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Title

Refugee Health: At Home and Abroad

Permalink

<https://escholarship.org/uc/item/4vx3j74m>

Author

Bruno, William

Publication Date

2017

William Bruno
ISP Chair: Wael Al-Delaimy MD PhD
ISP Committee members: Sunny Smith MD, Linda L. Hill MD MPH
April 2017

Refugee Health: At Home and Abroad

Background

It has been suggested that one of the earliest hallmarks of civilization is the practice of granting asylum to people fleeing persecution. Indeed, records dating back to over 3,500 years ago mention such persons seeking refuge in some of the early Middle Eastern empires.¹ Our modern day understanding of what it means to be a refugee can be traced back to the 1951 United Nations Refugee Convention, which defined a refugee as a person who "owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion, is outside the country of his nationality, and is unable to, or owing to such fear, is unwilling to avail himself of the protection of that country."¹

With much of today's modern world ravaged by political unrest, war and human rights violations, we have seen the development of an unprecedented refugee crisis. According to a recent report from the United Nations High Commissioner for Refugees (UNHCR), more than 60 million people worldwide are suffering from forced displacement, which includes refugees as well as internally displaced people and asylum-seekers.² In 2012, the UNHCR estimated there were 10.5 million refugees worldwide. By mid-2015, that number had reached an estimated 15.1 million, the highest seen in 20 years.² This sharp increase is mostly attributable to the war in Syria and, to a lesser extent, conflicts in Afghanistan, Burundi, the Democratic Republic of the Congo, Mali, Somalia, South Sudan, and Ukraine. Refugees currently reside in 169 countries. Turkey has the largest number of refugees totaling 1.84 million. The countries with the next greatest refugee populations, in descending order, are Pakistan, Lebanon, Iran and Ethiopia.²

The detrimental effect that refugee status has on a person's health cannot be overstated. Some of the most common health problems include accidental injuries, hypothermia, burns, gastrointestinal illnesses, cardiovascular events, pregnancy- and delivery-related complications, diabetes, and hypertension. In addition, female refugees are particularly vulnerable to sexual and reproductive health issues as well as sexual violence. Poor living conditions, suboptimal hygiene, and limited access to care during migration allow communicable disease like tuberculosis, human immunodeficiency virus (HIV), viral hepatitis, respiratory viruses, and vector borne illnesses like malaria to flourish. The act of migration itself can be deadly. For example, many of the current refugees fleeing the Middle East and Africa attempt the dangerous journey across the Mediterranean Sea on makeshift rafts. According to the UNHCR, in a 10 month period during 2015, over 3100 people were estimated to have died or gone missing at sea attempting to reach Europe.³

The history of resettling large numbers of refugees in the United States can be traced back to the Vietnam war when, following the fall of Saigon, some 360,000 Indochinese — Vietnamese, Cambodians, Laotians and Hmong fled to the US. San Diego in particular has settled more refugees than almost any other county in the country. In recent years, it has settled about 2,700 persons annually,⁴ which accounts for about 4% of all refugees resettling in the US and 40-50% of those arriving in California.⁵ As mentioned earlier, the war in Syria has been a major contributing factor to the increase in refugees worldwide. There is currently an estimated 4 million people fleeing that nation in response to the conflict. The US has agreed to accept 8,000 of these refugees over this year, a seemingly arbitrary number given the magnitude of those requesting asylum. Of those expected to arrive to the US, many will likely be resettled in San Diego.

The plight of the Palestinians should be of particular interest to those concerned with refugee health. Starting with the Arab-Israeli war in 1948, when more than 700,000 Arab Palestinians were forcibly removed from their homes, Palestine has been the site of a perpetual humanitarian struggle. According to the United Nations Relief and Works Organization, Palestinian refugees are defined as “persons whose normal place of residence was Palestine during the period 1 June 1946 to 15 May 1948, and who lost both home and means of livelihood as a result of the 1948 conflict.” About 1.5 million Palestinians live in 58 Palestinian refugee camps throughout the region.⁶ The refugee situation is particularly perilous in a small coastal region, internationally recognized as part of a future Palestinian state – the Gaza Strip. Since 1967, Israel has occupied the Gaza strip and the West Bank, restricting the flow of people and supplies in and out of Palestine, complicating the delivery of humanitarian aid.

Mental health is one of the most important and consistently unmet needs within refugee communities, particularly for those settled in Gaza. Risk factors for poor mental health such as stressful work or home conditions, gender discrimination, social exclusion, unhealthy lifestyles, risk of violence, medical comorbidities, and human rights violations, are pervasive. In light of this, the United Nations Relief and Works Agency (UNRWA) has been investing in mental health treatment for refugees in Gaza. Starting in January of 2016 they launched a pilot program in Saftawi Health Centre in Northern Gaza called Mental Health and Psycho-Social Support (MHPSS). The goal of MHPSS is to “fully integrate mental health care and psycho-social support within its primary care services”.

A ubiquitous problem in terms of providing mental health is the fact that the majority of people with mental health problems do not seek treatment. Indeed, some 70% of people with mental illness worldwide do not receive any mental health treatment.⁷ It is widely accepted that a few key factors are to blame in terms of this disparity between the prevalence of mental illness and those receiving treatment. These include lack of knowledge regarding mental illness, prejudicial attitudes, and anticipated or real acts of discrimination which taken together are referred to as stigma.^{7,8} This stigmatization has far reaching consequences, with one study

suggesting that 47% of the general public would be unwilling to work closely with a person with mental illness and 30% unwilling to socialize with them.⁸

According to a report published on mental health in Palestine there is a lack of understanding of mental health issues among Palestinians. The report also describes how stigma of mental illness is pervasive among this community.⁹ In Saftawi Health Centre, one year after the mental health program's implementation, attitudes and perceptions of mental illness are likely to be less misinformed and confounded by stigmatization compared to a similar patient population, for example, at another UNRWA clinic in Gaza in which these extensive mental health services have not been implemented. Comparing these two groups' perceptions on mental illness could provide important insights into the benefits of a fully integrated mental health program and could help highlight the program's influence on the patient's attitudes and perspectives toward mental illness.

My Project Abroad

Rationale

A Cochrane review published in 2013, outlined three general types of interventions for combating stigmatization: education, contact and protest.¹⁰ Education can take many forms, and as the review explains, the overarching goal is to "overcome myths about mental illness and replace them with facts" through films, seminars, or any other way of efficiently disseminating information. Contact is essentially familiarizing persons in the community who may stigmatize to people with mental illness. Finally protest is a more direct confrontation of inaccurate or negative representations of mental illness.¹⁰

As discussed earlier, stigmatization of mental illness within the community can be a major barrier to mental health services for people suffering from mental illness. With the introduction of Mental Health and Psycho-Social Support (MHPSS) at Saftawi Health Centre we would expect that stigmatization of the community served by the Saftawi Health Centre would be diminished compared to a similar health center in Northern Gaza that has not yet had the benefit of robust mental health services. Having mental health services provides for more opportunity for education for patients and staff.

In planning for my ISP, I wanted to devise a project with the aim at assessing the level of stigmatization following the implementation of the mental health services discussed above. I wanted to test the hypothesis that some of the benefits of a robust Mental Health initiative would permeate through the community and provide a better-informed population less likely to engage in stigmatized behavior. Furthermore, I suspected having mental health services at Saftawi would mean that people with mental illness would visit the clinic with a relatively high frequency, in order to receive their mental health services, compared to a clinic where mental health services are unavailable. Thus, the average patron or staff member at Saftawi would come in to contact with people with mental illness more often than patrons

or staff members from another clinic. We suspect that this contact could serve as a means of reducing stigmatizing behaviors.

Much literature has been published on various methods for evaluate stigma on the individual as well as the population level.¹¹ The Reported and Intended Behavior Scale (RIBS) was developed as way to assess behavioral discrimination at the population level.¹² It is an eight-part questionnaire that measures reported and intended stigmatizing behavior toward people with mental illness within a given population. It has demonstrated reliability and internal consistency in a heterogeneous population.¹² This relatively short and easily administrable questionnaire could serve as an efficient way for determine the level of stigmatizing behavior within a community serviced by Saftawi Health Centre and comparing that to a similar health clinic in northern Gaza without Mental Health and Psycho-Social Support (MHPSS). Additionally, an open-ended question will be added to the survey in an attempt to probe the respondents reasoning for any change in their intended behavior in regard to mental illness. In this way, we hope to understand if the respondents are aware that their experiences at Saftawi clinic may have affected their perceptions of mental illness.

What Was Done

Specifically, I organized a plan as follows: 1) We will recruit a random sampling of about 200 patients from the Saftawi clinic as well as a control group consisting of another 200 from a similar clinic in northern Gaza where MHPSS has not been implemented. Great care will be taken to in order to ensure that all demographics of the patient population of control clinic will be a similar to the Saftawi clinic as possible. The RIBS questionnaire will be administered to these groups through the help of an Arabic speaking translator. 2) The RIBS questionnaire will also be administered to a group of staff at the Saftawi Health Centre as well as to a control group of staff at a similar health center in Gaza where MHPSS has not been implemented. 3) In addition, the patient's will respond to the open-ended question "If you feel that in the past year or so your attitudes toward mental illness or people with mental illness has changed, please explain why". 4) After the data is collected, descriptive analyses will be done using SPSS statistics. 5) We will use the responses from the RIBS questionnaire to compare the levels of reported and intended stigmatizing or discriminatory behaviors towards people with mental health problems between the patients at Saftawi and the control clinic. A similar comparison will be performed between staff at the Saftawi clinic and a control clinic. 6) Finally we will use the comparison mentioned above to test the hypothesis that having MHPSS services available at a community clinic in Gaza will result in less reported stigmatization by both the patients and the staff at the clinic compared to their counterparts at a similar clinic in Gaza without MHPSS services.

Although the collection and synthesis of this data will not be completed in the timeframe allotted for an ISP project, the process was extraordinarily educational. The experience of thinking about a problem, researching the literature, and then

devising a project to address the question was invaluable. Furthermore, learning how to perform the practical skills necessary to conduct research such as writing a proposal and submitting an IRB will serve me well as I start my career.

My Project At Home

As mentioned earlier, San Diego is home to a relatively large proportion of recently relocated Syrian refugees. Through discussions with community leaders, it has come to our attention that there are certain needs within this population that are not being met. Anecdotally, we have heard that some of the biggest issues are housing and joblessness. We wanted to come up with a systematic way of assessing the needs of the population and then helping to meet these needs. To complement my experience of organizing and implementing a project abroad, I have helped to put together a group of Faculty, Medical students and undergraduates at UCSD and USD. Our plan is to form a sustainable relationship with recently relocated Syrian refugees who now reside in the San Diego area. In order to initiate this partnership I and the other members of the group planned a health fair that was held on April 21st, 2017.

What Was Done

The following services were present at the event:

Medical Services- We attained vitals and did health screening. Obviously the medical care that can be provided through this type fair is limited. To this end we had a booth set up where we were able to sign people up for Medical or Medicare, and help them locate an appropriate clinic for their primary care, etc.

Psychosocial support- It's unlikely that any significant counseling would have been well received in this first contact between our budding group and the refugee community. We had health care professionals available for mental health triage. Our hope is that this will become more robust as the relationship between our group and the community grows stronger.

Driver's License Transportation- Lack of transportation has been an issue in the community. To this end we had a member of our set up a booth that included details on how to get a driver's license as well as relevant info on public transportation.

Job Search- Joblessness is a problem in many resettled refugee communities and the Syrians in San Diego are no exception. Many of the Syrian refugees are highly skilled craftsman and professionals, while others are looking for more low skilled work. We partnered with local San Diego and El Cajon organizations present to help with job placement.

Legal Advice- There was a booth set up for legal advice especially in regards to housing. We coordinated with Community Law Project and had lawyers providing information on a range of topics including housing, which we understand is a recurring issue for many in the community.

Translators- The Syrian refugee community is largely Arabic. Our group recruited Arabic speakers from the community to work as translators for the fair.

As mentioned above, a major objective of the fair was compiling a way to assess the needs of this population. To this end a questionnaire was designed(attached at the end of the document.

What We Learned/ Results

Unfortunately, we had a very challenging time convincing the health fair attendees to complete the needs assessment survey. Based on our group's estimates, there were approximately 100 attendees at the fair and of those only 11 people agreed to fill out the survey. It is difficult to draw any conclusions from this small sample size; however, the information that we did obtain was extremely valuable. For instance, 8 of the 11 respondents stated that finding a job was the biggest challenge that they currently face. This finding is consistent with what we had expected based on discussions with community leaders prior to the fair. One encouraging result was that all but one respondent stated that they would like another similar event in the future.

Following the fair, we had a debriefing session to discuss what went well and what could have been better for future events. We decided that one way to improve the number of responses to the survey would have been to have it located at the entrance of the fair instead of the exit. Some people felt that perhaps after taking part in many of the services, the attendees were fatigued and less willing to answer the survey. One of our volunteer translators suggested that perhaps it would be best if we had a translator paired with each family, instead of floating about the fair, this way the translator would be able to form a relation with the attendees.

One of the most important contacts our group made during the fair was with a case manager who worked with about 200 Syrian refugee families. We spoke with her about what needs she had identified in the community. She agreed that jobs were likely the biggest challenge. We discussed with her that before future events we would like to have a larger number of our target population fill out the questionnaire. This way, we can target our services to their needs. The caseworker said that she would talk to the families and work with us over the coming weeks on a way to have our survey filled out by as many of them as possible.

My Experience

The experiences of researching and planning a study on refugee health abroad and well as organizing a group to provide a tangible service to a group of refugees have built the foundations of a two pronged approach I intend to incorporate in my budding career as a physician working to improve refugee health. The first is to identify applying a question or a problem and using a rigorous analytic approach such as I have initiated with the mental health survey in Gaza. The second is to identify practical needs within a community and then, in a relatively limited timeframe, set up an efficient way to deliver those needs. Although we did not receive enough responses to our survey to make informed decisions about moving forward and addressing the population's needs, I do feel that we made excellent contacts in the community and, with some perseverance, members of our group will

be able to continue with our needs assessment and develop more targeted future events. So, in conclusion, although my ISP did not unfold exactly as planned, the process provided valuable experience in my development as a future physician.

Questionnaire

1.) Number of Family Members

2.) Ages of Family Members (Check all that apply)

0-5

6-10

11-15

16-20

21-25

26-30

31-35

36-40

41-45

46-50

51-55

56-60

61-65

65+

3.) How long have you lived in the U.S.?

4.) Have you found any of the following tasks difficult? (Check all that apply)

Finding a job/Moving ahead in career

Driving/Getting license

Using public transportation

Finding housing

Locating health care providers

Attending clinic visits

Understanding English/Translating English

Cooking/Nutrition

Grocery shopping/Reading food labels

Education for you and/or your family

5.) Respondents were asked to rate the following statements on a 5 point scale. (From strongly agree to strongly disagree.)

I have had a very welcoming experience in the U.S. thus far.

I feel I have a lot of support and resources.

I am adapting better to the culture and society in the U.S.

I struggle holding a conversation in English.

I have difficulty paying for my bills and/or providing furniture for my home.

I don't enjoy life as much as I would like.

Please describe any challenging experiences you have faced in San Diego.

Would you like more events like this?

Yes

No

Maybe

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