilus influenza, or hepatitis B. It is important to review immunization history and develop a plan to immunize the child according to U.S. standards. If no immunization history exists, the physician must embark on an accelerated immunization strategy after taking care to be certain the family understands and accepts the plan.

Treatment, Prevention, and Follow-up

It is clearly important to treat existing infectious diseases and to provide family members and sponsors information about how they can avoid contracting the diseases (Franks *et al.*, 1989). Immunizations should be brought up to date. Information should be given about appropriate diet.

Much more difficult is the treatment and follow-up with respect to psychological and developmental issues. Ideally, the refugee child should have access to a child health professional with expertise in these issues as soon as possible after arrival in the United States. If the professional is uncertain about culturally appropriate approaches, it is essential that he or she request this information from someone who is from the same culture and who has lived in the United States for some time.

The Committee on Community Health Services of the American Academy of Pediatrics ([AAP], 1997) recently published a statement to inform practitioners about the special health care needs and vulnerabilities of immigrant children and their families. This article reviews the risk factors of access to health care services, infectious diseases, psychosocial issues, dental disease, and nutritional problems. The committee recommends that pediatricians should oppose denying needed services to any child who resides within the borders of the United States, and that child health providers should educate themselves about the special cultural and medical issues of immigrant children. They should tolerate and respect differences in attitudes and approaches to child rearing and also support the extended immigrant family in health care activities. The committee also recommended that chapters of the American Academy of Pediatrics should define the health care needs of immigrant children in their areas and work

with state legislatures and agencies to assure unimpeded access to all medically necessary services for all children.

Special Issues of Internationally Adopted Children

Many internationally adopted children have been refugees in a formal sense, or their past experiences have been analogous to those of refugee children. They have suffered the worst kind of loss, the loss of their parents, and they have often been moved from place to place over relatively long periods of time. The concept of adoption is not one that is known or acceptable in many countries such as Japan, Laos, Uganda, and Pakistan. In these and other countries children without parents may be raised by relatives without formal adoptions or they are often institutionalized. The disruption of early, vital attachment relationships between children and their caretakers is one of the major hidden tragedies of war. With the lack of attachment and lack of cultural stability and restraints, these children are likely to manifest antisocial behavior as adolescents and adults.

Thus, internationally adopted children may be regarded as at risk for all the physical and mental problems of refugee children. In addition, if they are beyond a year of age when adopted, they are likely to have serious problems of attachment. This has been a particular problem for children adopted from Eastern Europe over the past decade (Keck & Kupecky, 1995). Attachment problems are complicated by concurrent cognitive problems that may exist often in those orphans who have been born to alcohol abusing mothers or who experienced early malnutrition.

Such children are often indiscriminately friendly. They do not develop a true preference for their parents. As a result they do not perceive the parents as in charge. Because they may not have experienced loving caretakers who responded quickly to their early needs, they do not trust people, are often too independent, do not recognize risks, and do not develop qualities of empathy and love. Unfortunately, this may often occur in spite of their being placed in responsive, loving families. Such children are often manipulative because that has become a useful survival skill. The adoptive parents may suffer a great deal emotionally, feeling responsible, guilty, and angry. Experienced therapists may facilitate improved bonding, but many of these children do not truly bond and behave in sociopathic ways as they become older. In recent years adoptive parents in the United States formed a Parent Network for Post Institutionalized Children. This group provides resources for families whose adopted children are having attachment difficulties (Address: P.O. Box 613, Meadowlands, PA 15347).

A study of 643 Vietnamese refugee children (Sokoloff, Carlin, & Pham, 1984) found that 72% were adopted and 20% were foster children. Both adoptive and foster parents often said that the first year after placement "drained them emotionally" due to the excessive physical and emotional needs of the children. The children had many adjustment problems. Williams and Westermeyer (1993) reported family problems in four of six unaccompanied refugee adolescents. The strife engendered by the disturbed adolescents reached such an extent in two of the families that the parents eventually divorced. Older refugee children may feel rejected by both their original culture and the resettlement culture and fail to identify with or accept either society. The perception of alienation leads to antisocial behaviors.

There are five clinics in the United States that specialize in internationally adopted children. They are able to provide guidance and resources with respect to both the physical and psychological needs of these children. They are in the Department of Pediatrics, University of Minnesota, Minneapolis, MN, phone 612-626-6777; Department of Pediatrics, Tufts University, Boston, phone 617-636-5071; and in Rainbow Babies and Children's Hospital, Cleveland, Ohio, phone 216-844-3230.

Health Problems of Adult Refugees

General Issues

The health problems of adults include both physical and mental problems. Women are likely to have more problems than men related to discrimination against females in refugee camps. In general, the problems require multidisciplinary interventions from physicians, nurses, social workers, interpreters, and community leaders working together. Health care providers must consider cross-cultural issues such as whether a male physician can examine an adult female refugee. Regarding decisions about medical procedures, it is sometimes difficult to identify the family member who has the authority to make the decision. It may be necessary to involve a grandfather or a grandmother to approve a decision for an adult refugee. There were many problems related to medical procedures when Hmong refugees first arrived in the United States, because health care providers did not understand who were decision makers in the Hmong system.

Health care providers should consider the possibility of the following health problems of adult refugees:

- Posttraumatic stress syndrome
- Depression
- Sexually transmitted diseases, including HIV
- Parasitic diseases
- Infectious diseases such as melioidosis, brucellosis, rickettsial infections, leishmaniasis, and typhoid
- Nutritional deficiencies including iron deficiency, vitamin deficiencies, and micronutrient deficiencies
- Dental problems
- Tuberculosis
- Use of indigenous herbs and drugs that the family may have brought from overseas
- Genetic diseases peculiar to the ethnic group

Adult refugees who are parents have skills in child rearing that are relevant in the society of origin. Most can benefit from education and training in child nutrition, growth and development, management of behavior problems, immunizations, accident hazards, and social resources for parents. For example, Minnesota Early Learning Design (MELD), an agency that provides long-term support groups for parents, included special support groups for Hmong parents. Sometimes the refugee parenting skills may be better than those of parents in the resettlement country. A study comparing Hmong parents and American parents of comparable socioeconomic level in Minnesota found that Hmong children had significantly fewer accidents than the children born in the United States. However, a major problem for Hmong children was obesity, especially in boys. Parents overfed them in the new society.

Refugee parents often perceive themselves losing control as their children outpace them in acquisition of the English language and in cultural adaptation. A Russian father brought his son in for counseling because the 7-year-old boy made fun of his father's poor English. The father, an engineer in Russia, was sad and frustrated. These problems are all too common, and they increase as the children move into adolescence. Most refugee parents can benefit by group sessions for parents like themselves who are immigrants with adolescent children.

Informed Consent and Refugee Patients

Unfortunately, there are examples of researchers taking advantage of refugee patients in research endeavors without adequate consent. This has happened both overseas and in the United States. This also happens with respect to consent for treatment. Consent issues are complicated by the fact that belief systems in some cultures do not hold that the patient should be informed truthfully about diagnosis and prognosis, and that fam-

ily decision making is preferable to individual decision making.

American informed consent requirements are the most rigid in the world. Full information must be presented to the person about the benefits, adverse effects, and risks of either treatment or a research protocol. The person must be legally competent and understand the information, and then make a voluntary choice free from outside influence or coercion. Each of these elements may pose a problem for refugee patients from different cultures.

Gostin (1995) has recommended that physicians seek an independent ethical review when the patient has different cultural expectations of the therapeutic relationship. Those involved in the review should have experience and understanding of the patient's culture, customs, and language. There can be deviation from usual formal standards of informed consent if the change focuses on patient-centered values. At all times genuine respect for human dignity, including different culture and values, must prevail.

Cross-Cultural Issues

Appraising a patient or parent's cultural beliefs, values, and customs should be an essential part of a health assessment regardless of whether the patient is a refugee (Olness, 1997). Cultural assessments are helpful in understanding patient behaviors that could otherwise be interpreted as negative or noncompliant. Cultural norms are usually unwritten but, nonetheless, are understood as the rules and values by which a culture functions. People are expected to abide by these unwritten rules or norms. When they violate them, they may be criticized or ostracized by others within the culture. Cultural norms include unwritten definitions about what is health and what is sickness.

Americans, although criticized for their lack of awareness about world events, actually are more experienced in relating to multiple cultures than most people in most countries. Because of the hundreds of different cultures and ethnic groups represented in the United States, television, the mobility of the citizens, and universal education, it is rare to find an American who does not know someone of a different racial or ethnic background. American children do not run after strangers of a different skin color yelling "foreigner," as they do in countries such as Laos or Uganda. American health care providers represent a wide spectrum of racial and ethnic backgrounds, but, of course, no individual provider can be knowledgeable about the cultural backgrounds of all patients.

In doing a cultural assessment it is important to consider the following:

1. Are there specific genetic diseases associated with the refugee's racial or ethnic group?
2. What is the refugee patient's interpretation of his or her symptoms?
3. What alternative treatment might he or she already have received?
4. What are the meanings of body language such as head nods? Am I insulting the patient by some of my body language? (e.g., pointing the sole of my foot toward the patient)
5. What are the dietary practices of the patient?
6. Who in the family or tribal constellation makes the decisions about whether or not to accept treatment?
7. Is the interpreter relating well to the patient?

Prevention of Health Problems for Immigrants: Recommendations for Refugee Camps

Those who are decision makers in refugee settings outside the United States are often and understandably preoccupied with issues of water, housing, food, and security. However, recognizing that many refugees will

eventually be relocated to new countries and cultures, there is much that can be done to prepare refugees, ensure better health, and reduce problems for the refugees as they become immigrants. Special attention to the most vulnerable (i.e., pregnant or nursing mothers, children, and the elderly) is crucial.

Once the acute settlement needs are over (usually a matter of a few weeks) those in charge of refugee settings should focus on the following:

1. Conducting anthropometric assessments of children under 5 years of age.
2. If malnutrition is found, urgent refeeding programs should be implemented. Also, efforts should be made to define the causes of malnutrition, that is, diversion of available food, improper preparation of food, improper weaning practices, high incidence of infectious diseases, or a combination of factors. Programs should then be implemented to prevent further malnutrition.
3. Facilitation of breast feeding for mothers.
4. Establishment of reproductive health care for women. This is something that occurs rarely in refugee settings (Wulf, 1994).
5. Immunization programs for adults and children.
6. Provision of consistent surrogate mothers to unaccompanied minors.
7. Organized school and recreation programs for children.
8. Literacy programs for refugees who cannot read and write.
9. Surveillance programs not only for infectious diseases and malnutrition but also for child abuse, including sexual abuse of young males and females.
10. Orientation programs for refugees related to new languages, cultures, and occupations.
11. Vocational training programs.

These interventions can do much to reduce physical and psychological problems for new immigrants. Often, there are many well-educated refugees who can work to implement programs such as school, recreation, literacy, and orientation programs.

Training of Refugee Camp Workers

Because of the increasing number of complex humanitarian emergencies in the world, there is now a major effort to develop excellent training for persons who are employed by humanitarian agencies and for the thousands who volunteer to help in refugee situations (Burkle, 1995; Olness, in press). The training is helpful not only for work overseas but also for work in domestic disasters and for work with refugees who are relocated to the United States. In recent years, several training programs have become available in the United States. They include the following:

1. Center for Excellence in Disaster Management and Humanitarian Assistance, University of Hawaii. This center sponsors a 3-week intensive course on Disaster Management in April each year. The director of the course is Frederick Burkle, Jr., M.D., phone 808-973-8387, fax 808-949-4232.
2. HELP program sponsored by the School of Hygiene and Public Health of Johns Hopkins University. This is a 3-week course held in Baltimore each July. The director is Dr. Gilbert Burnham.
3. Management of Complex Humanitarian Emergencies; focus is on children and families. This 1-week course is sponsored by Rainbow Babies and Children's Hospital in Cleveland, Ohio and endorsed by the American Academy of Pediatrics and the International Pediatric Association. The director is Karen Olness, M.D., phone 216-844-3122, fax 216-844-7601, e-mail kno@po.cwru.edu.
4. Interaction program. Interaction, a consortium of 120 nongovernment humanitarian agencies, has received a grant from USAID to develop a de-

tailed curriculum in Management of Complex Humanitarian Emergencies. This course will be a 12-day course, given over 2 weeks and was piloted in 1997. Phone 202-667-8227, fax 202-667-8236.

Recommendations for U.S. Sponsors of Immigrants

These recommendations are based on the author's personal experience with refugees, as well as conclusions from the follow-up study, and recommendations from the American Academy of Pediatrics' Committee on Community Health Services.

Sponsors also benefit from orientation programs. Their misconceptions are often similar to those of the new arrivals. They may be unprepared for cross-cultural differences and unrealistic expectations among the immigrants. They fail to recognize the inherent inner strength and resolve that is part of many new immigrants (Torjesen *et al.*, 1981). They also may not appreciate the long-term effects of cruelty and abuse suffered by refugees and the malnutrition experienced by many of the small child refugees. Sponsors sometimes do too much for immigrants initially and not enough later on in terms of social support.

There are many reports of problems between sponsors and new immigrants. In Buddhist cultures, for example, after an individual has provided assistance such as money or house appliances, it is assumed that he or she has made a commitment to provide in similar fashion forever. The Southeast Asian refugee would consider it appropriate to demand a new house, car, and so on as his or her due. Recently arrived Hmong in Minnesota were told by their sponsor that he was not wealthy and they would need to work together to provide necessities of life. Imagine the surprise of the sponsor to return home to find the proud refugees presenting him with a bag of live squirrels they had captured. They said that this would provide the family meat for the next week! A frequent problem among refugees who are well educated is that they cannot immediately gain employment in their area of expertise and must take more menial tasks, a concept not acceptable to educated people from many Asian or African cultures. This may lead to depression in the new immigrant. Sponsors can do much to guide the new immigrants into an understanding that they do well to gain job experience and a job record in menial work. Two Vietnamese physicians who arrived in Minnesota at the same time demonstrated opposite approaches to this issue. One immediately accepted employment in a nursing home, and used the opportunity to practice his English with the elderly who were only too happy to help him. He also studied for examinations given to foreign medical graduates. He passed the language examinations easily in a year, passed the medical examinations, and obtained an internship within 2 years. His colleague refused to take menial work and 3 years later had still not passed the language examinations.

Sponsors (foster or adoptive parents) of unaccompanied minors may be unprepared for the problems of attachment that are usual. Children may seem initially charming, pleasant, and courteous to anyone but fail to develop a true parent–child relationship with the sponsor or adoptive parent. Such children may also manifest behaviors reflecting their earlier deprivation such as binge eating, hoarding food, and demanding many clothes and toys.

If possible, prospective sponsors should do the following:

1. Learn as much as possible about the culture and language from which the immigrants have come.
2. If unaccompanied minors are involved, meet with persons who have long experience in working with such children and anticipate that therapy will be required by the children.
3. Whenever an immigrant family is involved, share the sponsorship with a small group, for example, several members of the same church or service club.

4. Make arrangements for training in language for adults prior to arrival.
5. Make medical appointments for all members of a new family as soon as possible.
6. Facilitate meals that are familiar to the new family.
7. Find families of the same ethnic group who have been in the community for some time and who are willing to help with orientation.
8. Get children into school as soon as possible. If the school does not have ESL classes, arrange for ESL training for the children.
9. Facilitate self-sufficiency for the family in every way possible.
10. Support new immigrants in taking jobs that may be more menial than their previous profession and explain that this is the American way.

These interventions will increase the likelihood of good mental and physical health among the new immigrants and, therefore, the likelihood that they will be productive citizens.

Summary

Immigrants who arrive as refugees have many more problems than those who arrive directly from their countries of origin. Most refugees have suffered physical and mental traumatization. These experiences may lead to lifelong problems and affect adjustment to life in the United States. Refugees have often spent substantial time living in squalor and are at great risk for health problems, including many infectious diseases and malnutrition. Refugee children have often witnessed atrocities and may arrive as orphans or unaccompanied minors. This may lead to attachment problems in their new families and to PTSD symptoms. On the other hand, many refugees are people of enormous inner strength. The same energy that facilitated their escapes leads them to overcome the trauma and to adjust very well in their new country. American sponsors and health care professionals benefit by orientation to the cultural issues of refugees from specific areas. They then become key figures in facilitating a healthy adjustment for the refugee immigrants.

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