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Health Education: An Unmet Needs for Refuges

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International Rescue Committee (IRC) –Oakland

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Abstract:

The International Rescue Committee (IRC) is one of the organizations that serves refugees and asylums arriving into the United States. Each year between 4 to 500 individuals will resettle in Oakland through the IRC. However, after relocation, these individuals need information about life in the new country , community resources , and social services especially health care system in the country. Life pressures during the resettlement process, along with the language barrier and poverty usually lead to a less healthy diets and lifestyles. During the time, these factors will put refugees at the risk of obesity and later, chronic disease. Through Health education project, IRC aims to provide necessary information for refuges to increase their knowledge and persuade them to a healthier lifestyle. The program implemented through the short series of presentations for refugees in Oakland during the months of May and June 2015.

This 300 hours fieldwork was a small part of the movement to help and serve this under deserved population with their unmet needs. Continued growth of these sorts of interventions will help more and more vulnerable individuals to stay healthy rather than only survive. It would be a valuable step having the attention of public health professionals on the refugee communities' issues. Providing more resources in the field of primary prevention is as necessary as needed health care in secondary and tertiary prevention level.

Introduction:

The city of Oakland with its highly diverse population (U.S. Census Bureau, 2014), is one of the targeted cities for refugees and asylums arriving into the United States. The United Nations define refugees as individuals who have left his country with fear for his life and were not able to return to his country (United Nations Convention, 1951. Asylum has the same definition; however, asylum seeker have been already entered the destination and sought approval after they arrived (U.S. citizenship and immigration services, 2015). According to the United Nations Global Trends, 59.5 million individuals were internally displaced, ended up in the camps, or entered other countries to seek protection by the end of the 2014. Among this population, 19.5 million were refugees (United Nations High Commissioner for Refugees, 2015). Several rescue centers in the United States are helping with resettlement for the newcomers. International Rescue Committee (IRC) is one of the primary organizations, helps refugees in almost 40 countries around the world. In the United State, 22 offices engage in the resettlement of refugees. The process includes, help with housing, employment and legal work authorization, education and school enrollment, social benefits and access to the healthcare (International Rescue Committee ,2015).

Oakland is one of the refugees' destination cities in the North California. During the year 2014-2015, there were around 422 registered clients in the Oakland IRC office. A majority of these clients were adult men(Table 1, Appendix 1). International Rescue Committee of Oakland also, has a diverse population of clients depending on their origin countries . The majority of the entries belong to Afghanistan, Burma, Iraq, Eretria and Syria. Table 2 Appendix 1, categorized the Oakland arrivals in 2014-2015 by their nationalities (International Rescue Committee ,2014).

As a result of coming from various backgrounds, different health situations, and different cultures these new arrivals have hard time adjusting to the life in the United States. One of the most important parts of this adaptation is health behavior and health needs. Many of our clients come from hardship of war ,or have been lived in an unsafe environment for long time. Specific attention to the level of health and related concerns is necessary to help this population.

Public health problem:

Health care for refugees in the United States starts with a pre-arrival obligatory medical exam. Based on the Center for Disease Control and Prevention (CDC)'s policies, each refugee needs to have two medical screenings by an approved physician. The first is pre-arrival(before admitted to the U.S.) and the second is the post-arrival (during the first 30 days in the U.S.)(Center for Disease control and prevention, 2014). Among all IRC clients in 2013, twenty-two percent had a pre-existing medical condition at the time of their entrance to the U.S. (8).Tuberculosis was the most observed health conditions among refugees; however, the identified cases are mostly latent tuberculosis or treated individuals and are not an active threat to the communities' health.On the other hand, IRC internal annual report indicates that chronic conditions like hypertension and diabetes have the second highest pre-existing condition rate among this population (Table 3 Appendix 1) (International Rescue Committee ,2013).

Even without any pre-existing condition, the stress of a new life put an enormous burden on the physical and mental health of these individuals. This stress could be a result of the several factors including a leaving loved one behind, unfamiliarity with life in the United States , shortage of income, and the lack of social and family support. A research indicates that there was an increased rate of chronic disease, including obesity (46.8%) and hypertension (22.6%) among this population during their time staying in the U.S. (Doorman et al ,2010). A similar study on 356 refugees also, documented significant weight gain over a two-year period (Table 4, Appendix1). These research indicated that the risk of chronic disease among the refugees would increase during their time in the country. This increase could be as a result of unfamiliarity with health care and lack of prevention visits, new diet and new food market, and lack of physical exams (Careyva ,2013). Pre-existing conditions, like hypertension and diabetes, along with overweight and obesity

are significant risk factors for ischemic heart disease (leading cause of death in the United States). There is an essential need for public health professionals' attention to implement new policies or interventions and decrease the number of risk factors among this population. One of the first and most feasible interventions is to target primary prevention through a health education program .

Implementation of the Project:

The IRC Health education program aims to provide necessary information for clients who arrived recently in Oakland to help them increase their health information and adopt healthier diets and lifestyles.

There aree three different goals identified for this project (Appendix 2):

1- To introduce the health care system in the United States for new arrival refugees.

To implement this objective, IRC interns worked on the existing cultural orientation material to improve and add more needed information. The cultural orientation consisted of multiple presentations introducing different parts of the life and community in the United States to refugees. These topics include the legal system and policies affecting life and works in the U.S. , housing, job, social services, social benefits and more. Based on IRC policies, every single individual had to participate in this class during his first months of his arrival. In the first initial month of the project, interns worked on the existing materials of the presentations. The health orientation included several topics like basic information about the healthcare system in the Alameda County, different level of health care delivery and variation between them, and how to reach each care level of care as needed. Those presentations also talked about healthcare providers and their responsibilities, health insurance including Medi-Cal , its coverage and its policies. The new

materials and edited parts were adopted in the existing cultural orientation and have been continually taught to the new arrivals.

2- To educate newcomers on prevention and care for chronic diseases based on healthy nutrition and healthy lifestyles.

Based on the learning objectives (Appendix 2), implementation of this goal was through a 30-minute health education presentation offered to the clients through the home visits. The main topic of the presentation was chronic disease prevention insist on ischemic heart disease , talking about diabetes , hypertension, smoking cessation, exercise, healthy foods, and eating habits. During the second month of the project, the presentation materials became adopted from resources available in the Department of Health website (11) and from a similar existing program delivered at San Diego in 2009 (12). To evaluate the outcome and identify each person's response to the education, a pre-post survey was prepared. During the third month of the project, home visits were conducted in the frequency of one to two per weeks. Each visit was around an hour, including the pre-education survey, lectures, post education survey ,and an open question session to help with other healthcare concerns of the families.

3- To increase the awareness about other common health concerns among immigrants and refugees

There were specific other issues as the experienced in working with refugees brought up and needed to be addressed. Two topics included. First Tuberculosis and the possible concern about positive skin test among some families, second oral health and how to receive appropriate dental care in the U.S. Theses two topics

were addressed by intern separately through the printed brochure and materials after health presentation.

Result and Discussion:

During the last month of the project, I conducted seven home visits. The program targeted refugees with families and home visits were scheduled at the time both parents were in the house. The program had overall 14 adult participants with an equal number of the male and females. The age distribution ranged from 22 to 35 with the mean of 28.7 (Table 1 Appendix3).

Among these group 28.57 percent (n=4) had a history of smoking but all of the smokers were self describe light smokers. All smokers were male. Only 21.43% (n=3) of participants reported exercise regularly. Half of the clients knew about what a heart attacks. Among this group 14% knew how to prevent a heart attack. Half (57.14 %) of the individuals (only one female) were able to describe different levels of health care in the U.S. system. Three individuals (21.43 %) had active medical insurance. Most of the participants (71.43%) indicated they have a healthy diet, mainly vegetables (Table 2 Appendix 3).

The linear regression analysis showed that an average individual knowledge about heart attack and prevention was positively associated with being female (Table 3 Appendix 3). It also showed that an average increase in the age of participant was related to an average decrease in their knowledge (Insignificant relation all $p>0.005$).

After the education session had been done, 78.57 % of participant reported that they learned a lot from the presentations. No one mentioned getting nothing from the presentation. The future behavioral changes as the clients mentioned were impressive (Table 4 Appendix3). Ten persons (71.43%) indicated that they wanted to increase the number of the days they will regularly exercise.

Two people (14.29%) wanted to stop smoking, and the rest will continue to not smoke. 28.57 % indicated they wanted to change their diets based on what they learned. Almost all of the participant (92.86 %) mentioned they wanted to schedule a dental appointment for themselves and their families.

The linear regression indicated that reported change in exercise behavior was related to age and sex. Having the history of doing exercise was not significantley associated with desire to change the behavior . It was also associated with the feedback of participants to the presentation and indicating some changes in desire to regulary exersise as a result of education . All of the relation were insignificant $p>0.005$ which could be related to our small sample size (Table 5 Appendix 3). The linear regression for change in smoking behavior after education indicated a appositive relationship between the outcome and age and sex. However, the relation were insignificant $P>0.005$ (Table 6 Appendix 3). Regression in the change in dental care approach an average was associated with the person feedback to the presentation was insignificant $P>0.005$. (Table 7 Appendix 3).

There were several cofounder variables affecting the statistic results. Small sample size was the first parameter could affect all the results. Another confounder was a nationality. All these refugees were from Afghanistan, so they have almost the same health condition and information. Also they all were Muslim and ate halal food. As a result, they preferred to not eat outside and not to buy prepared food,which was an explanation of why this participant mostly had healthy diet before health presentation. Conducting the program for other clients like single men or other nationalities would have very different pre and post education survey result.

Public Health Significance:

During the short implementation of this program, the changes in the client's approach to their lifestyle and health care were significant even though that was not shown quantitatively. Because of the intervention, small sample size of 14 individuals (along with their kids) are mostly going to follow a healthier lifestyle which in the long term will helps their community and decrease the burden of chronic disease in the U.S. healthcare system. . This result indicated that although screening and treatment for necessary for individuals coming from unknown health situation; however, giving them a chance to have enough knowledge to live healthier and stay healthy is essential too. There is a need for direct health adviser for these families to help them connecting to the county healthcare system, adopting the healthy lifestyle, eating healthy, making necessary appointments and follow up with their treatments. Also, the health adviser should provide health education sessions for each newcomer in the appropriate time and places.

The existing healthcare services and policies addressing refugees mainly concentrate on the identification and control of probable communicable disease and needed immunization and treatment. However, less attention is paid to identifying what they need to stay healthy in the country. Health education, including introducing healthcare system, basic prevention of chronic disease, healthy diet, and healthy lifestyles, should be important priority for this population to not only survive but also to live healthy in the new environment.

Personal Reflection:

Working in the diverse environment of Oakland with an underserved population of refugees, who needs help and support in all aspects of their new life to survive, was an enormous experience.Spending 300-hours fieldwork in the rescue committee was a touch on the bittering face of the life in the most impoverishment situation of the community. Although it was sometimes

exhausting to spend 2 to 3 hours waiting for a hospital appointment or in the social services with clients. However, it was a positive got back at the time they received their social benefits or needed treatment. However these daily positive and negative waves were not the only things that me or other volunteers and interns looking through working with theses population. Our time and our efforts will not be enough if the existing policies never changes and if the needed new policy not integrated into the system.

As an example, oral care is one of the most critical unmet need for refugees. As a result of their background, most of these individuals never have been to dental office. During my conversations with these families, I realized that most of them did not have any information on dental coverage available on their Medi-cal. In the other hand, for the ones who need to see a dentist, it is almost impossible to make a schedule like all most all the providers are full and will not accept a new patient. Also, the dental coverage (Denti-Cal) for adults is very limited and is not covering most of the main procedures. It seems necessary to increase dental insurance coverages for this underserved population or increase the number of the healthcare provider in the area who accepting Medi-cal. Also, adding dental screening to the refugees post-arrival medical checkup could provide a necessary information about their oral health and help with later follow-up and needed procedure.

As I experienced, the first few weeks of arrivals for refugees is full of stress. The most significant concern for individuals at this point is how to cope with this new situation. Finding a house, finding food, and at one word "survival ". As the result, they pay the less attention and have less concern about the health care system and their general health needs (unless they get sick or have the previous medical condition). Cultural orientation brings a tremendous amount of material and information. The listener is usually bombards with materials. So it is not an appropriate time

for health education. There is a need to schedule later appointments for separate health cultural orientation in the next few weeks after initial resettlement that would result in a better concentration and attention of the audience.

Conclusion :

International Rescue Committee has been serving the individuals who run from disaster in the United States for several years. It helps with resettlement process for refugees who are usually not familiar with the language, culture and life in the United States. Health is one of the important areas of concern for these new arrivals. IRC has been helping with introducing the system, applying for health insurance and scheduling required medical exams and follow-ups. This program used the existing recourses in the IRC and added new informational materials for families or individuals who recently arrived in the U.S. The aim of this program is to help refugees population applied a healthier lifestyle and became more informed about U.S health care system and their medical needs. The result of these past three months indicated that almost all participant enjoyed the educational session and would try to adjust their life in the healthier way.

This program was just a recall for more attention and support from other health professionals. In future, it needs to cover more educational topics and long-term impact evaluation for behavioral changes among the participant. Long time follow up with the program would help public health professionals to identify and address not all, but at least most of the health concerns for this diverse population as a considerable part of our underserved communities.

References:

1- U.S. Census Bureau: State and County Quick Facts

http://quickfacts.census.gov/qfd/states/06/0653000.html

2- United Nations 1951 Convention Relating to the Status of Refugees, United Nations Refugee Agency
http://www.unhcr.org/3b66c2aa10.html

3- US citizenship and immigration services, Refugees and Asylum, 2015
http://www.uscis.gov/humanitarian/refugees-asylum

4-World at War: Global Trends, Forced Displacement in 2014, 2015, United Nations High Commissioner for Refugees.

5- International Rescue Committee, Who we are, 2014
http://www.rescue.org/about

6- General Report, International Rescue Committee, Oakland 2014- 2015

7- Center for Disease control and prevention, Immigrants and refugees health, 2012

http://www.cdc.gov/immigrantrefugeehealth/about-refugees.html

8- Overview and Analysis of Medical Case Tracking FY2011 - FY2013, International Rescue Committee.

9- Doorman NM, Battaglia T, Cochran J, Geltman PL. Chronic disease and its risk factors among refugees and asylums in Massachusetts, 2001-2005. Prev Chronic Dis 2010; 7(3):A51.
http://www.cdc.gov/pcd/issues/2010/may/09_0046.htm

10- Careyva B, Mills G, Lanoue M, Bangura M, de la Paz A, Gee A, Patel N. The impact of living in the United States on refugee patients' body mass index scores. Submission Pending

11-Department of Health and Human Services Office of Refugee Resettlement, Healthy Living Kit for refugees

http://www.refugees.org/resources/for-refugees--immigrants/health/healthy-living-toolkit/

12- San Diego public health department, Understanding your cardiovascular health, Bushra John, 2014

Appendix 1:

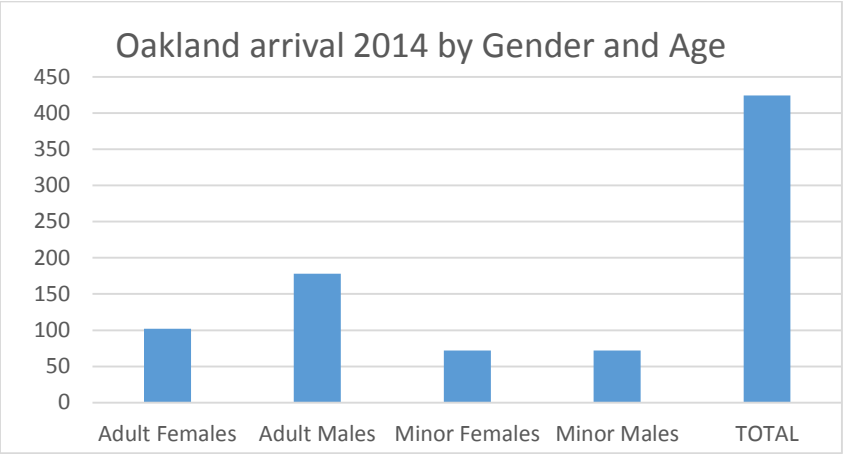

Table 1- Oakland arrival 2014- 2015 by Gender

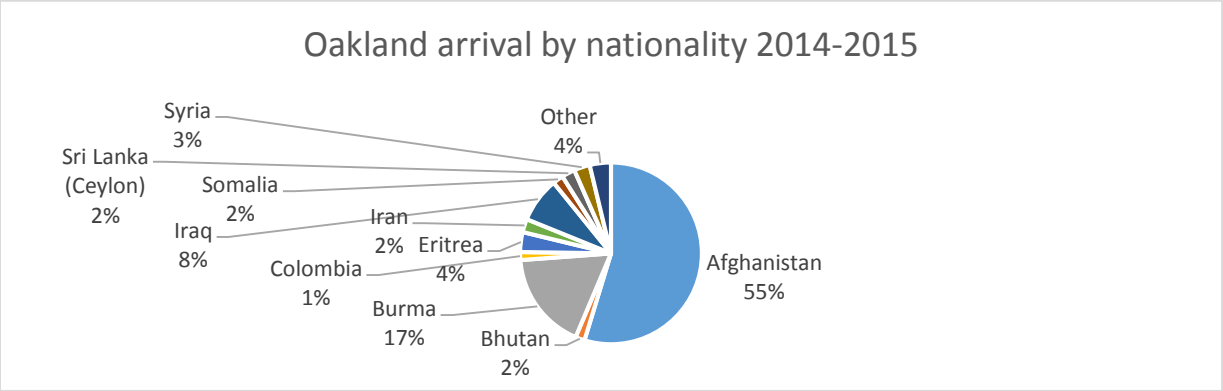

Table 2 – Oakland refugees' arrival 2014-2015 by nationality

Common Condition	FY2013	
Tuberculosis	611	52%
Hypertension	350	30%
Diabetes	122	10%
Asthma	46	4%

Table 3- Common pre arrival medical condition in Refugee population at IRC, 2013.

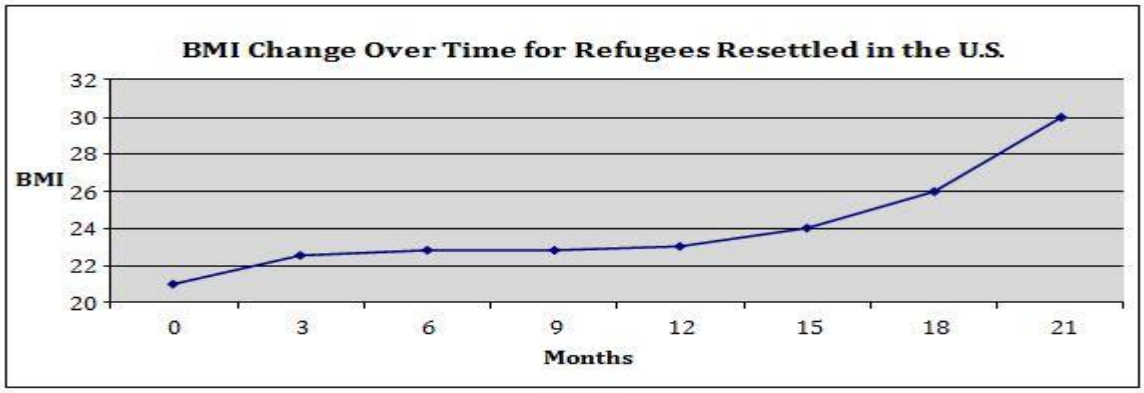

Table 4- BMI changes over the time for refugees resettled in the U.S

Appendix 2-

Student Learning Contract

Goal	Objective	Action Plan
Introduce health care system in the United States to New arrival Refugees	During the first two months of the program, IRC intern will conduct health orientation presentation once a week for all the clients who arrived in the past week at the same time of their cultural orientation class.	1- IRC intern will adapt and add a new health access orientation material to the existing cultural orientation available at IRC. 2- Each client who comes to cultural orientation will participate in the pre-presentation survey. 3- Health access presentation will conduct for 10 min after pre-test by the IRC interns. 4- Post presentation survey will be carried out for each client participated in the cultural orientation.
To Educate newcomers on prevention and care of chronic diseases based on healthy nutrition and healthy lifestyles	1- During the first phase of intervention10- 15 home visits will be conducted by IRC interns for clients who can talk English, Farsi, or Dari. 2-After two first month's education, at least 50% of clients who received the home visit will adopt the healthier lifestyle.	1- IRC interns will provide a complete educational material includes nutrition, smoking, and physical exercise. 2- IRC intern will schedule the home visit for clients who can communicate in English or Farsi-based on their arrival time and pre-health condition. 3- one to three home visits will be conducted each week for two months by IRC interns. 4- During each visit pre and post survey will be conducted.
Increase awareness among immigrants and refugees about particular health condition (Tuberculosis, Dental Care)	1- During the first phase of the intervention, 10 home visits will be conducted by IRC interns for clients who can speak English or Farsi or Dari, 2-After two first month's education, at least 50% of participant who received the home visit will be more aware of chronic health condition and their prevention.	1- IRC interns will prepare educational material. 2- IRC intern will schedule the home visit for clients who can communicate in English or Farsi-based on their arrival time and pre-health condition. 3- One to three home visits will be conducted each week for two months by IRC interns. 4- During each visit prepared materials would be shared with clients

Appendix 3- result:

Variable	Obs	Mean	Std. Dev.	Min	Max
age	14	28.71429	3.811492	22	35
sex	14	1.5	.5188745	1	2

Table 1- participant age and sex

Variables before education	Yes	No	
Smoking History	n=4 (28.57)	n=10 (71.43)	
Heart attack knowledge	n=7 (50%)	n=7 (50%)	
HA prevention information	n=2 (14.29%)	n=12 (85.71%)	
Regular Exersise	n=3 (21.43%)	n=11 (78.57%)	
Healthcare system knowledge	n=8 (57.14%)	n=6 (42.86%)	
Healthy diet	n=10 (71.43)	n=4 (28.57)	

Table 2 – Pre- education variables

Tabulation Heart attack knowledge and sex:

sex \ Heaknow	1	2	Total
1	6	1	7
2	1	6	7
Total	7	7	14

Heaknow	Coef.	Std. Err.	t	P>|t|	[95% Conf.	Interval]
sex	.6917108	.269356	2.57	0.026	.0988621	1.284559
age	-.0049383	.0366686	-0.13	0.895	-.0856453	.0757687
_cons	.6042328	1.346281	0.45	0.662	-2.358912	3.567377

Table 3- Regression Heart attack knowledge sex and age

Post Education Behavioral change	will not consider	will consider	will start it now	Already start and will countinue
Doing exersise regulary	0	0	n=10 (71.43%)	n= 4 (28.57%)
Stop smoking	0	0	n=2 (14.29%)	n=12 (85.71%)
Consumption of a healtier diet	0	0	n=4 (28.57%)	n=10 (71.43%)
Sceduale a dental appointment	0	0	n=13 (92.86%)	n=1 (7.14%)

Table 4- Post-education variables

(The value for personal feedback to presentation was 1 for the most and 3 for the least so increase in the value of response was in reality decrease in their feedback from presentation . which means the negative regression is showing the increase in the feedback not decrease)

```
. regress chanexe posedu age sex Exe
```

chanexe	Coef.	Std. Err.	t	P>|t|	[95% Conf.	Interval]
posedu	-.4815473	.3016464	-1.60	0.145	-1.163919	.2008244
age	.026714	.0437145	0.61	0.556	-.0721751	.1256032
sex	.1407505	.3178056	0.44	0.668	-.5781757	.8596766
Exe	-.6119518	.3095498	-1.98	0.079	-1.312202	.0882984
_cons	3.985022	1.527747	2.61	0.028	.5290171	7.441026

Table 5-Regression change in exercise, post edu feedback, age ,sex, past exercise history

```
. regress chansmo posedu age sex smohis
```

chansmo	Coef.	Std. Err.	t	P>|t|	[95% Conf.	Interval]
posedu	.237225	.2471652	0.96	0.362	-.3219014	.7963515
age	.021207	.0382963	0.55	0.593	-.0654252	.1078392
sex	.5178793	.3564184	1.45	0.180	-.2883952	1.324154
smohis	-.1773266	.3114904	-0.57	0.583	-.8819669	.5273138
_cons	2.48731	1.306104	1.90	0.089	-.4673027	5.441922

Table 6 – Regression change in smoking, post education feedback, age, sex, past smoking history

```
regress chandent posedu Healcarekn  age sex
```

chandent	Coef.	Std. Err.	t	P>|t|	[95% Conf.	Interval]
posedu	-.1010181	.2074948	-0.49	0.638	-.5704039	.3683677
Healcarekn	-.0248064	.2000426	-0.12	0.904	-.4773341	.4277213
age	-.0130485	.0316345	-0.41	0.690	-.0846107	.0585138
sex	-.2098509	.2427741	-0.86	0.410	-.7590441	.3393424
_cons	3.918985	1.100886	3.56	0.006	1.428608	6.409362

Table 7- Regression analysis of change in dental care , post education feedback, healthcare knowledge , age , sex