

ASSESSMENT OF COMMUNITY MEMBER ATTITUDES TOWARDS HEALTH NEEDS OF REFUGEES IN SAN DIEGO



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I. Executive Summary

❖ Introduction

Evaluations of refugee health most often focus on infectious diseases and health shortly after arrival in the United States (U.S.). There are very few assessments of long-term refugee health status and chronic diseases in resettlement countries. The following assessment is a preliminary, qualitative survey of long-term health concerns in the refugee community of San Diego.

Our assessment began with an extensive review of health and medical literature on refugees resettled to California, followed by a phone survey to identify available resources in the community. In-depth interviews were conducted to examine perceptions, attitudes, and knowledge of:

- 1) Refugee resettlement agency personnel (also known as voluntary agencies or VOLAGs),
- 2) Health care workers that serve the refugee community,
- 3) Volunteers/employees of community-based organizations that serve refugees (also know as mutual assistance agencies or MAAs),
- 4) A small, stratified convenience sample of refugees from the 8 largest nationality groups recently settled in San Diego.

It is our hope that the findings of this assessment will be used by the County of San Diego Health and Human Services Agency and community organizations to improve the delivery of health care and health promotion programs to refugees. The assessment may also assist local and regional decision makers in making policy decisions and identifying areas in need of greater funding and programming.

The specific goals of this assessment were to:

- 1) Determine the primary long-term health care needs of the major refugee groups in San Diego,
- 2) Determine the main barriers to health care for the largest refugee groups of San Diego,
- 3) Evaluate the best methods of accessing and sampling the full refugee population of San Diego for future health surveys and interventions focusing on identified health needs.

Specifically, current health conditions and chronic diseases were evaluated. Other topics evaluated included: socio-cultural issues affecting refugee health, health care access, health promotion, and suggestions for conducting future health assessments of refugees in San Diego.

❖ Perceived Major Health Issues

Main health conditions affecting overall adult refugee population

Overall, mental health was the most commonly mentioned health concern affecting the San Diego refugee community (Figure 1).

- Awareness of and attitudes towards **mental health** were discussed in the vast majority of interviews. Cultural and structural barriers to getting treatment for mental health problems were a common theme.
- **Hypertension** and **diabetes** were considered emerging problems in the community; however, participants did not discuss in detail the extent to which these conditions are being controlled in those affected.
- **Dental health** has been determined to be a common refugee health concern upon arrival in the U.S.. Additionally, the majority of participants noted that dental health continues to be a problem post-resettlement due to limited access or use of dental services and poor dental hygiene.

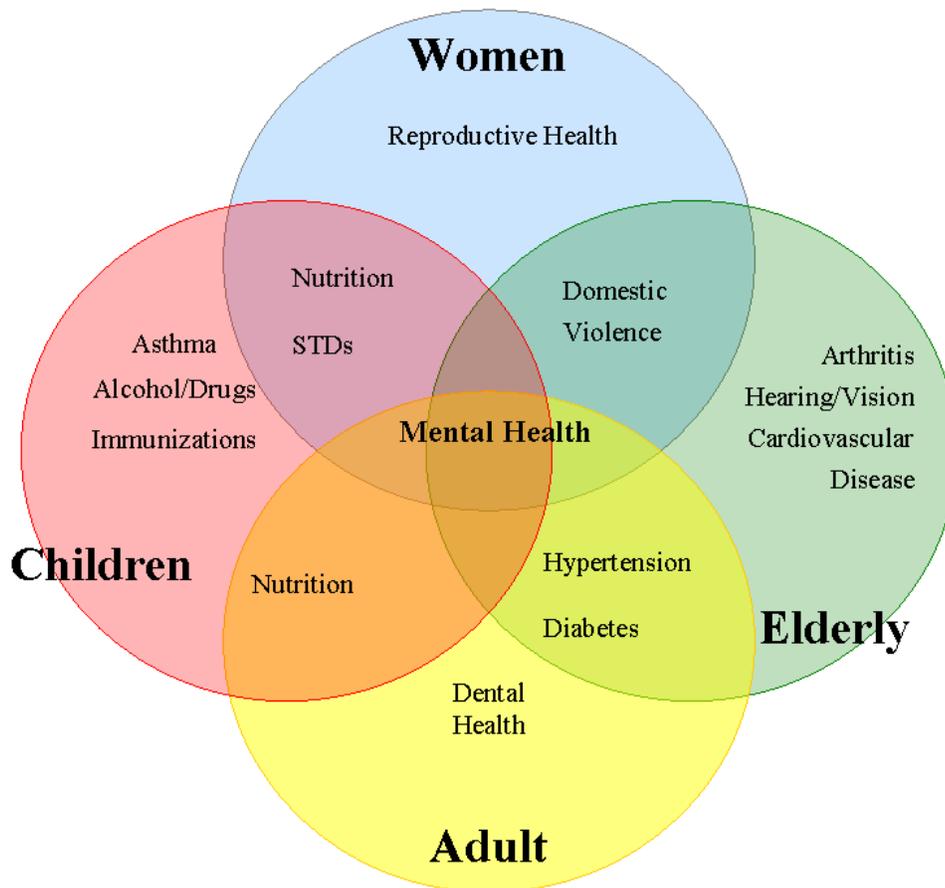


Figure 1: Perceived Major Health Conditions by demographic group

Perceived health conditions affecting refugee children and adolescents

No single health care issue of children dominated the interviews. In general, however, interviewees tended to be concerned about the changing eating habits of children of recent refugee arrivals (Figure 1).

- While few children were considered obese, **nutritious foods** weren't often included in diets and **weight gain** was thought to be increasingly common. Higher cost of nutritious foods and a perceived desire of children to 'fit in' among their peers were cited as reasons

for choosing fast and junk food over more traditional cuisine. In addition to diet, a change to a more **sedentary lifestyle**, for a variety of reasons, was considered an important component to the nutrition/obesity issue.

- The refugees interviewed were concerned about **drinking/drug use** and **sexually transmitted infections** (STIs) in their children, although health care providers did not specifically discuss these issues.
- Several health care providers mentioned **asthma** as an urgent problem among young children, but it was not as commonly mentioned as other health issues.

Perceived health conditions affecting refugee women

Perceived health issues specific to women were dominated by reproductive health concerns.

- Failure to access **prenatal care**, barriers to accessing **family planning** methods, and **STIs** were top issues.
- **Nutritional issues** were also a common concern. Lack of inclusion of nutritious foods in the diet was believed to be associated with either **weight gain** or, for some, **malnourishment**. This sometimes overlapped with reproductive health issues, as several health care providers linked **anemia** in pregnant women with inadequate diets. Anemia was observed, in particular, in Somali women seeking prenatal care.

Perceived health conditions affecting elderly refugees

- Perceived health care issues of the older refugee community included increasing prevalence of **hypertension** and **diabetes** among this age group as well as untreated **mental health** issues.
- **Arthritis** and **cardiovascular diseases** were also commonly mentioned. Refugee serving organizations, providers and refugees were in agreement regarding these issues and almost all participants mentioned them.

Perceived Major Health Care Access Barriers

Discussion of health conditions was dominated by perceived barriers to accessing care. These barriers inhibited refugees' ability to obtain preventive care, resulting in less than optimal health status. Many of these barriers are related to one another and jointly contribute to the larger access to care problem of the refugee population.

- As a barrier, **language** was mentioned during every interview as a strong barrier to health care access as well as other services within the community (Figure 2).

Participants also mentioned the lack of interpretation services (oral) and availability of translated (written) health information as a barrier to accessing preventive services.

- **Language** and **transportation** were often described as interdependent barriers. For some refugees, it is difficult to obtain a driver's license or understand the bus system, and for most taxis are not affordable. Transportation was particularly problematic for older refugees, due to their lack of knowledge of the transportation system or isolation within their community.
- While **lack of insurance** was mentioned as a major barrier, most respondents perceived expenses not covered by MediCal as a greater obstacle.
- **Cultural barriers** cited included differing perceptions of the role of physicians, a strong stigma associated with mental illness, and reluctance to be seen by a doctor of the opposite gender.
- Lack of **knowledge** of the U.S. health care system resulted from language difficulties and often was discussed with or related to cultural barriers.

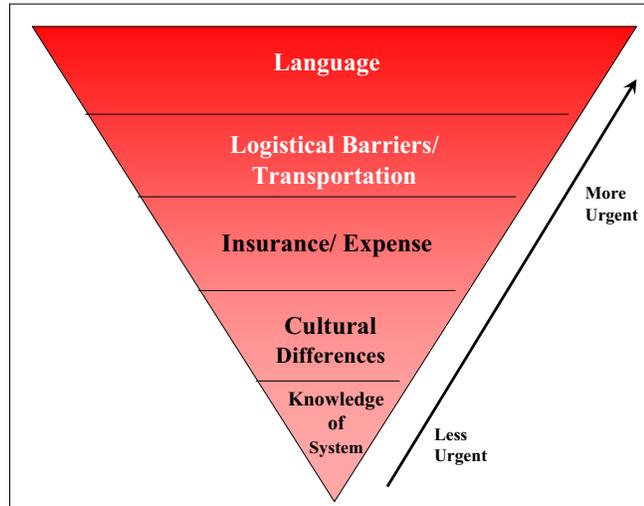


Figure 2: Top 5 Perceived Major Health Access Barriers

❖ Resources available

San Diego County is fortunate to have a large array of community-based organizations that target their services to the refugee community. These organizations work tirelessly to utilize their limited resources to serve those at various stages of the resettlement process. A list, by no means exhaustive, of refugee serving organizations and health care facilities serving a large refugee clientele can be found in Appendix 6. The distribution of these services is also highlighted in maps in the Resources Available section.

Due to the size of certain population groups, their specific needs, and time since the establishment of their group within San Diego, it is understandable that some ethnic communities would have more services and programs targeted specifically to them. However, it is worth highlighting the need for increased collaboration and linkages between existing services, so that they can more effectively reach those in need. Throughout this report a discussion of existing services as well as suggestions from assessment participants on how to improve services can be found.

❖ **Conclusions/Future assessments**

Throughout the Findings section of the report, recommendations are denoted by the  icon. The main recommendations that were derived from the assessment were in relation to education and promotion activities. Educational programming needs to be created or improved to increase awareness of the issues affecting refugees' long-term health - especially in critical areas such as mental health, diabetes, nutrition, hypertension, and women's reproductive health issues. In addition to health promotion, services need to be expanded or created to address language and transportation barriers. Funding for mental health programs that provide culturally and linguistically appropriate services should be expanded. Increased sharing and reporting on health conditions found during the refugee health assessments that take place upon arrival to the U.S. would be useful. Finally mobile clinics with services tied to the aforementioned health needs would help MAAs, VOLAGs and health care providers to anticipate the long-term health needs of San Diego's refugee community.

II. Background

A. Introduction and Background

San Diego is the third largest site in California for resettling refugees, secondary refugee migrants, asylees, parolees, and victims of human trafficking (for the purpose of this report, all of these subgroups are defined as “refugees”). While over 25% of San Diego’s population is foreign born, only a small fraction of immigrants in San Diego are refugees by this definition. According to the United Nations Convention on Refugees, a refugee is: “any person who is outside any country of such person's nationality... and who is unwilling or unable to return... because of persecution or a well-founded fear of persecution on account of race, religion, nationality, membership in a particular social group, or political opinion.”² Unlike the hundreds of thousands of documented and undocumented immigrants who most often settle in San Diego for economic or social benefit, refugees are uprooted from their home involuntarily and often violently. Their resettlement in San Diego marks the end of a journey that is better measured in years spent in resettlement camps than in miles traveled.

Table 1: Demographic Information of San Diego Refugee Arrivals (2001-2005) (n=5090) ¹

Category	%
Age (years)	
< 15	29
15-24	27
25-34	17
35-44	12
> 45	15
Gender	
Male	52
Status	
Primary refugee	76
Secondary migrant	2
Asylee	21
Parolee	1
Victim of trafficking	<1
Country of Origin	
Somalia	27
Iraq	15
Vietnam	8
Sudan	7
Iran	7
Afghanistan	6
Ethiopia	6
Russia	4
Other (76 countries)	20

Between 2001 and 2005, 5,090 refugees arrived in San Diego. They represent a wide diversity of refugee categories, nationalities, educational backgrounds, language abilities, and age groups (Table 1).³ According to the California Department of Health Services, over half of refugees resettled to San Diego County from 2000-2004 were less than 25 years old, with a third younger than 15 years of age. Approximately 80% (4,091) of the refugees arriving in San Diego from 2001-2005 originated in just 8 countries: Somalia (27%), Iraq (15%), Vietnam (8%), Sudan (7%), Iran (7%), Afghanistan (6%), Ethiopia (6%) and Russia (4%) (Table 1, Figure 3).³

Beyond an initial health assessment completed upon entry into the U.S., little is known about the long-term health needs of refugees during their later years of resettlement. For years prior to coming to the U.S., the majority of refugees live in camps, often with minimal food, shelter, clothing, and medical care. If deemed eligible by the U.S. Justice Department to resettle to the U.S., refugees are screened for communicable diseases of public health concern according to criteria set by the U.S. Centers for Disease Control and Prevention. Refugees with conditions such as tuberculosis, intestinal parasites, or sexually transmitted infections (STIs) are given a classification status which allows U.S. entry, but provides U.S. health authorities with information for follow-up

II. Background

after arrival. Within 30 days of their arrival, refugees are recommended to have health assessments by pre-designated health screening programs. Like the overseas screening, the key focus of post-arrival screening is on communicable diseases of public concern. In San Diego, the post-arrival screening is carried out by the County of San Diego tuberculosis (TB) Control/Refugee Health Program and Catholic Charities of San Diego Diocese (CCSD). The exam includes a general physical examination, infectious disease screening, and screening for abnormalities in basic physiological parameters such as hemoglobin level, complete blood count (CBC), and blood pressure.

According to a 1997 literature review (Meghan, is this correct), the most common acute health issues among resettled refugees in the U.S. are tuberculosis, nutritional deficiencies, intestinal parasites, chronic hepatitis B infection, lack of immunizations, and depression.⁴ Whether any of these issues remain chronic health concerns is unknown. Most of the literature available on refugee health in the U.S. is focused on mental health and chronic health problems related to the long-term physical effects of psychological trauma. A collaboration between San Diego State University and the Islamic Council of San Diego in 2005 found direct links between persecution in country of origin and harassment in the U.S. of Middle Eastern, North African and East African adults and the number of psychological symptoms acknowledged.⁵

A recent survey of members of the San Diego Refugee Forum, an affiliation of refugee service providers, found that 56% ranked health or health care as the most important issue facing refugees during their initial years in the U.S.⁶ The health care resources available to refugees change dramatically after they have been in the United States for some time. Refugees have up to eight months to become economically independent. After that time cash assistance from the U.S. government is usually terminated and refugees become subject to MediCal's standard eligibility requirements.

This assessment focused on health issues of refugees in the period after governmental assistance has usually ended (1-5 years after resettlement) – a period in which refugees may be particularly vulnerable but for which very little information is available. Organizations serving refugees have often expressed to our advisors at the San Diego County Health Department a need for information to be gathered on major health needs of refugees. Their ability to serve their clientele and carry out their mission is dependent upon data on their clients' needs. The enclosed report is first step in trying to provide such information.

II. Background

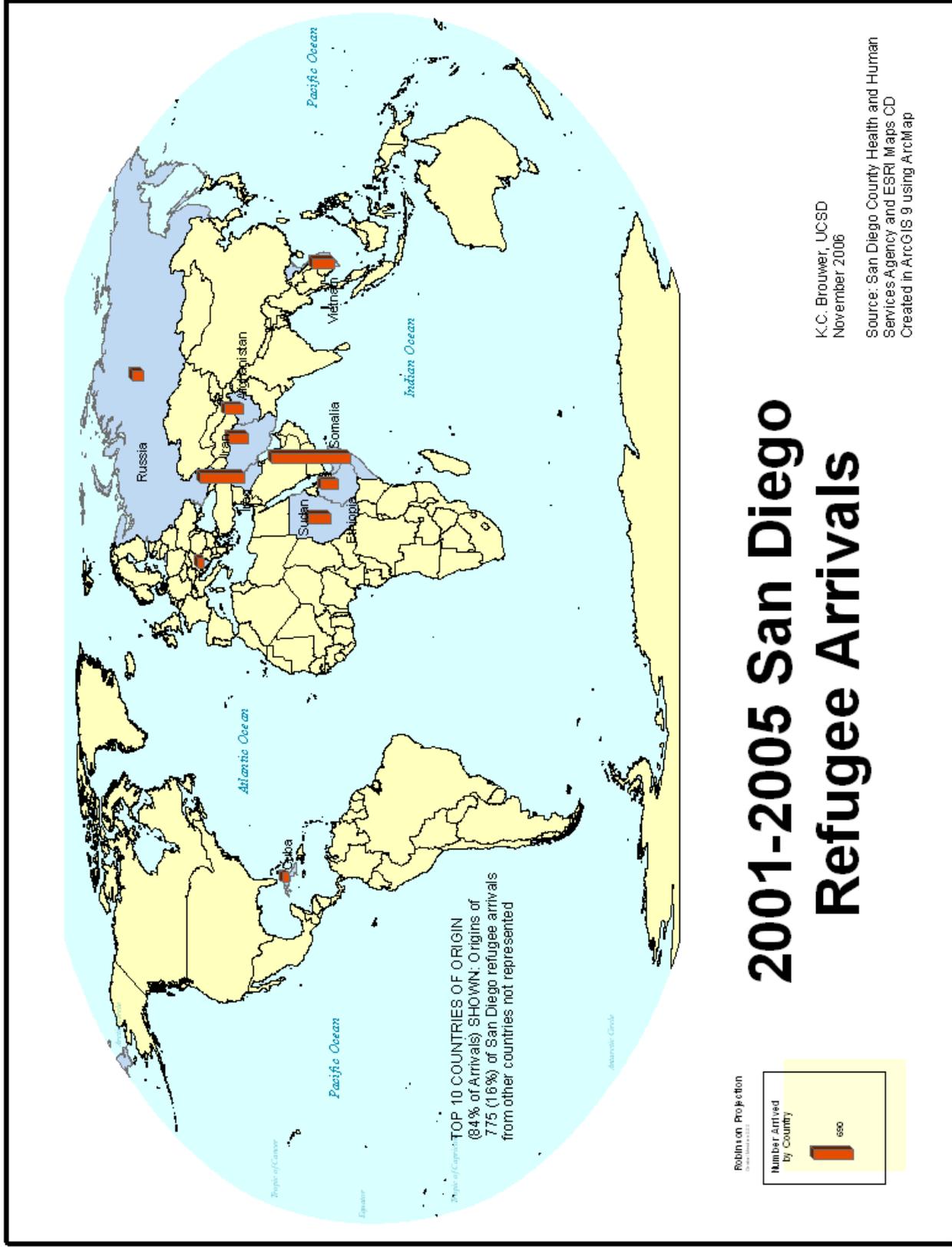


Figure 3: Top 10 Countries of Origin of San Diego Refugee Arrivals (2001-2005)

III. Methods

A. Assessment Design and Methods

Design of the assessment was based on the concept of **triangulation**, using multiple methods to explore and evaluate a question in order to maximize reliability and validity (Figure 4).

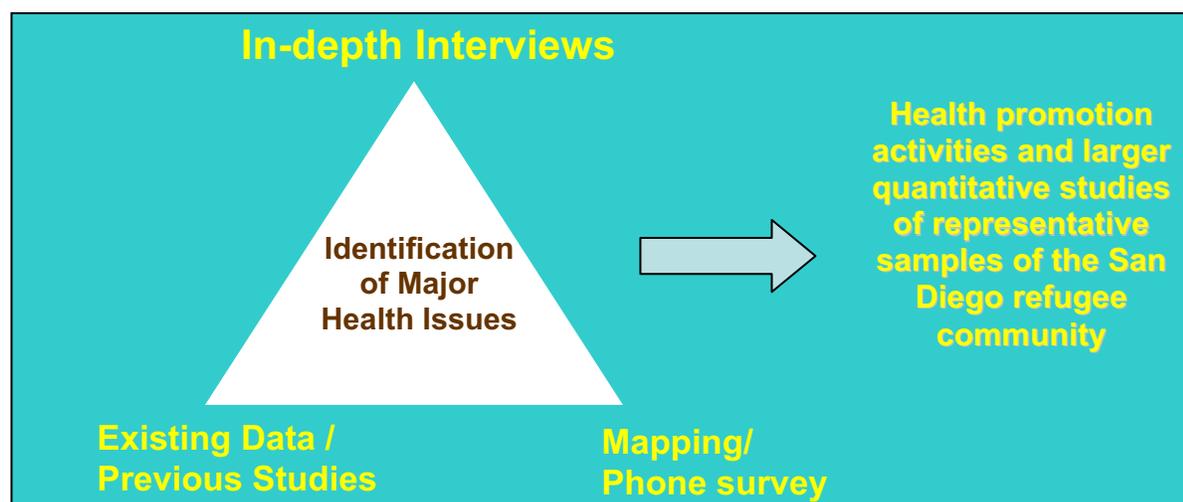


Figure 4: Assessment Design- Triangulation

1. Background Research: Review of Existing Data

One point of the three-pronged approach to this assessment consisted of an initial review of existing data and previous health assessments pertaining to the San Diego area. This was compiled in the Fall of 2006 by searching PubMed (www.pubmed.gov), EBSCO (search.ebscohost.com) and Google Scholar (scholar.google.com) databases. In order to identify relevant information, our search strategy included the following terms: refugee health; refugee health California; refugee health assessment; chronic diseases + refugee; mental health + refugee; health access + refugee; refugee screening California. Bibliographies of articles were consulted to find further information on published reports from the San Diego area. We also sought out researchers who had previously worked with refugee groups in San Diego as well as mutual assistance agencies working with refugees to see if that had any reports not available through traditional publicly available sources. The purpose of this phase was to learn more about the refugee population, determine past survey strategies, and determine health conditions of possible concern to refugees in California, thereby creating a stronger assessment instrument.

2. Identifying Resources: Phone Interviews/Mapping

The phone survey portion of the assessment was conducted from December 2006 through March 2007 in an effort to catalog organizations and health care providers in San Diego that serve refugees on a regular basis (Appendices 1 and 2). In turn, the goal was to indirectly identify neighborhoods where refugees tend to seek services. The original list of refugee serving

organizations and health care providers was compiled from the membership roster of the San Diego Refugee Forum, information from the San Diego County Health and Human Services Agency, and a list of providers in the MediCal Provider Directory; the list expanded as new health care providers and organizations were identified by subjects interviewed in the health assessment. Organizations and health care providers who were contacted and indicated that they no longer regularly serve refugees were removed from the list. Project staff contacted each organization or medical office no fewer than (5) times by phone (during normal business hours, 8:00 a.m. to 5:00 p.m. Monday through Friday), fax, email and ground mail before striking an organization from the list.

3. Primary Data Collection: In-depth Interviews

We conducted qualitative, informational interviews with 40 informants (Figure 5). In order to develop a more comprehensive view of local perceptions concerning refugee health and health care accessibility, we recruited a targeted, or ‘purposive’, sample of ‘key informants.’ A key informant for this assessment is an especially knowledgeable individual who is strategically placed in the refugee community and who holds detailed information on refugees and refugee needs.

Descriptions of the four types of predefined categories of informants follow:

- 1) **Health care providers:** Clinics located in neighborhoods where a large number of residents are recent refugees (e.g. City Heights and El Cajon City) often have personnel experienced in or familiar with the health needs of refugees. This is in part due to the specific language skills of the personnel at the clinics, but also due to word-of-mouth referrals among the refugee community. We recruited subjects from this group of health care providers as they were especially knowledgeable about refugee health needs and barriers involved in treating the refugee population of San Diego.
- 2) **Employees/volunteers of resettlement agencies (also known as voluntary agencies or VOLAGs):** These agencies are funded by the federal government to provide resettlement services to refugees. Resettlement encompasses the core services for a refugee's first 90 days in the United States including the initial contact, housing, food, health care (screening, immunizations, and MediCal enrollment), school enrollment, employment search services, and English as a Second Language (ESL) instruction. VOLAG employees are often contacted on an informal basis for health care advice. Many of the managers of the VOLAGs in San Diego were once themselves refugees. They generally maintain contact with refugees during their first year in the U.S. VOLAG representatives have an intimate knowledge about past and present health problems common to different refugee populations and about barriers to health care refugees face immediately after arrival to the U.S.
- 3) **Employees/volunteers of mutual assistance agencies (MAAs):** MAAs are a diverse group of non-governmental, community-based organizations that primarily serve a particular refugee group. After their relationship with a VOLAG has ended, refugees may turn to MAAs for services ranging from preventive health programs for youth to pre-

school to job training. They are generally smaller than VOLAGs and are more likely to be staffed by and have input from refugees in the community they serve. MAA representatives have insight into designing services to fill the needs of refugees and have knowledge regarding current health and social service needs of refugees. These organizations also have unique information on how best to reach certain refugee groups.

- 4) **Recent Refugee Arrivals:** By inviting recent refugees from eight of the largest refugee groups in San Diego into this assessment, we were able to get first hand information on what issues refugees themselves have had to deal with in regards to health and health care. Although these individuals were not spokespersons for their particular refugee group, their insights provided rich data on health concerns that can be explored in more depth in future health needs assessments. In order to avoid excluding refugees who may be less adjusted to life in the United States than fluent English speaking refugees, interpreters helped conduct interviews with those who preferred to express their opinions in their native language, rather than English.

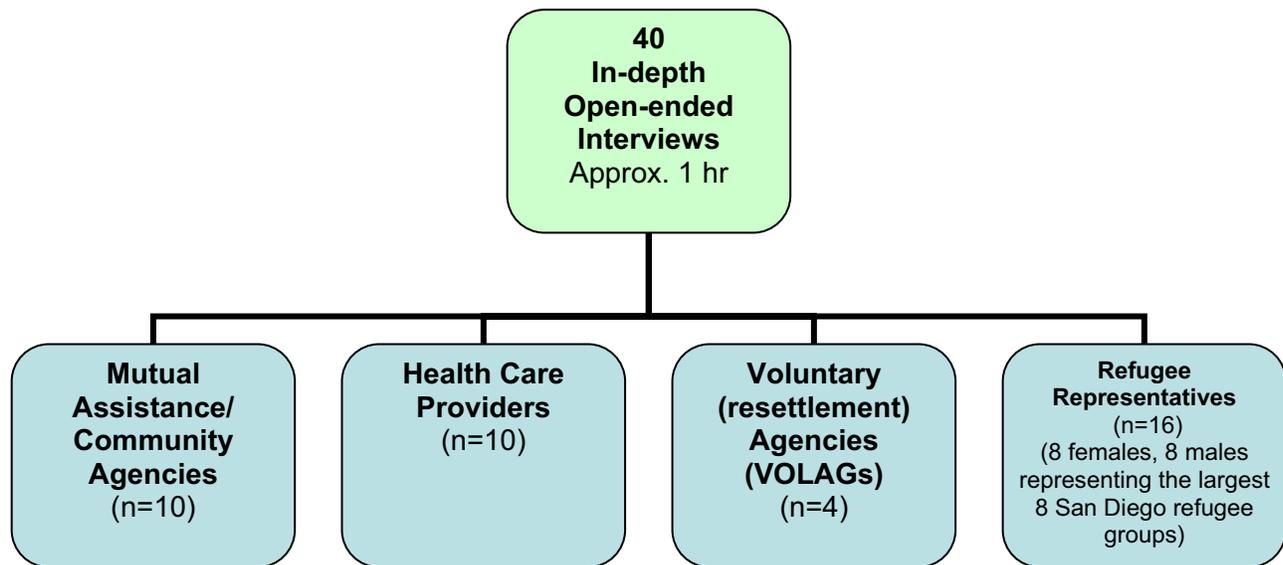


Figure 5: Sampling Scheme of In-depth Interviews

Eligibility for the assessment was as follows: 1) ≥ 18 years old, 2) able to provide informed consent and 3) belong to one of the predefined categories. No exclusions were made due to race, ethnicity. Every effort was also made to avoid exclusions due to language ability.

Sampling for In-depth Interviews

In qualitative surveys, the sampling strategy aims to reflect a diversity of viewpoints, rather than an accurate statistical representation of the population. The minimum number of interviews on a subject needed in order to identify major themes on an issue, is generally agreed to be 15-20.⁷ By conducting at least 40 interviews, we anticipated the assessment’s findings to be representative. Firm conclusions regarding attitudes/practices within any of the four key

informant groups, however, were less likely. Therefore, the main aim of this assessment was to identify general themes upon which to make some conclusions about the health situation in general.

For the first three categories of participants (health care providers, VOLAGs, MAAs), participants had to be **familiar with the refugee populations in San Diego** and their specific health needs. In addition, health care providers had to have **provided clinical services** to a segment of this population. Sampling of key informants who provide services to refugees was stratified to get representation from a variety of refugee groups in San Diego, with stratified random sampling if several organizations focused on the same refugee group.

In conducting in-depth, informational interviews with 16 refugees, participants had to have refugee, asylee or parolee status from the government and have resided in the U.S. (primarily in the San Diego area) **more than 1 year but less than 5 years**. Sampling was stratified to include **one male and one female informant from each of the eight largest San Diego refugee groups** based on recent arrival data (Somalis, Iraqis, Vietnamese, Sudanese, Iranians, Afghans, Ethiopians, and Russians).⁸

In-depth Interview procedures

After providing written informed consent (Appendix 5), each participant completed a face-to-face interview performed by a trained member from our team. To optimize rapport, interviewers were matched to respondents based on gender when logistically possible. Gender matching was accomplished for all interviews with refugees and in 63% of service/health care provider interviews. Our staff conducted each interview using a general interview guide, to ensure that certain topics were addressed, but the interview was open-ended and conversational (Appendices 3 & 4). Initial domains of inquiry included: **health conditions of concern to the refugee community, socio-cultural issues, health care access, health promotion, and issues related to conducting future health assessments of the refugee community in San Diego**. The interview guide was modified as the interviewing process progressed to include new topics, to investigate themes arising from the interviews, and to ensure that data were triangulated on an ongoing basis.⁷ Interviewers were trained to probe each respondent for additional details in order to get an idea of the context behind opinions on health issues.

Interviews were approximately one-hour in length and were conducted in private locations based on availability and participant preference. Each interview was audio taped, translated into English (if necessary), and transcribed into text. No specific identifying information was included in the transcript or on the tape. Participants were offered \$15 USD as compensation for their time.

In-depth Interview Analysis

All transcripts were read and hand coded to identify trends and emerging patterns. Key themes were determined based on comparison of transcript coding by two different trained staff members.

B. Community Input

We sought community input during all stages of the project. The following are some examples of community input sources:

- **San Diego Refugee Forum meetings:** Project staff began attending and observing Forum meetings in September of 2006 as the assessment plan was submitted for institutional review board (IRB or ethics) approval at the University of California, San Diego (UCSD). A presentation to the Forum in November gathered additional input regarding assessment design.
- **Individual input from Forum Members and San Diego County Public Health Department:** Design of the assessment was adapted and developed based on input primarily from Forum members and San Diego County, Health and Human Services Agency, TB Community Projects and Partnerships.
- **Phone surveys:** In order to identify resources available to the San Diego refugee community and develop a sampling frame for in-depth interviews, we conducted phone surveys of VOLAGs, MAAs and Health Care Providers working with refugees in San Diego County to gather contact and location information. At the end of each survey we asked each organization if they knew of other groups who provide services to refugees that we should also contact.
- **Preliminary interviews:** Phone survey and the first round of interviews done with VOLAGs and MAAs greatly increased the list of health care providers and helped guide the targeted sampling of providers and refugees.
- **Staffing:** We were able to incorporate views from the refugee community by including on our staff (interviewers, transcribers, interpreters, consultants) persons with close ties to a variety of ethnic groups within San Diego. Not only did these personnel provide services such as translation, they also advised the team on how and where to target recruitment and how to improve survey questions to be more culturally suited to refugee needs

IV. Findings

A. Literature Review

B. Health Evaluations upon Refugee Arrivals in US- intake data

C. Participant Demographics

D. Interview Results

- Priority Health Issues

- Perceived Health Care Access Barriers

A. Literature Review

A literature search of past surveys and work on refugee health in California was conducted. The results from this search, which was by no means exhaustive, can be found in Tables 2-5. The purpose of this phase was to find out more about the refugee population, learn from past survey strategies, and determine conditions of possible concern to refugee arrivals - all of which aided design of our assessment instruments.

- The literature review search was limited to California and to studies that addressed health related topics among refugees. It did not include health education programs or health conditions of immigrants unless the word *refugee* was also included. The search was limited to the past 20 years.
- The literature search was compiled through searching PubMed, EBSCO, and Google scholar databases (Meghan, please briefly define what these are – e.g. for someone who has never heard of pubmed before). Search terms were limited to relevant information and research on refugees in California (see “Assessment Design and Methods on page 10). Bibliographies of articles were consulted to find further information on published reports from the San Diego area.

B. Summary of Past Surveys Conducted in California

Literature Review - Mental Health Studies (Table 2)

- There is a large amount of literature regarding mental health in the immigrant population but little of this focuses specifically on the mental health of refugees.
- All studies presented on refugees within California addressed the mental health conditions of refugees who have been living in the U.S. for many years.⁹⁻¹¹
- There were fewer than expected studies focused on PTSD or depression in refugees given their past experiences. Instead, mental health antecedents such as past trauma, stress, and physical/emotional abuse were described.

Literature Review - Health Conditions (Table 3)

- Many health studies were focused on issues affecting the refugee population upon arrival in the U.S.
- Mental health, dental health, diabetes, and heart disease were identified to be common conditions affecting refugee populations.^{12, 13}

IV. Findings

- Perceived underlying causes of health problems included past health problems, access to care barriers, and behavior changes post-resettlement.¹³⁻¹⁶
- Suggested improvements included increasing education and awareness about health conditions and treatment options.^{14, 17} Suggestions were made to increase occupational and economic stability of refugees as well as improve cultural understanding by physicians so that they can better connect with refugee patients.^{13, 17}
- Emphasis was placed on the health needs and conditions of recent refugees (within the first 8 years after arrival).

Literature Review - Prevalence Studies (Table 4)

- We identified only two published studies in California focused on determining the prevalence of certain health conditions (the total number of cases of an infection in a population at a given time) within the refugee communities. Prevalence data is extremely useful for deciding resource allocation to specific health needs.
- The included studies focused on parasitic diseases and other conditions common upon arrival in the U.S..¹⁸ Discussion was given to how acculturation could positively affect the health of refugees.¹⁹
- It would be valuable to see implementation of more quantitative assessment designs, perhaps clinic-based, to evaluate health related conditions affecting refugees after their initial resettlement in California.

Literature review - Outreach strategies and Access to care Barriers (Table 5)

- All reports assessing barriers to accessing health care concluded that refugees are faced with an array of system and cultural barriers.^{13, 20, 21}
- Many went on to suggest that these barriers create limitations in refugees' ability to adapt to their new environment.
- Suggestions for conducting successful outreach projects included increasing first hand knowledge of the target population and continuing one's presence within the community well after a project is implemented.²²

Table 2: Literature Review- Mental Health Studies

Study	Refugee Population	Location	Sample size	Aims	Methodology	Main Health-Related Outcomes
Helsel et al., 2005	Hmong Shaman	Central California	11 Hmong Shaman (6 female/5 males)	Understand participant's perspective of chronic illness, it's nature, effects, and management	In-depth interviews and evaluation of diet, medications, and testing equipment	<p>Chronic diseases are not well understood, resulting in:</p> <ul style="list-style-type: none"> ▪ Inconsistent medication use ▪ Incomplete dietary changes ▪ Limited awareness of potential complications ▪ False impression that chronic diseases can be cured rather than managed
Lipson et al., 1993	Afghani	Northern California	38 telephone interviews 7 community meetings Survey of 196 Afghan families	Describe common potential causes and examples of mental health problems in Afghan refugees	Ethnographic study	<p>Mental health issues identified:</p> <ul style="list-style-type: none"> ▪ Depression ▪ Somatic symptoms ▪ Posttraumatic stress disorder (PTSD) <p>Suggestions to mental health providers:</p> <ul style="list-style-type: none"> ▪ Elicit immigration history to better understand adjustment problems and identify PTSD ▪ Tradition psychiatric approaches do little to help aid PTSD sufferers. Instead, support groups prove to be helpful
Palinkas et al., 2003	Somali and East African refugees	San Diego County	N/A	Examine the interaction between challenges and the mobilization of organizations to develop a program of health promotion and assess programs for disease prevention	Focus Groups	<ul style="list-style-type: none"> ▪ Initiate health promotion measures on HIV and mental illness education ▪ Efforts are needed to disseminate messages relating to cancer, diabetes, and cardiovascular disease to East Africans, Iraqi Kurdish, and Vietnamese refugee groups ▪ Acculturation brings further stress and contributes to mental distress

Mental Health

Table 3: Literature Review- Health Conditions

	Study	Refugee Population	Location	Sample size	Aims	Methodology	Main Health-Related Outcomes
Health Conditions	Lipson et al., 1992	Afghani	Northern California	<ul style="list-style-type: none"> ▪ 60 Afghans of all ages ▪ 20 health and social service providers 	Identify health and adjustment issues, access to care barriers and family integration conflicts as they pertain to health	Descriptive study using in-depth interviews	<p>Main issues identified:</p> <ul style="list-style-type: none"> ▪ Dental caries (41%) ▪ Dermatologic disorders (39%) ▪ Gastrointestinal disorders (23%) ▪ Musculoskeletal pain (12%) <p>Problems related to acculturation:</p> <ul style="list-style-type: none"> ▪ Belief that some illnesses can be prevented by living in accordance to Islamic religion ▪ Access to care dictated by acculturation barriers: transportation, language, education, knowledge of system, cultural differences
	Lipson et al., 1995	Afghani	Northern California	196 Afghan families	Assess health concerns and health education needs	In-depth interviews	<p>Health Conditions include:</p> <ul style="list-style-type: none"> ▪ Mental health and stress related problems ▪ Physical health problems, such as heart disease, diabetes, and dental problems <p>Increased Education needed for:</p> <ul style="list-style-type: none"> ▪ Current occupational and economic problems ▪ Cultural conflicts
	Morioka-Douglas et al., 2004	Afghani	Fremont, CA	9 Afghan Elders	Increase information available to clinicians and educators to care for Afghan elders more effectively	Focus Groups	<p>Cultural Considerations Important for Improved Care:</p> <ul style="list-style-type: none"> ▪ Participants identified their health status and effective treatment with their faith in Islam ▪ Emphasized importance of care given by same-sex providers
	LoBue et al., 2004	All refugee groups (immigrants included)	San Diego County	571 refugees	Evaluate tuberculosis (TB) screening program and compare demographic and clinical characteristics of pulmonary TB cases	Retrospective study based on medical records	<p>Tuberculosis related findings:</p> <ul style="list-style-type: none"> ▪ 93 (7%) had active TB ▪ 433 (76%) had latent TB
	Vryheid et al., 2001	All refugee groups	San Diego County	65 refugee families	Summarize vaccination coverage in refugees and identify barriers to getting immunizations	"Rapid appraisal" using informant interviews and door-to-door surveys	<p>Vaccination Coverage has greatly improved in the immigrant community over the past 10 years:</p> <ul style="list-style-type: none"> ▪ DTP, Polio, MMR completion rate among children ranged from 33% (1984-1985) to 60% (1996-1997) ▪ 40% of the populations surveyed are still without adequate vaccination coverage ▪ Further measures should be taken to increase vaccination coverage

Table 3: Literature Review- Health Conditions (Continued)

	Study	Refugee Population	Location	Sample size	Aims	Methodology	Main Health-Related Outcomes
Health Conditions	Erwin, et al. 2001	Bosnian and those from the former Soviet Union	Northern California	22 surveys of Bosnian refugees 23 in-depth interviews with service providers	Examine health, illness, and health care use patterns of refugees	Database analysis, medical record review, semi-structured interviews and focus groups	<p>Areas of utilization included:</p> <ul style="list-style-type: none"> ▪ Management of chronic diseases ▪ Smoking cessation ▪ Children's and women's health programs ▪ Dental health ▪ Nutrition and diet ▪ Family planning <p>Barriers to care included</p> <ul style="list-style-type: none"> ▪ Obtaining health insurance ▪ Understanding US health care system ▪ Coping with physical and psychological effects of war
	Barnes et al., 2005	Bosnian, Iranian, and Cuban	Northern California	187 medical records reviewed participant observation 31 semistructured interviews	Explore refugees' knowledge and perceptions of nutrition, physical activity and smoking by using the Health Promotion and Transtheoretical Models	Descriptive study	<ul style="list-style-type: none"> ▪ Some knowledge of dietary health and physical activity ▪ Aware of both benefits and barriers for health behaviors <p>Nutrition related perceptions:</p> <ul style="list-style-type: none"> ▪ Show a realistic perception of their weight (55% overweight) ▪ None thought obesity was a positive characteristic <p>Behavior changes post-resettlement:</p> <ul style="list-style-type: none"> ▪ Changes in diet, physical activity and smoking since arriving in the US ▪ Experience positive for some, negative for others

Table 4: Literature Review- Prevalence Studies

	Study	Refugee Population	Location	Sample size	Aims	Methodology	Main Health-Related Outcomes
Prevalence Studies	McCaw et al, 1985 (18)	Ethiopian and Afghani	San Francisco	110 Ethiopian refugees 59 Afghan refugees	Determine prevalence of parasitic diseases and other health conditions affecting refugees within first year of resettlement in U.S.	Retrospective study based on medical records	<p>Health conditions in Ethiopian participants:</p> <ul style="list-style-type: none"> ▪ Parasitic diseases (38%) ▪ Dental caries (33%) ▪ Dermatologic conditions (31%) ▪ Gastrointestinal complaints(25%) ▪ Musculoskeletal complaints (21%) <p>Health conditions in Afghan participant:</p> <ul style="list-style-type: none"> ▪ Dental caries (41%) ▪ Dermatologic diseases (39%) ▪ Parasitic diseases (36%) ▪ Gastrointestinal complaints (23%)
	Palinkas et al, 1995 (19)	Cambodian	San Diego County	4 case studies	Address how acculturation should be considered when examining it as a potential risk for chronic disease and how it should be measured so that it becomes both theoretically and clinically meaningful	Case-study review: 4 case study interviews	<p>Although acculturation sometimes is associated with increased health risk, it can also help:</p> <ul style="list-style-type: none"> ▪ Bridging different cultural understandings of health ▪ Improving health care access (by better understanding of the "health care system") ▪ Leading to adoption of behaviors that promote good health <p>(Note: Acculturation = a merging and adoption of behavior patterns between cultures as a result of prolonged contact)</p>

Table 5: Literature Review - Outreach strategies and Access to care Barriers

	Study	Refugee Population	Location	Sample size	Aims	Methodology	Main Health-Related Outcomes
Outreach Strategies	Choy et al, 2000 (22)	Southeast Asian	Northern California	N/A	<ol style="list-style-type: none"> 1) Increase thalassemia awareness in community 2) Encourage people of reproductive age to have genetic trait testing 3) Follow-up with supportive counseling and refer individuals to appropriate prenatal and perinatal care 	Program evaluation	<p>Points to consider for an effective health program in this community:</p> <ul style="list-style-type: none"> ▪ Define and get to know the target population ▪ Respect their belief system ▪ Educate yourself about their culture and history ▪ Get to know population slowly and steadily and maintain a presence in the community
	Lipson et al, 1992 (13)	Afghani	Northern California	38 telephone interviews, 7 community meetings, Survey of 196 Afghan families	Describe cultural characteristics that influence women's access to health care, approach toward preventive care, control of information regarding sexuality, and spousal abuse	Ethnographic study	<p>Problems affecting healthcare access include:</p> <ul style="list-style-type: none"> ▪ Language barriers ▪ Economic challenges ▪ Unemployment ▪ Substantial psychological and cultural adjustment issues
Health Care Access	Uba et al, 1992 (20)	Southeast Asian	Southern California	N/A	Identify and understand barriers to accessing health care for Southeast Asian refugees	Review	<p>Barriers to health care access:</p> <ul style="list-style-type: none"> ▪ Lack of familiarity with American culture makes health care services geographically and economically inaccessible ▪ Poor knowledge of existing services and how to access them
	Beine et al, 1995 (21)	Somali	San Diego County	14 women	<ul style="list-style-type: none"> ▪ Understand cultural beliefs and behaviors during pregnancy ▪ Determine attitudes about prenatal care in order to inform providers and improve services 	Focus Groups	<ul style="list-style-type: none"> ▪ Women are well informed, understand, and take part in healthy prenatal practices, such as nutrition and exercise ▪ Women preferred to be seen by a female doctor/health care practitioner who is knowledgeable of female circumcision practiced in Somalia and is conservative in the decision to perform cesarean section deliveries

C. Summary of In-depth Interview Findings

1. Demographic Summary of Participants

Our survey population was comprised of a total of **40 individuals from the four groups** mentioned above (VOLAG, MAA, health care provider, and refugee). Most service providers (VOLAG, MAA, health care provider) interviewed had a college degree or higher (84%) and

Table 6: Characteristics of Service Provider Participants (n=24)

Category	Number
Gender	
Male	9
Age (years)	
<25	2
25-39	8
40-54	11
≥55	3
Interview Type	
Voluntary Agency (VOLAG)	4
Mutual Assistance Agency (MAA)	10
Health care provider	10
Highest education level completed	
High School or below	1
Trade/Technical school	2
College Graduate	5
Masters	5
PhD/MD/JD	10
Other	1
No. years organization has served refugees	
Median (Inter-Quartile Range)	9 (5-20)
Primary populations served	
All refugees and non-refugees	11
Vietnamese	8
Sudanese	11
Somali	12
Russian	7
Iraqi	3
Iranian	3
Ethiopian	8
Afghani	6
Born in U.S.	
No	17
Former refugee	
Yes	12
Country of origin of former refugees (n=12)	
Ethiopia	2
Iraq	1
Poland	1
Somalia	3
Sudan	3
Vietnam	2

were female (62%) (Table 6). As some non-governmental organizations are short-lived and do not have a long history of working with the refugee community, we asked participants for the number of years their employer had worked with refugees: median 9 years, inter-quartile range (IQR) 5-20. Half of the service organization employees had arrived in the U.S. as refugees themselves, although most of these participants had resided in the U.S. for over 10 years (median 15 years, IQR 9-23).

Since the assessment focused on long-term health issues, only refugees from the eight countries of origin mentioned in the Background Section who had lived in the U.S. between 1 and 5 years were included. One male and one female were interviewed from each country of origin. Refugees were more or less equally likely to have been here one year (25%), two years (19%), or three years (19%), with slightly more who had been in the U.S. four to five years (38%) (Table 7). Most refugee participants (57%) had no educational experience beyond high school and were older than 40 years old (57%), although 25% had a college degree or higher. With only 2 representatives from each nationality group, it was not possible to interview subjects representing all the different ethnicities from each country of

origin; hence, ethnicity data are not presented.

Table 7: Characteristics of Refugee Participants (n=16)

Category	Number
Gender	
Male	8
Age (years)	
<25	2
25-39	5
40-54	6
≥55	3
Highest education level completed	
Elementary school or below	4
Middle school	2
High school	3
Trade/Technical school	2
Some college	1
College Graduate	3
PhD/MD/JD	1
Country of Origin	
Afghanistan	2
Ethiopia	2
Iran	2
Iraq	2
Former Soviet republics	2
Somalia	2
Sudan	2
Vietnam	2
Number of years in US	
1 year	4
2 years	3
3 years	3
4-≤5 years	6

2. Priority Health Issues

Tables 8 and 9 provide a summary of some of the health conditions that emerged as major perceived concerns during interviews. As this part of the assessment was qualitative, not quantitative, rankings should be taken with some caution. The discussion on these particular health topics that follows provides a better context to the extent and degree of concern for each issue.

Table 8: Major Perceived Refugee Health Concerns by Demographic Group

Rank	Children†	Women‡	Elderly‡‡
1	Nutritional Issues: Obesity/Malnutrition	Reproductive Health Issues	Hypertension
2	Mental Health	Domestic Violence	Diabetes
3	---	Mental Health	Mental Health
Other important health conditions	Alcohol/Drugs, Asthma, STIs, Immunizations	Nutritional issues, Obesity, STIs	Arthritis, Cardiovascular conditions, Hearing, Vision

Categorizations based on responses to the following interview guide questions:

- † Are there issues affecting the health of refugee children that you feel are important?
- ‡ Are there current common or serious women's health conditions affecting the refugees?
- ‡‡ What are the main issues affecting the health of elderly refugees that you feel are important?

Table 9: Major Perceived Refugee Health Concerns by Participant Group†

Ranking	Refugee Perspective (n = 16)	Health Care Provider Perspective (n = 10)	Service Provider Perspective (n = 14)	Overall (n = 40)
1	Hypertension	Mental Health	Mental Health	Mental Health
2	Mental Health	Diabetes	Hypertension	Hypertension
3	Dental Health	Dental Health	Dental Health	Dental Health
Other important health conditions	Diabetes, High cholesterol, Arthritis, Obesity	Hypertension, Cancer, Asthma, Latent TB, Chronic Pain, Obesity	Chronic Pain, High cholesterol, Arthritis, Cancer	Diabetes, Latent TB, Obesity, high cholesterol

†Categorizations based on responses to the following interview guide questions:

- In your opinion, how do the refugee communities in San Diego feel about their overall health?
- What do you think are the most serious or common current health conditions affecting refugees in San Diego?
- Are there infectious diseases affecting the refugees that you feel are important?
- Are there chronic diseases affecting the refugees that you feel are important?



: Throughout the below discussion of Priority Health Issues and Perceived Health Care Access Barriers, suggestions for improvement are denoted by the icon at left.

Mental Health

As can be expected given the hardships, violence, and stresses experienced by refugees in the past, mental health issues were perceived by health care providers and community members to be a common and urgent health priority of the San Diego refugee community. Mental health concerns were most often associated with depression, but mutual assistance agencies mentioned Post-Traumatic Stress Disorder and “traumatized living” as the most common mental health problems.

Difficulty in getting those suffering from mental illness to realize that they have a problem was a common concern. Cultural issues and a fear of appearing “crazy” were related to this. For instance, one VOLAG case manager described the issue as follows:

“Mental health is a taboo so it’s something that most of them will not even admit to having unless it’s so severe that we wouldn’t notice, but most of the times they will not even admit to it.” - *Female, VOLAG representative*

For many, the stigma associated with mental disorders was a strong obstacle to acknowledging the symptoms and accessing treatment and care:

"[Mental health education] is very tough to handle because the culture shock of their privacy is so much deeply hidden in their own problems. They can even just go ahead and die before they tell somebody that they have a problem that will affect their life for a long time." - *Male, Mutual Assistance Agency Employee*

“In our country people hide their mental problem, and depression is considered as mental problem too, and here it takes time for our people to understand that they can go and get help. We are not used to in our country especially for therapists like psychologists....”
- *Female, Refugee from Former Soviet Union State*

These beliefs make it difficult to get those who would benefit from care to seek help. One provider discussed U.S. and Mexican born children seeing a psychiatrist but admitted that “I can’t think of any [refugees] that we found that are seeking mental health (care).” – *Female, Nurse*

Refugees sometimes end up getting mental health care indirectly, when seeking relief for other symptoms. If untreated, mental health issues (e.g. depression or anxiety), can lead to physical symptoms, such as headaches. Comments on this issue included the following:

“They present with somatization. They complain a lot about their physical problems and concerns even though sometimes they experience mental health problems.”- *Female , Nurse*

“They have more um, more signs of depression, but you can’t really nail it. So they’ll come in with, with multiple presenting problems that seem to be physical, and then you get through them, and it’s not really physical.” – *Male, Health Care Provider*

“[An Iraqi mother was] complaining of multi-system issues, and we thought probably there’s an issue of depression. Another one from... Afghanistan also had the same issue..and one more...Sudanese...who had the same thing. So mainly, [mental illness] its kind of more depression and multi-system complaints sometimes.”- *Female, Physician*

In addition to sometimes ignoring depression, some refugees thought that other refugees do not understand its symptoms. For instance, two refugees in the assessment discussed their own knowledge of depression but described others who lacked such knowledge:

“[Refugees] can't explain to themselves what they experiencing, what they're feeling, what is it, they probably don't even know it's depression. They don't know the symptoms for depression. I think there are people of this kind, such people.” - *Female, Refugee from Former Soviet Union State*

"I know a lot of people who are depressed but they won't go because they don't believe in it. You know they are depressed but they won't go." - *Female, Refugee from country in Africa*

Feelings of loneliness, lack of control over their environment, and hopelessness were cited by refugees as contributing to depression. For those who recognized their condition and sought care, accessing treatment and counseling was seldom straightforward due to a lack of expertise in the community of those able to treat patients with such unique stressors. Language barriers also posed a major obstacle.

"We cannot find anybody who provides culturally and linguistically appropriate mental health [services]." - *Male, MAA Employee*

Poor mental health is one more obstacle preventing refugees from resettling successfully:

“ [Mental illness] is there and it's doing its damage and you are asking them to go and do their best to look for a job and present themselves this way or that way a lot of times that is one of the biggest burdens. They are just not ready mentally. So, unfortunately, it should be addressed as its own issue, but it becomes a problem... it really becomes an issue, but it's not being addressed as much.” – *Female, VOLAG employee*

Mental health of older refugees was a serious concern of many MAAs and health care providers. The most serious issue was that elderly are more affected by barriers to health care, such as lack of transportation. They are usually unable to drive, and are often hesitant to walk around their neighborhood for fear of getting lost or for their safety. Few elderly refugees work

in the U.S., so they end up staying home alone. This adds to their feelings of isolation. Senior refugees are susceptible to depression because of all of these factors.

One of the refugees interviewed described the situation of elders in her community as follows:

“Our eldest are really suffering in terms of not knowing where to go. When they came to this country, they do not have relatives you know, and they cannot walk distance to go for something or to go their relatives home, all they do is just sitting at their home... This is really affecting their performance or their way they live here, they’re too domestic, they stay home, and they’re really depressed.” - *Female, 35, Refugee from Country in Africa*

One of the most troubling scenarios for a refugee resettled far from their homeland is to end up returning to the country they fled while it is still dangerous to do so. One provider had seen several elderly refugees make this decision; they found adjustment to life in the United States too difficult:

“Some refugee elders actually decide after a year or two that they’ll go back home. And whether it’s safe or not they’ll move to a neighboring country or someplace. It’s just very difficult for elders to make the transition.” – *Female, Mental Health Care Provider*

Despite concerns that mental health issues are both common and often under-treated in the San Diego refugee community, there were several programs that participants believed were effectively addressing mental health problems among adults and seniors in their community. Many of San Diego’s Iranian, Iraqi, Somali and Russian elders have access to adult day care centers with staff that speak their language. Such centers are funded by MediCal or Medicare to treat seniors at risk of institutionalization, usually due to mental illness or cognitive issues. Some refugee groups were aware of other communities with such centers and wished that their community could have social or adult centers for their community in general. These centers not only provide a venue in which elderly refugees can socialize with each other and receive health care, they also address transportation barriers by organizing Metro Transit System van services to and from the homes of senior citizen patients. Many of the drivers transporting refugees to these centers speak the refugees’ language. While such van services are available to much of San Diego’s elderly or disabled for their use in general, older refugee participants only described using such transportation services for access to adult day care centers. It was beyond the scope of this assessment to investigate the effectiveness of these centers, but refugees and providers saw them as a positive means of addressing older refugees’ mental health needs.



Suggestions for Improvements:

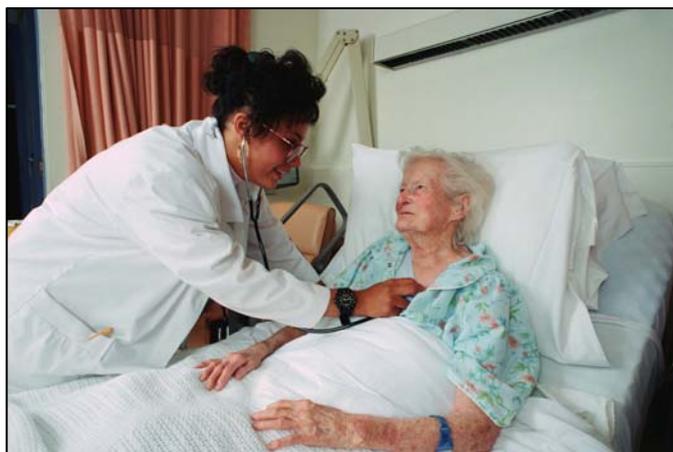
Overall, the most needed improvement to mental health services for San Diego’s refugees were:

- Increasing the number of culturally appropriate mental health programs.
- Increasing refugees’ access to such programs.
- Making an effort to align such programs with the cultural understandings of mental illness in each refugee community.

According to many providers and mutual assistance agencies, refugee mental health programs that had been successful in the past eventually closed down due to lack of funding. Given that mental health continues to be the largest unmet health need of San Diego's refugee population, greater emphasis needs to be placed on ensuring the sustainability of refugee mental health services in San Diego County.

Hypertension

High blood pressure or hypertension was mentioned by more subjects than any other chronic health issue, with the exception of mental health. Almost all VOLAGs, nine of the ten MAAs and most of the refugees named hypertension as a top chronic health problem of older refugees who had been in the U.S. between 1 and 5 years. On the other hand, less than half of health care providers mentioned hypertension as a common chronic health issue of refugees. Perhaps this may be in comparison to their U.S. born patients, where approximately 66% of adults aged 60 or older have high blood pressure.²³



Reasons behind development of hypertension were rarely discussed, although diet was sometimes singled out: “I see a lot of high blood pressure from the women and I think what brings that on to them, it may be bad eating habit... They don't have control to what they should eat everyday... They just eat whatever is available. They don't have to balance.” *Male, MAA Employee and Former Refugee*

Age was another common theme - as expected from a progressive chronic disease:

“In older ages, I'd say 1 in 2 complains about high blood pressure.” *Female, 35, VOLAG Employee*

“We see more [cholesterol and high blood pressure] in men like 45, 47, 48, that age range.” *Male, MAA Employee*

Research into the causes of this complex condition has identified stress and psychosocial issues to be contributing factors.²⁴ Thus, the mental health stressors faced by recent refugee arrivals may be exacerbating the hypertension issue.

Among all 40 people interviewed in-depth, only a few said that refugees struggle to manage their hypertension:

“When we tell a person...they have hypertension, there is a lot of denial, which is a culture thing because they never think they have hypertension... We have to work very

hard with them to tell them that... they need medications...need to diet and exercise.”
Male, Case Manager and Former Refugee

The major concern expressed about hypertension was how common it is. Although participants discussing hypertension usually mentioned it only briefly and did not discuss contributing factors or ways to improve management of the condition, any programs undertaken to address hypertension in refugees should consider these issues.

Diabetes

Diabetes, like hypertension, was often brought up by subjects as an emerging health issue, but its different forms, treatment, and management were not frequently discussed. However, it was mentioned that some refugees suffering from diabetes have difficulties managing their condition: “They don’t know how to manage that [diabetes]...They have to check and they have to write down... like the sugar, you have to write it down the number is in the morning and later on check and you have to make your diet is correct, but they don’t know.” - *Female, VOLAG Employee and Former Refugee*

Of the 17 interviewees who mentioned diabetes, all focused on Type 2 diabetes. Opinions were evenly split as to whether the disease was exacerbated by the change in diet and activity level upon arrival to the U.S. or by refugees’ diets in their home country. Diabetes prevalence would be expected to vary widely in many of the refugees’ countries of origin. Some providers indicated that the diet in the refugees’ home country was the major contributing factor. For instance, an MAA employee working with the Russian community said the following:

“We have a huge ridiculous amount of diabetics here at our center. I would say almost 50% of our clients are diabetic. A lot has to do with their cultural diet...” *Female, Mutual Assistance Agency employee*

Others indicated that diabetes was instead a disease associated with the change in diet upon acculturation to an American lifestyle:

“Diabetes tends to, to run more rampant here, and you know we’ve noticed that it’s based a lot on food choices and the differences in the food choices from here to the, their countries of origin, so that would be probably be a main concern.” *Female, Social Worker*



Refugee participants seldom directly discussed the causes of diabetes; however, they often mentioned obesity, weight gain and change in activity levels upon arrival to the United States. Discussion of those topics follows in the Nutrition Section.

Management and treatment of diabetes were not often discussed during interviews. However, it was mentioned that some refugees suffering from diabetes have difficulties understanding how to manage their condition. This discussion was highlighted during one such interview:

“They do not know how to manage [diabetes]... They have to check and they have to write down... like the sugar, you have to write it down the number is in the morning and later on check and you have to make your diet is correct, but they don’t know.” *Female, VOLAG Employee and Former Refugee*

Nutritional Issues:

Obesity/Malnourishment

Undernourishment, nutritional deficiencies (such as anemia), weight gain and obesity can be caused by similar economic and social factors. For instance, lack of familiarity with healthy food choices, illiteracy, and unavailability of fresh fruits and vegetables can contribute to undernourishment and obesity simultaneously. While the medical literature on refugees resettled to the U.S. is generally unclear as to the relationship between resettlement in a developed country and nutritional health, in this health assessment long-term resettlement to the U.S. was associated with a perceived increase in obesity and unhealthy food choices.



1: Photo by Fowsiya, a participant in the AJA Project photography program

Steve – is there a reason why the photo captions are numbered?

Such issues as obesity, weight gain, malnutrition and anemia were brought up by approximately a quarter of participants. Most said that obesity was becoming increasingly prevalent in refugees resettled in San Diego - especially affecting those who have lived in the U.S. for longer. Nutritional issues were often brought up in response to direct questions about the conditions most affecting the long-term health of refugees. Refugees who had been here for more than a year were said to be increasingly vulnerable to both obesity and undernourishment due to poor diet choices or lack of knowledge of healthy practices. While every VOLAG mentioned nutritional problems, none emphasized obesity. It is worth repeating here that the majority of VOLAG clients are refugees who have been in the U.S. for less than a year, whereas MAAs and health care providers generally see refugees who have resided in the U.S. more than one year.

Malnourishment and Anemia

Malnourishment was a dominant topic during service provider interviews. Existing data from the health assessment performed when refugees arrived to San Diego lists anemia as one of the most prevalent conditions reference, and several respondents mentioned anemia and malnourishment

as a problem that continued among refugees who have been in the U.S. longer-term. Malnourishment was thought to particularly affect women and children.

Regardless of the age group, the prevalence of undernourishment and/or malnourishment before their arrival in the United States was cited as a possible cause of poor eating habits upon resettlement to the U.S.:

“For the refugees that were in camps and were eating mostly beans and rice, it’s, you know it’s a whole variety and ...[they couldn’t have been] adding fruits and vegetables and meat into their diets...because it was not available to them.” *Female, VOLAG Employee*

“Many of them are starved in their past, whether it was from war traumas or just, um lack of finances, so when they do have food, they will eat until they literally explode, not literally, figuratively of course, but I’ve seen it here.” *Female, Provider*

Acculturation problems have been found to affect refugee’s ability to shop and prepare food using new ingredients. One recent study of Liberian refugees resettled to the Northeastern United States found that they were more likely to suffer from hunger if the primary shopper in the family had difficulty speaking and writing English.²⁵ This study found that 42% of households in the sample experienced childhood hunger and that recent refugee arrivals indicated that they struggled to prepare healthy meals in the United States because they were only familiar with their home country’s food choices and recipes. These same difficulties were cited during the present assessment interviews.

Most concerns about malnutrition were general across all ethnic groups; however, malnutrition was specifically noted by health care and service providers serving Somali refugees. Opinions vary regarding prenatal nutritional needs in refugee mothers, and this subject is discussed further under the Reproductive Health section. Malnutrition in children and women dominated the discussion on this topic, although a few participants also noted that they saw far fewer nutritional problems with teenagers.

Some groups face nutritional problems as a result of the diet that they bring with them from their home country. One health care provider interviewed cited nutritional deficiencies among her Southeast Asian patients:

“I do see like a lot of the Vietnamese...um they or Southeast Asian mostly, they like to do a lot of rice, the like to do a lot of milk. Milk, but definitely a lot of rice and rice water, and that really has an effect because I see children with severe anemias sometimes, iron deficiency anemias.” *Female, Pediatrician*

Obesity and Physical Activity

Most participants believed that an American diet and lifestyle can cause obesity. Indeed, long-term weight gain and obesity after a refugee has been in the United States for several years was the most common topic among those interviewed who discussed nutrition. One provider made a

clear distinction between obesity due to refugees' home country diet and the practices they adapt when they get to the United States:

“We see, for example, um refugees who their diet changes quite a bit. And so all of a sudden we're seeing diabetes in refugee groups that never knew what it was...” *Female, Director of Clinic Serving Refugees*

Participant's ideas for the causes of this weight gain varied depending on the age group of refugees. Many described weight gain or obesity among children specifically related to fast food or junk food marketed and available to them. Additionally, many participants mentioned the difficulty parents have in controlling what their children are eating due to the change in social interaction their children have with peers.

“I think the kids get affected by lack of fresh healthy foods, by the stress as well, and just by the overwhelming American society... So the kids, they get pulled by the allure and all the neon colors and ‘please, please, please’... there's already that social pressure. You already have the natural pull to individuate and pull away from your parents a little bit and the schools often have a lot of junk food...” *Female, Mental Health Provider*

The amount of time that refugees spent in the U.S. before weight gain became apparent varied. One refugee interviewed put it in alarming terms:



2: Photo by Habib, a participant in the AJA Project photography program

some of the kids are really looking chubby.” *-Female, Mental Health Provider*

“They will eat whatever, they don't watch healthy food; they will just eat fat, the sugar that is the problem... Gaining weight fast. Over there is really hard to find food... So the weight gain, when you see the person when they get here they are 110 lbs and a year later they are 200 lbs so that is fast.” - *Female, 33, African Refugee*

On the other hand, others estimated that it takes years for weight gain to become apparent, if ever:

“The third year we start wondering, ‘Wow, that's a really big kid’. The fourth year often, and of course if they're hitting their adolescence at the same time, at the third year you wonder, ‘Well she's just developing or is she going a little overboard.’ And then by the 4th or 5th year

Weight gain among adults and senior citizens was more often attributed to lifestyles that are much more sedentary than refugees' active lifestyles in their home country.

“He put on 30 pounds in the first year he was here... And he was basically sitting at home. He didn’t speak English very well so he didn’t go out very often. He went to his English class, which was very close by...yet and didn’t give him much exercise and wanted to join the gym, but it was too expensive, didn’t own any sort of bicycle or anything like that so basically he’d walk a few blocks...and come back again and sit and watch TV and eat fast food for dinner. Our whole family’s getting fat and we’re not really eating much.” -*Female, Mental Health Provider*

Several respondents also mentioned a lack of safety in their neighborhoods as a reason for refugees not being more active. For women this seemed to be a strong hurdle to being physically active outside. But the majority of participants pointed to the change in overall lifestyle as the strongest reason for increase in weight.

Summary:

In summary, contributing factors to long-term undernourishment and obesity among refugees to San Diego were:

- Diets in refugee camps that varied minimally and didn’t include meat or fresh fruit and vegetables.
- Diets from home countries that do not include certain nutritional needs and/or contribute to weight gain.
- A lack of knowledge about how to prepare a variety of foods that is available in San Diego food stores.
- A decrease in activity level upon resettlement to San Diego, in part due to environmental factors such as a lack of affordable and safe ways to exercise.
- Ready availability of foods of low nutritious value and popularity of such foods among children.
- Diminished control parents have over their children’s diet.



Suggestion for Improvements (Nutritional Issues):

- Research into the prevalence and degree of weight gain experienced by refugee arrivals, especially children, is needed.
- There is a need for more information into **whether or not the anemia and malnourishment often seen among recent arrivals resolves** as refugees acculturate.
- Programs that already address refugee nutritional needs or the onset of obesity could be made sustainable and culturally appropriate for each major refugee population in San Diego.

High Cholesterol

High cholesterol was a topic of discussion for MAAs, health care providers and refugees, although it was not mentioned by VOLAGs. Much like hypertension, high cholesterol was discussed in terms of its occurrence with obesity or poor food choices; issues associated with its management and/or dietary adjustments made to lower cholesterol were not brought up.



3: Photo by S. Popper. San Diego McDonald's.

High cholesterol was also brought up during discussions of hypertension or heart disease as a condition that emerged upon resettlement due to change in diet and lifestyle, such as eating fast food.

One interviewee noted that high cholesterol is just as common among his Persian community as it is in the population at large - inferring that this is by no means a problem specific to the refugee community.

Cardiovascular Disease

Cardiovascular disease was not a major concern of any group interviewed in the assessment, although it did emerge as a common theme that was briefly discussed by many. Issues that were discussed included congestive heart failure among elderly refugees and general concerns about the effects of a sedentary lifestyle and poor diet on refugees' cardiovascular health.

Cardiovascular disease is a complex condition with various antecedents. The emergence of hypertension, diabetes, mental health stressors, and poor dental health in the San Diego refugee community, all common contributors to cardiovascular disease, may be an indication that this condition will continue to become more common as refugees adapt to life in the United States.

Emergent Chronic Diseases: Hypertension, Diabetes and Nutritional Issues



Summary of Suggestion for Improvements:

- **Quantitative studies examining obesity, diabetes, hypertension, high cholesterol and cardiovascular condition prevalence** among refugee populations in San Diego need to be undertaken.
- Since these conditions are emergent chronic diseases, screening and prevention efforts are needed. Programs which already assess refugees' health upon resettlement to San Diego could **seek funding to monitor the long-term emergence of these issues in refugees from 1-5 years** after resettlement.
- If screening and prevention efforts are not undertaken specifically addressing these diseases, efforts to reduce barriers to care, increase refugees' utilization of preventive services and improve health care to elderly refugees should consider and address these emerging diseases.
- Participants have indicated throughout the survey that refugees would welcome more **health education programs addressing exercise, diet, lifestyle and medications**. In addition, a few participants in this survey indicated that refugees may not understand the nature of chronic disease and the patient's role in managing such diseases.

- The necessary tools for monitoring diabetes, hypertension and obesity are already available at many pharmacies and clinics. Making sphygmomanometers, scales and glucose testing equipment more accessible or easily utilized by refugees could be a key part to enabling refugees to manage these diseases.
- Finally, efforts to address refugees mental health illness and refugees' management of stress are likely to help address obesity, hypertension and cardiovascular health.

Dental Health

Dental health was a major concern brought up by VOLAGs, MAAs and health care providers. Dental caries are the most common diagnosis in recent refugee arrivals, as shown in the literature review (Page 16) as well as the intake information from the Refugee Health Program Statistics, 2001-2005. Dental hygiene is also related to overall health as it can sometimes result in serious complications, e.g. endocarditis.

Dental health continues to be an inadequately treated health condition after resettlement in the U.S. Many service providers discussed the need for preventive dental care. Refugees who discussed dental health were under the perception that people in their communities seldom go to the dentist, and almost never for preventive care.

Covering the cost of dental services was a major obstacle to dental care. Many interviewees thought that MediCal coverage of dental services, or DentiCal, was incomplete or poor:

“There are a lot of dentists especially in the Mid city area that would take MediCal. Simple cavities are not a problem, but when it comes to root canals, dentures, anything other than simple pulling out, extraction of teeth or simple cavity fixers, it is a problem... There are providers that would, there is plenty of them, but it's just getting MediCal to approve most of the work is where [we] run into problems.” - *Female, VOLAG Employee*



Two dental health issues unique to East African cultures were raised. The use of khat (a flowering plant containing an amphetamine-like stimulant) among Somali populations was thought to stain teeth. Likewise, one Sudanese MAA thought that the practice of removing teeth from the lower and upper jaw of men among certain ethnic groups was dying out as refugees decided that it was better to keep those teeth in order to have better dental health.



Suggestion for Improvements:

- Given that dental caries are the most common condition present among recently arriving refugees, **continued education as to the importance of regular dental visits would be helpful.**

- Programming by VOLAGs and MAAs to ensure that refugees are able to use their dental coverage effectively and/or arrangement for alternative forms of payment for needed services would be helpful.

Latent Tuberculosis

Tuberculosis was identified by many interviewees as a chronic disease affecting refugees. It received equal attention from each of the three service groups - VOLAGs, MAAs, and health care providers - although this was a rare topic in the refugee interviews. Health care providers and service providers perceived **latent tuberculosis** (TB) to be a very common chronic disease issue. Distinguishing between active and latent infection was a cause for confusion among refugees. In several interviews, health care providers noted that this created difficulties in convincing refugees to finish a complete course of treatment.

There were two concerns of interest expressed by interviewees. First, several interviewees thought that refugees were confused about the difference between latent and active forms of the disease: “Most of the refugees who come here their PPD are positive and when a health educator tells them that positive PPD [it] doesn't mean that you have the disease is an infection and then they do not know the difference between infection and disease.” - *Female, MAA Employee and Former Refugee*

Confusion about the nature and cause of tuberculosis was not restricted to refugees interviewed. It was clear from the words of one MAA director that he was confused about the nature of the disease, as he stated that smoking and second hand smoking caused TB among people in his community. Despite the confusion, several participants mentioned education programs that educate refugees on the difference between latent and active forms of the disease.



Suggestions for Improvements:

- **Increase education about TB** and make education programs more widespread.
- Make appropriate **TB educational materials in refugees' first language** to help alleviate confusion and ensure that medications given for TB are taken correctly.

Sexually Transmitted Infections (STIs)

In general, STIs among women were a more frequent topic in the assessment than STIs among men, however, no participants suggested that there were significant differences in STI prevalence by gender. In regards to serious infections affecting reproductive health of refugees, participants mentioned the following: Chlamydia, Syphilis, Gonorrhea, Herpes, and HIV. Several MAAs and health care providers mentioned that that some refugees had Hepatitis B upon arrival to the U.S., in particular, it was mentioned as a problem in the Vietnamese community. Likewise, Hepatitis C was thought to be present among some recently arrived refugees.

The spread of sexually transmitted infections were believed to be affected by the following issues, as discussed among our informants:

- 1) **Lack of preventive care or checkups:** Both men and women are not receiving adequate preventive education and treatment for their reproductive health. For instance, many female refugees do not get Pap smears or normal checkups.
- 2) **Unprotected sex:** Cultural and gender norms sometimes interfered with the ability for negotiation to have protected sex..
- 3) **Sensitivity of the issue:** As an issue, sex and sexually transmitted infections are difficult to address in the refugee community. According to several refugee participants, some are uncomfortable or ashamed to talk about these issues and are too shy to buy contraceptives in public for fear of getting recognized. Many participants agree that education and awareness about this issue is crucial and necessary.

One MAA employee was especially concerned with STIs among women and their lack of control in practicing safer sex:

“[STIs and HIV] is something that is very much hidden, but women are very, very much concerned about... their partners that are going outside... having unprotected sex. They don't know with whom they are disappearing, drinking... and if we are talking about the classic domestic violence situation, they are not in the position to demand that he would use protection, condoms or to just say no because they simply cannot do that because of the power control issues.” -*Male, MAA Employee and Former Refugee*

One interviewee brought up a particular situation whereby women are re-infected after treatment because they are unable to convince their husbands to seek treatment.

Another common concern was a change in cultural norms in regards to pre- or extramarital sex. The potential for STI spread in young people was a particular concern:

“Many of the [young people] between 16-30, especially [women] have been in a sheltered world. Now they come here and are free, and we are seeing a sexual revolution of sorts. They have sexual intercourse because they can, not because they want to, and none of them have the education on it... Contraceptives are illegal in [country of origin], so the youth do not know how to use them or why they need to. So the spread of sexual related diseases is spreading in our community. We need a system to educate them before we can stop this cycle.” -*Male, Iranian*

It is concerning that safer sex or the use of condoms as a means of preventing the spread of STIs was generally regarded as an uncommon practice among refugee groups. Finally, most refugees are not aware of the effects of sexually transmitted infections and are unaware that such diseases are often asymptomatic in women.



Suggestions for Improvements:

- **Increase education about STIs** and offer educational materials in the refugees' languages through refugee health care providers through discreet, and culturally appropriate means. .
- Work with community based organizations, including churches or faith groups, to address the issue of STI prevention, screening and treatment; if necessary, address STIs separate from contraception in order to increase the receptiveness of refugee communities to STI prevention, screening and treatment programs.

Immunizations

It would be expected that immunizations would be a common concern of VOLAGs, who are often involved in making sure that refugees' initial health assessment upon arrival in the U.S. goes smoothly. VOLAGs are also involved in making sure that children are prepared for school, including having all required immunizations. Surprisingly, immunizations were only brought up as a health concern by mutual assistance agencies.

Immunizations were usually brought up in the context of enrolling children in school when children had been here less than two years: "the parent doesn't know about that [immunizations] because he can't explain, and you can't go the doctor and explain what the child have so they have to contact with us." *-Female, MAA Volunteer and Former Refugee*

Immunizations were also discussed as a problem that was exacerbated by transportation or language barriers to health care: "They don't know who is going to take them lack of transportation, language problem. They may miss the time that the children would be immunized and then until it is going to be too late to do it." *-Male, MAA Employee*. There was also a common misbelief that schools would check refugee children's immunization records and make sure that all immunizations had been administered.

If these comments are indicative of any underlying problems in ensuring that refugees and their children are immunized, such problems will fall to the VOLAGs and the initial refugee health survey performed by Catholic Charities. If any action is taken to ensure proper immunization by organizations other than VOLAGs, it should focus on addressing the aforementioned barriers to health care.

Alcohol/Drugs

All participants identified alcohol and drug use as a condition associated with acculturation. Discussion of alcohol and drug use by San Diego's refugee population was not consistent among respondents. When the topic was approached many MAA/VOLAG participants mentioned alcohol and drugs in the context of teenagers acculturating more quickly than their parents. These participants as well as Refugee participants went on to add that it became very difficult for parents to control their children and the children were therefore more likely to use alcohol or drugs.

One mutual assistance agency who often works closely with teenagers saw drugs as the most important issue affecting refugee children, in part because, “drugs lead to bad decision-making.” It is important to mention that the discussion of drug use among young refugees included only marijuana, alcohol, and tobacco use.

Given that alcohol and drug abuse is such a common concern among young people in the United States, these discussions of alcohol suggest that San Diego’s refugee populations are on the whole much less affected by substance abuse than the general U.S. population.



Suggestions for Improvements:

- None of the evidence contained within the survey would suggest an unmet need for alcohol or drug treatment among refugee populations in San Diego.
- There is no research in the literature as to how drugs and alcohol affect refugee teens upon resettlement; given the concerns expressed by the community in this survey, **research examining drug and alcohol use among San Diego refugee teens** would help determine if abuse is a problem.
- In this survey, many participants thought that drug and alcohol use was one of the many challenges of refugee youth in acculturating to life in the U.S. **Programs that promote positive models of acculturation for refugee teens** would help in addressing these challenges.

Asthma

Only a handful of MAAs and health care providers mentioned asthma as a health concern of the refugee community. However, those that mentioned it gave it great importance, citing it as either an important chronic disease or the most important disease affecting children. Some thought that its management among children was a serious concern. One health care provider discussed it as an important emerging disease in the general population, alluding to the fact that the state of California has higher childhood asthma rates than any other state. Asthma is one of the most common chronic childhood diseases in the United States.²⁶ Since there was insufficient mention of this condition to draw conclusions about how extensive a problem it is or what if any management concerns there are in the refugee community, it is certainly a topic worthy of further investigation.

Reproductive Health

Reproductive health was the most common health issue cited when participants were asked about health issues affecting women. The following issues emerged in discussion of reproductive health during the assessment: 1) family planning, 2) access to pre and postpartum care, 3) sexually transmitted infections and 4) female genital cutting.

Family Planning

Family planning is defined as the use of contraceptives and/or other methods to prevent and/or plan for a pregnancy. Most participants stated that refugees do not actively practice ‘family planning’. However, many refugees did discuss using contraception themselves or knowing of people within their community who do so. The subject may be taboo for some refugees, but interest and use were present.

Reasons cited for not considering or using family planning included:

- 1) Birth control and certain other family planning practices are not supported by a number of religious groups.
- 2) Having large families is considered the cultural norm among many refugee communities.

“...it creates prestige in the community, the more kids you have, the more respect you are and so forth.” -*Male, MAA Employee and Former Refugee*

Participants cited the following contraception methods as being used in the refugee community: injections, birth control pills and intra-uterine devices (IUDs). Religious populations tended to prefer more “natural” birth control methods: “Other people take a different bedroom and stay away in between... others go to their church or their mosque for advice on how they should plan their families. Sort of the rhythm of childbirth...” -*Female, Mental Health Provider*

Nevertheless, participants noted that contraception usage slowly becomes more accepted in the refugee community over time. Different standards of living in the United States prompt some refugees to reconsider ideal family size. Furthermore, it was mentioned during several interviews that when one or two women within the community used contraception others would follow and the interest in learning how to access and utilize contraception increased.

Access to Pre- and Postpartum Care

Receiving pre- and postpartum care is crucial for both a mother and her baby’s health, however, a significant number of participants said that the refugee populations whom they work with lack access or do not regularly access pre- and postpartum care.

“[Refugee women] do get services but if you compare it to the general public, I would say no, probably a very limited number of them do get that... And also after the birth, I don’t think they have that kind of services and the follow up.” -*Male, MAA President*

Lack of postpartum care was cited as a more frequent issue than prepartum care. This was mentioned as a problem in all populations except the Vietnamese community, in which there are many Vietnamese health care providers. The reasons for not accessing services included system barriers referred to in the “Perceived Health Care Access Barriers” section listed later in the report.

Cultural barriers were also cited as reasons for low utilization of pre- and postpartum care among refugee women:

- 1) Fear of going to the doctor:



“One barrier is lack of knowledge and they are also scared because it’s not a common thing that they would go for checkups and use all of those equipment that they use here and they are a little bit afraid of that, but once they get familiar with that they all love it, the attention and all the information that they get. Postpartum it becomes more difficult because once the baby is born, then she’s saying I don’t have time anymore.” – *Female, VOLAG Employee*

2) Finding doctors who are understanding of their cultural needs:

“[The problem is] finding a doctor who can educate them in a way that they understand.” -*Female, Nurse*

3) Lack of knowledge and awareness about pre-partum and postpartum care:

“They don’t understand what it is. And maybe when they are just pregnant, they just saw doctor, they don’t go normally to check it if they’re healthy like breast, ovary, or you know... They need somebody to encourage them.” -
Female, VOLAG Employee and Former Refugee



Credit: (c) 2004 Philippe Blanc. Courtesy of Photoshare

Nearly all our informants said that women give birth in hospitals, although there were two women who recalled incidents in which refugee women chose to give birth at home. This brought about complications for the family:

“A lot of women, they are pregnant, and they don’t want to go to the doctor when they start contractions... They are scared. They want to stay home and the baby is just coming in the house... It’s kind of hard too. I saw one [woman], she has a baby in home and before 9-1-1 came, they cut the [umbilical cord]... Then they said when she want a [birth] certificate, who is witness, who? And it takes like 9 month to get her [birth] certificate.” -*Female, VOLAG Employee*

However, such incidents ultimately serve as examples for the rest of the community in realizing the importance of getting prenatal care and giving birth at the hospital.

Sexually Transmitted Infections (STIs)

Please see the above STIs section above for a discussion of this issue (page 37).

Female Genital Cutting

Another issue that may affect the reproductive health of refugee women is the issue of female genital cutting or female circumcision, which a small percentage of our informants mentioned. In particular, one participant mentioned its association with Somali culture:

“Speaking on the Somali culture, there is circumcision that you know used to take place back home. I don’t think it is a big, major thing, but again, you never know. It might be you know, some people might... still [be] practicing without [knowing].” -*Male, MAA President and Former Refugee*

Among those who mentioned female circumcision, no one claimed to have any knowledge of it being practiced in San Diego; most thought it was an issue of declining importance that had received more attention when refugees were first arriving.

Several health care providers were concerned about the practice because they believed it could affect the reproductive health of women. For example, one medical care provider, who acknowledged this issue as both “serious” and one in which one has to be “culturally sensitive” to approach, believed that female genital cutting increased susceptibility to urinary tract infections. Another health care provider discussed having studied the issue and having conducted focus groups. She agreed that female circumcision caused more urinary tract infections, and also could result in difficulties during childbirth, more painful menstruation and difficulty doing strenuous exercise that involves running.

Although both of these providers expressed similar concerns, there was no consensus that action needs to be taken by San Diego health care providers to address the issue. Likewise, there was no indication by refugees who worked at MAAs or at VOLAGs, or refugees whom we interviewed that their communities felt that health care providers were handling the issue poorly. As the community works to address the unmet needs of prenatal and postnatal care, any problems related to female circumcision should also be addressed in the process.

Conclusion

Overall, our assessment suggests that lack of education, information and awareness about attaining health care for reproductive health negatively affects the health of the female refugee population. Refugees are under-utilizing pre- and postpartum care. There is also a need for increased awareness of family planning options.



Suggestions for Improvements:

- **Increase education** about how to practice family planning, including proper contraceptive use. Community-based workshops with individuals within each population leading the discussion and answering questions would be a positive and acceptable environment in which to disseminate this information.
- Many of our informants believe that the female refugee population would be very receptive to **education about reproductive health issues**. **The challenge is making the information culturally appropriate.**

Domestic Violence

The issue of domestic violence emerged as a common issue affecting the San Diego refugee community. Two thirds of those surveyed about domestic violence said it was an issue especially affecting adult refugee women, while the rest said they were either unsure of its prevalence or believed that it was not an issue in the refugee population that they knew best.

Domestic violence, as defined by our informants, includes the following:

- *Verbal abuse*
- *Physical abuse*: “Two years ago we had a client who was beating his wife constantly. He was a client of our office and we did not expect that from him.... His wife came to our office and spoken to one of the case managers and said, ‘this is what’s happening at home,’ and... she wanted out of it.” *Female, MAA Employee*
- *Denying or hiding regular health needs and basic living conditions*: “...when it comes to victims of domestic violence... he did not want to take you. Or to not give you money to go to the doctor or just simply said not, you’re not going and did not provide transportation. And many women say it’s because of that very often they are not only mental but their regular health needs are not met because of their violent partner; this is the way of hurting her also, and part of the abuse.” *Male, MAA Employee and Former Refugee*

Though domestic violence was widely described as abuse between a husband and wife, it is also important to recognize that it may also incorporate violence or abuse against senior citizens and children as well. Several informants mentioned incidences of domestic violence between men of the household and elderly parents: “there is a practice where they hit [their elderly parents], and if they don’t... respond the way they like, they’ll hit their elderly parents.”

More than half of those that said domestic violence was a far-reaching issue believed it to be exacerbated by two main issues:

- 1) the definition of “domestic violence” in the refugee populations,
- 2) the breakdown of expected gender roles both inside and outside the household.

Our informants suggest that the definition and treatment of domestic violence in the United States may differ from what and how some refugee populations might perceive abusive relationships between a husband and wife to be. For example, refugee women did not consider domestic violence an issue that needed to be addressed because of their ‘culture’:

“Domestic violence is something that’s not often talked about very often and often refugee women don’t think of it in those terms. They’re accustomed to being belittled or yelled at or oppressed or their rights taken away or their access to education to driving, to medical care, all of that taken away. It seems it’s normal for them, for their cultures.”
Female, Mental Health Care Provider

Other contributors to domestic violence that were mentioned were financial issues and the breakdown of expected gender roles inside and outside the household:

“[The problem is] probably around money, around you know general. If a woman goes to work, the child in the house culturally men don’t clean children, men don’t cook and it is hard for a woman to work eight hours and you come to the house you find that your child is sitting in a dirty diaper not changed and you don’t have that voice to say, oh you did not change the diapers of the baby... so you are telling me to do this, don’t you know that I’m not supposed to do that as a man. Cleaning children is your responsibility, cooking is your responsibility. So, I’m tired too, I went to work, I’m bringing income to support us now why don’t you do this... It’s like a change in gender roles.” *Male, MAA Employee and Former Refugee*

“When a woman gets her money, her salary, a man feels he is overall everything, this woman should bring her check and give it to him. He is the one to cost it or to put it in the bank and uses it the way he wants. But the wife is like, I suffered too can I use at least something for me.” *Male, MAA Employee and Former Refugee*



Suggestions for Improvements:

Domestic violence has not been adequately assessed and attended to in the refugee population, perhaps because it is a sensitive issue to address directly.

- Information should be distributed about **domestic violence support groups** and organizations such as Survivors of Torture that assist in helping victims of domestic violence.
- Greater financial support for the San Diego Police Department’s Multi-Cultural Store Fronts, which have faced recent funding cuts, is important as such offices and the Community Service Officers who staff them are important **resources for refugee communities** when domestic violence occurs.
- **Increasing education** about the many forms domestic violence can take and how prevalent it is, both within refugee communities and the general population, may help to address some of the cultural issues in confronting this matter

Arthritis

Arthritis and other rheumatic conditions comprise the leading cause of disability among adults in the United States.²⁷ This creates a huge public health burden in terms of treatment and care. The burden of arthritis increases with age - as also seen in the results of this assessment. It was found that arthritis was one of the top-five current health conditions affecting older refugees in San Diego. Many participants mentioned both the health affects of arthritis as well as the indirect decrease in quality of life it creates. As is the case for the general U.S. population, arthritis is a condition which affects one’s ability to participate in daily activities such as working, walking, shopping, and personal care, all of which directly affect other aspects of one’s health.

Many interviewees had seen senior citizens within their community who suffer from arthritis and believed that because of the condition these individuals were more likely to stay inside and isolate themselves. Some believed that working conditions prior to resettlement, in addition to the aging process, had contributed to this condition.

Even though arthritis was a common health condition affecting older refugees, very few participants knew what treatment refugees were seeking for it - if any. Refugees were reluctant to take medications for their arthritis and if less willing to undergo any medical procedures as treatment. For instance, one participant shared an experience a friend had which caused her to never return to that doctor again:

“She went to the doctor, they go every month. But sometimes if she doesn’t have transportation [she didn’t go] for three months. She complained of arthritis in her knee... her knee needed surgery. The doctor told her, ‘I will give you medicine- if it doesn’t work we will do the surgery.’ She hasn’t gone back...” *Female, 22, African Refugee*

Chronic Pain

Chronic pain was thought to include severe headaches and back pain and pains more related to torture or trauma such as broken bones, burns, muscle damage, head injuries and nerve death due to phalange or the beating of the soles of the feet. As mentioned by a health care provider, Chronic pain is perceived to be an ongoing problem among refugees that was a result of trauma, torture and/or stress. The few MAAS and health care providers who discussed chronic pain did so generally, mentioning symptoms and indicating that chronic pain is common, but not detailing specific examples. Several refugees mentioned chronic pain in terms of general body pain that did not respond to treatment. Some went on to comment on their frustration that these pains were not being ‘cured’ when seen by doctors- inferring that they expected chronic pain to be cured instead of managed by treatment. One former refugee said that:

“There are a lot of pains and due to the language barrier that I mentioned before, some of the diseases are not been detected... people keep feeling pain with no end and we don’t know why.” - *Male, MAA Employee*

Strategies for managing chronic pain were not discussed at large by participants. However one provider did mention group therapy techniques that use a psychosocial educational approach to help refugees understand their chronic pain and learn strategies to reduce it: “[We have] lots of folks coming to talk with us about their chronic pain and how it blends with psychological pain and their, their experience in life in general.” *Female, Mental Health Provider*

Cancer

Cancer was a concern of some interviewees, particularly older respondents. Mutual assistance agencies and health care providers discussed it more often than resettlement agency personnel and refugees. Interestingly, one of the few discussions of cancer by refugees considered it to be a disease related to stress and hardship.

While no single type of cancer was thought to be more common than others in the refugee community, breast cancer was mentioned by several health care and service providers as a concern. One program a MAA launched to raise awareness about breast cancer was widely attended, whereas the prostate cancer program held for men by the same MAA was not popular at all.

Although it has been identified as a risk factor for development of a variety of cancers, smoking was not frequently mentioned as an issue of concern to San Diego refugees. One health care provider pointed out useful anti-tobacco campaigns in San Diego, including a campaign specific to refugees run by Catholic Charities. Generally, smoking was thought to be of greatest concern in the Russian, Persian and Vietnamese communities.



Suggestions for Improvements

- Given the concerns expressed elsewhere in the survey regarding obstacles to accessing preventive care (please see Perceived Health Care Access Barriers section on the next page), it is likely that refugees, particularly the elderly, would benefit from education and prevention programs screening for various types of cancer.

Hearing and Vision

Vision and hearing problems were mentioned in several interviews but not discussed in-depth. While it was not believed that hearing and vision loss are more often observed in refugee arrivals than the general population, there was some concern that it was more frequent for refugees to not get these problems resolved. For instance, a service provider believed that many refugees receive an eye exam and prescription glasses in refugee camps abroad but then do not get the prescription updated. Schools provide an effective venue in which to screen children for a variety of conditions, including hearing or vision loss. While many respondents discussed refugees getting immunizations through screenings at children's schools, no one discussed vision or hearing screening in schools – although they likely are occurring. Community health fairs and mobile clinics would also be effective locations at which to screen for hearing and vision problems in the general refugee community.

3. Perceived Health care Access Barriers

Table 10: Top 5 Perceived Health Care Access Barriers

Rank	1	2	3	4	5
Barrier	Language	Logistical Barriers/ Transportation	Insurance/ Expense	Cultural Differences/ Anxiety	Knowledge of System

Preliminary analysis reveals that the majority of refugees do not regularly access health services due to lack of transportation, language barriers, gaps in insurance and unfamiliarity with the health system. More in-depth discussion of these issues follows:

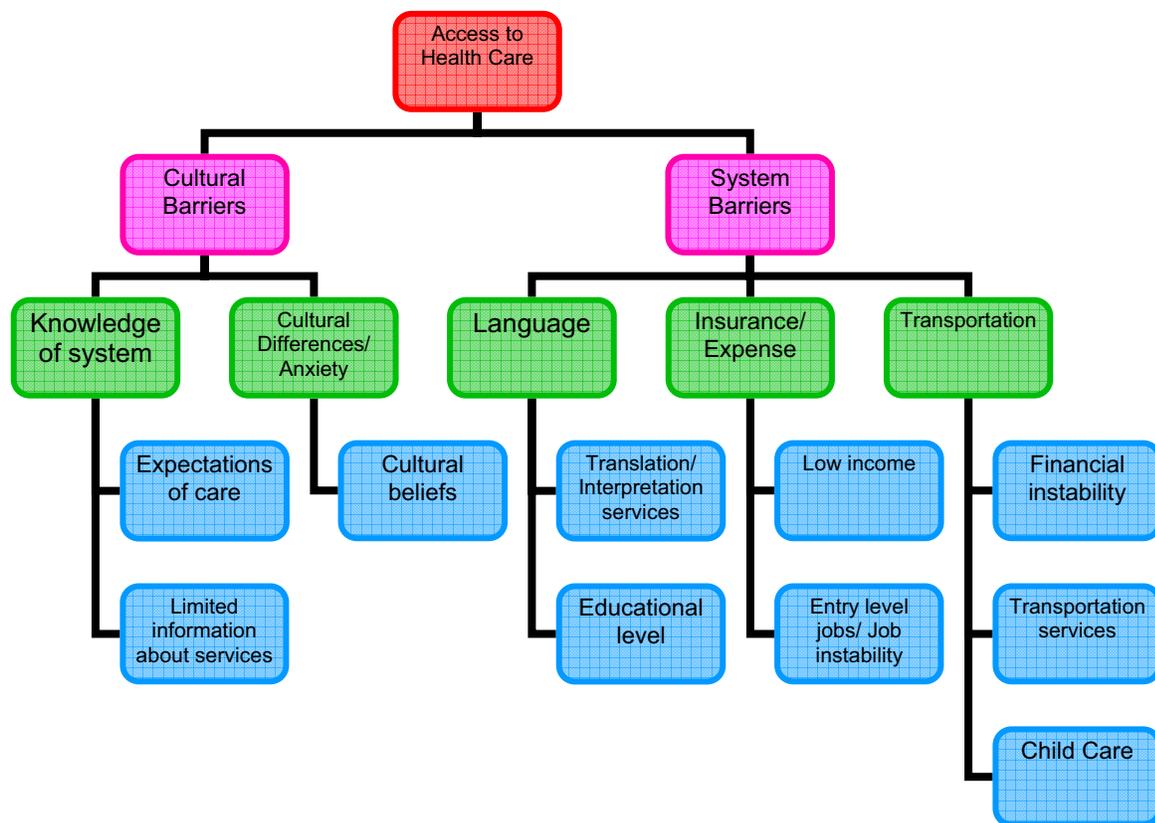


Figure 6: Perceived Barriers to Accessing Health Care

Language Barriers

Language, specifically the unavailability of medical interpreters for face-to-face communication between refugees and providers was cited by virtually every participant as a major barrier to care. This concern was most common among refugees whose ethnic community did not include many physicians and nurses. In contrast, the Vietnamese community had far fewer language issues because of the availability of Vietnamese health care providers in the San Diego area.

The language barrier directly affects refugees' ability and willingness to access health care services, and thus the quality of care achieved.

“A lot of times the refugees will get so frustrated that [they do] not bother going to the doctor unless something is seriously wrong.” - *Female, Case Manager*

“People refuse to go to the hospital knowing that they won't be able to communicate.” - *Male, MAA organization employee*

The lack of oral interpretation negatively affects the ability of refugees to make appointments, communicate with providers, fill prescriptions, understand providers' instructions related to prescriptions, and follow up with specialists.

“It's needless for [the refugee]... to see the doctor and he cannot be able to explain what happened to him and something like that.” *Male, 43, MAA Employee and Former Refugee*

The language barrier also presents an obstacle to understanding health information and treatment:

“If there is a breakout of disease or something like that, they don't get the information as quick as possible in their own language because most of the refugees they came here illiterate sometimes and not everybody speaks English.... They live with nobody who can really tell them what is happening around them.” - *Male, MAA Employee & Former Refugee*

In cases where interpreters were available, they were often non-professionals with limited proficiency in medical terminology or phone interpreters paid through the AT&T language line phone interpretation service. Many refugees and service providers mentioned that to overcome the language barrier they look to children and relatives to accompany them to doctor appointments and provide interpretation. Even though many refugees see this as the only reasonable solution, it creates new problems of misinterpretation and breach of confidentiality

“I just take my son and my problem is solved because he translates for me. But when we first came none of us knew the language, so we would just go to the doctor; we had a lot of difficulties back then.” *Female, 54, Middle Eastern Refugee*

“Sometimes [refugees] rely on their little kids to translate for them and they can mislead and, of course, most of these youngsters don’t even speak English, the Somalia language and their own native language, so some of what their parents are telling them they might not know what to say in English... So it’s a serious challenge.” - *Male, Former Refugee and current MAA employee*

Language lines- a live interpretation service provided over the phone -are one service which many providers use to aid the language problem. However, there are difficulties surrounding this service as well. Many participants mentioned that these services are not culture specific, which hinders effective communication. Also, service providers shared that the language bank services do not allow physicians to interact with their patients in the most effective manner:

“My experience with language line services is also a problem because you’re on the phone, and you're trying to communicate back and forth with them on the phone, and it is really difficult vs. having someone in the room.” – *Female, Physician*

Furthermore, many participants interviewed were unaware of the availability of language lines. Instead, a number of refugees and service providers spoke of providers who refused to serve them because they had not brought their own interpreter.

“People refuse to go to the hospital knowing that they won't be able to communicate; they are afraid to go to the hospital, it is a hostile environment because they won't verbalize what's going on. They refuse to go to the hospital for this reason.” *Male, Refugee from former Soviet Republic*

Language issues do not only affect access to care and basic physician communication, but also limit the patient’s ability to read and understand medical instructions and prescriptions. This can translate into misuse of medicine and further complicate health problems.

“She told me one day ...she want to take birth control pills. I said, show me. [She] show me the Tylenol. I say are you taking this every night? She said, ‘Is this Tylenol or Birth Control’?... ‘she doesn’t know which one is which... [the language is the problem].”
Female, Health Educator

Likewise, lack of translated written materials means that refugees sometimes blindly sign documents giving consent or acknowledging understanding of health care policies.



Suggestions for Improvements:

Language is a major barrier for refugees and other immigrant groups in the U.S. In San Diego County 33% of residents speak another language other than English [<http://quickfacts.census.gov/qfd/states/06/06073.html>] The vast majority of immigrants to San Diego speak Spanish. Many San Diego businesses and organizations have realized the need for creating services and materials for this population. However, the refugee community is comprised of many different ethnic groups that speak a multitude of languages and have diverse literacy levels. It is for this reason that it is difficult to remedy the language problem.

Nevertheless, a number of concrete steps to alleviate this problem were identified during the assessment:

- 1) In neighborhoods with high concentrations of refugees (e.g., City Heights), health care providers could **provide translated consent forms and basic health education materials** in languages commonly spoken by refugees in the area
- 2) **Improve and expand translation/interpretation services-** Several organizations within San Diego County offer translation and interpretation services for local businesses and health care providers- some for a reduced fee for refugee serving participants. Increased awareness of these services by health care providers could help bridge some of the communication gap. While some of these services offer professional translation, none were found that offer on demand interpretation that can quickly be accessed by health care providers.
- 3) **In addressing the above, emphasis should be placed on oral interpretation.** One innovation in this area was the use of medication bottles with the ability to record and play instructions from the pharmacist in the refugees language. Similar technology could be applied to give refugees oral instructions from the doctor in their own language.
- 4) **Improve access to English as a second language (ESL) classes-** issues surrounding transportation, childcare, and hours of operation make attending ESL classes offered by mutual assistance agencies difficult for the refugee population.
- 5) **Provide medical dictionary reference materials for health care providers-** This could include basic medical terms and phrases in languages common to the refugee community served by the health care provider. Such materials could serve as references for medical providers, patients, and people patients bring along to help interpret. Overcoming the obstacle of communicating often difficult medical terms should facilitate understanding during patient visits.

Logistical Issues/Transportation

Logistical issues, including items such as transportation, hours of service, wait times, appointment availability, child care needs, and scheduling, were a recurrent theme in the interviews. Logistical barriers to accessing health care are by no means unique to the refugee community, but are felt by many interacting with the current structure of the health care system in the US.

Discussion of logistical issues was dominated by the issue of transportation. Most refugees do not have a driver's license or other mode of personal transportation. This makes transportation to medical appointments and other health services difficult. While relying on friends, public transportation, and specialized services for refugees are options to meet the transportation need, they are often not straightforward solutions given language and knowledge issues:

“We provide transportation to our facility because it's required in our regulations, but transportation to physician's appointments are often very difficult. Many of them have transportation services approved by MediCal, but there's only one Russia-speaking transportation services and again they refuse to use English-speaking services many times

IV. Findings: Perceived Health care Access Barriers

because they can't speak the language, so a lot of times they will come and say could you cancel my appointment for me because I can't get there—so that's a barrier definitely.”
- *Female, Program Director*

“Transportation is a big issue. We can't provide it other than bring them home or to the center, but very often they come in and they say, ‘I really need to go to this medical appointment and there is nobody who can drive me.’ There is no way we can help them. They become very frustrated with us.” -*Female, Program Manager*

When services are available to help decrease the burden of transportation related barriers the quality of the transportation is limiting:

“Transportation is another big burden on refugee communities... We don't even have vehicles that can assist or transport people in wheelchairs.” -*Female, Case Manager*

“Often the bus is late or doesn't come at all.” – *Female, Refugee*

Despite the existence of transportation services for the older refugee population and coverage for their costs under MediCal, transportation was as a common barrier to care among older recent refugee arrivals. Reasons given included: lack of knowledge of the public transportation system, or isolation within their community.

“Our elders are really suffering in terms of not knowing where to go [for care]... they do not have relatives you know, and they cannot walk [long] distances... This is really affecting their performance or their way they live here, they're too domestic, they stay home, and they're really depressed.” -*Female, Iranian Refugee*

Financial instability is a contributing factor to logistical barriers. Participants noted that because refugees dedicate most resources to family expenses such as food, clothing, and shelter, they often do not have the money to use public transit services, let alone own a vehicle. The financial barrier also affects utilization of child care. Many refugee participants commented on the difficulty of finding someone to watch their children or those in their extended family in order to make medical visits.



Suggestions for Improvements:

All refugee populations and ages are affected by logistical barriers to efficiently accessing health care. Transportation was the most commonly cited barrier, felt most acutely by the elderly. This is a problem that affects recent arrivals somewhat more than those who have lived in the U.S. for a greater period of time, as knowledge of public transit and community connections tends to increase over time. Improvements to the public transit system would benefit both the refugee communities as well as the general public in San Diego. This, however, is a larger structural



4: Photo by S. Popper. San Diego Bus Stop.

issue. Smaller, simpler steps would also tremendously aid transportation access of refugees. Suggestions brought up during the course of interviews included the following:

1. **Generate information on existing services.** There already exist free or reduced fee transportation resources in San Diego for seniors and the disabled- such as MTS ACCESS. A number of refugee service providers and refugee participants, however, were not fully aware of these low cost door-to-door services or were unsure how it worked.
2. **Translate public transit information.** Mutual assistance agencies already work to introduce new refugee arrivals to public transportation resources. Providing translated public transportation information in languages common to the largest refugee groups in San Diego would facilitate use of these services.
3. **Mobile clinics.** Sending mobile clinics to community events in neighborhoods with large refugee populations could help to introduce and troubleshoot logistical issues that refugees are currently facing.



5: Photo by Milano, a participant in the AJA Project photography program.

Many service providers and mutual assistance agency employees believed that additional services and programs are needed to address specific logistical needs of refugees seeking health care. However they suggested “Tagging onto existing services instead of building new services.” -Female, Assistant Clinical Director

Insurance/Expense

Upon arrival to the U.S., each refugee is prepared a resettlement plan that includes initial contact with government services and employment agencies. During this time, refugees begin paperwork for 8 months of MediCal coverage. However, for a variety of reasons, for many refugees there is a delay in the MediCal enrollment process and therefore a gap in coverage. Often a refugee may not fully complete the enrollment process until two or three months after they have arrived. This means they have lost these months of coverage.

Even though refugees initially receive MediCal coverage, often they do not fully understand the services available to them or how to access them. This lack of understanding of the U.S. health care system and how to navigate within it (a problem faced by many Americans) creates one of many barriers to accessing care that extends beyond the first year in the U.S.

New challenges arrive after the initial year in the U.S., when, in most cases, MediCal coverage has expired. Even though resettlement organizations work to find refugees employment, often

these are entry level positions without health care insurance benefits. Lack of medical insurance coverage as well as gaps in coverage were cited by all participants as major barriers to accessing health care services. Some mutual assistance agency participants admitted that they did not have health insurance for their family.

“Once their MediCal is over, those who are over 18, the MediCal will stop and for most of them, the jobs that they take do not have medical insurance. Most of them take entry-level jobs like working in a gas stations or small businesses and they do not have access to medical insurance.” -*Male, Case Manager & Former Refugee*

Gaps in coverage were often related to prescription coverage. Several participants mentioned the frustration they felt when medications their provider prescribed were not covered by MediCal. This is a problem that also affects the trust these patients have in their provider:

“My daughter was sick. When I tried to take her [to the] doctor, I was told that some medication that doctor prescribed for my daughter was not covered by MediCal. So what can I do, I'm not working. I have no money to pay for the medication... so I ended up not buying that medication.” -*Female, 35, African Refugee*

These gaps in coverage in addition to a lack of knowledge of insurance plans lead participants to be hesitant to access services in fear that the service would not be covered. This specifically affected refugees' access to specialty services such as pre- and post-partum care.



Suggestions for Improvements:

- **Increase education about services covered by MediCal:** Specifically brochures or audio tutorials in several languages could be created to educate and inform refugees about the health insurance system. Even if the materials were as simple as a list of basic services available, where they are located, and the cost associated with each service it would provide a basic sense of empowerment for these patients
- Workshops or **community outreach activities** geared toward **educating the refugee community about MediCal coverage** could be performed. Such events could help patients choose an appropriate provider for their specific needs, navigate the medical system, or provide an open forum in which to ask questions about where and how to access services.

Cultural Barriers

Preventive health care and chronic conditions are foreign concepts to some. Instead, members of the refugee population in San Diego are more likely to seek health care services when their conditions affect their daily activities or when they are acute.

“They consider the health issue when somebody is getting sick and then that's when you can look for your health, but before they are affected for a certain disease that they can take care of, they fall into that trap, they just ignore..” -*Male, 42, MAA Employee*

Refugees resettling in California come from a rich variety of backgrounds, each with strong cultural traditions and unique health beliefs. While these beliefs and traditions often provide

comfort to newly arrived refugees entering a foreign place, they can at times make accessing and navigating the health care system more challenging.

Many refugee serving organizations and health care providers believed that refugees often try traditional remedies before seeking Western health care services. Reasons for this include confidence in traditional remedies and a perception that Western medicine can be costly and sometimes detrimental with too many negative side-effects. However, not acquiring health care early for certain illnesses and physical conditions puts one at risk for more serious complications.

“[Elders] feel more into the cure of the cultural traditional medicine and so forth. So there seems to be more problem with elders accepting the... modern medical needs. An example [was] an elder, the age of 70... [who] had an abscess here in the thigh and it was getting worse and worse, but she was under the perception that you get better and better... and she doesn't need to get medical help and it got to the extent to where it got infection and so the doctor said if she would have come a week ago or so, this would have been prevented, but now it deteriorated to the extent that she could have almost lost her leg..”
-Female, MAA employee and Former Refugee

A number of interviews also revealed that many in the refugee community do not want to depend on physicians or take up their time for what they perceive to be small, non-serious health conditions. Instead, participants refer to two alternatives of care: as mentioned above, waiting until the condition worsens or using herbal remedies or traditional medicine to alleviate the condition.

“I think the idea of not depending a lot on the doctors and that the more often you go to a doctor, the more problems... the more side effects.... There will be dependence on coming back to the doctor and so forth, so they attempt to avoid and they also feel the idea of traditional healing, staying home, heal itself, through and so forth.” *-Female MAA employee*

Lack of respect or sensitivity by health care practitioners towards the cultural beliefs of refugees is another dimension to the problem that can lead to resistance to accessing care or less effective outcomes. Mental health conditions, which have been cited as one of the top health conditions affecting refugees resettling in the US, require an exceptional level of cultural sensitivity and understanding. A need for improvement in this area was cited by many participants:

“They need...really serious mental health [care] but something rather different than traditional western approach. There has to be more cultural sensitive. There has to address the spiritual and then religious needs, and it's altogether, it just has to be more comprehensive.” *-Male, Director of MAA organization*

"We cannot find anybody who provides culturally and linguistically appropriate mental health [services]." – *Male, Mutual Assistance Agency employee,*
“The mental health professionals mainstream... are totally not prepared to meet the needs of these, the person of communities here.” *-Male, MAA Employee & Former Refugee*

However, the most commonly mentioned culturally-related access to care barrier was patients not wanting to be seen by a physician or health care provider of the opposite gender. This was more important when discussing the health access of women due to cultural and religious beliefs. In several interviews female refugee participants explained that they felt comfortable speaking with their female doctors- but if they had a male doctor “[they] wouldn’t tell him” about some health related problems; especially reproductive health questions,



Suggestions for Improvements:

- Many refugees and mutual assistance agency participants interviewed mentioned the importance of **matching, when possible, refugees with same gender health care providers**- especially for female refugees.
- All groups of participants agreed that there needs to be **more education and training of service providers about specific cultural beliefs** to help them better communicate and care for their refugee patients.
- Many participants referred back to the language barrier as it relates to the above cultural obstacles. They suggested that better **trained interpreters who are knowledgeable about the cultural needs of patients** would help provide a bridge between provider and patient.
- **Train former refugees to work within the health field**- Many refugees suggested encouraging former refugees to get involved in the health field, through nursing or other professions, so that they can directly serve their community.

Expectations:

A common theme refugee participants shared was a feeling of disappointment that their health and economic situation did not greatly improve upon arriving in the US. Many have endured extreme struggle and hardship on their journey to resettlement and had expectations about what their lives would be like once they arrived. In several interviews, refugees mention their frustration and disappointment with their health and how this affects their decision to access health care.

“Most of them once they come here they think maybe I, I uh, should go back to school ... and be a better person, so they start out, start in class a semester or two, and they dropped out within a few months. People I guess have to work, have to have more than one job. They have to juggle two or three jobs to support themselves... So how long do we have to work this hard?” -*Male, African Refugee*

Knowledge of System

The health care system is frustrating enough for those that have grown up in the U.S.- but for those who are foreign born and speak a foreign language, it can be frightening. Apprehension and fear when dealing with the insurance and medical care system and feelings of being overwhelmed while trying to navigate the system were reasons given for limited or lack of health access.

“People who do have access to health care like they having the benefit of using the medical system that they have, but they cannot go because they don't know where to go. They really don't know where to go. Even if they know, who is going to help them when they get there?...Or they may not meet somebody that will take care of them... Even though they have benefit of medical, they don't go.” -*Male, MAA Employee*

For many refugees, language barriers and their education level contribute to feelings of fear when faced with accessing health care. These characteristics also contribute to an inability to navigate within the system. Many participants shared how these barriers create feelings of fear and frustration. Further, many were unsure about which doctor to see and did not understand why they needed to see one doctor for one service and another for another service.



Suggestions for Improvements:

When asked how to improve access to health care among refugee communities,

- The majority of participants suggested **more education programs specifically targeted towards increasing provider knowledge** of refugee specific needs and their cultural beliefs.
- Programs to **increase knowledge of existing services** are sorely needed among refugee populations.
- **Mobile clinics** would be a great tool to reach a larger population of refugees and expand knowledge of services. In addition to bringing needed services to the community- thereby decreasing the effects of physical access barriers such as transportation- mobile clinics can also help build relationships between health care organizations and the refugee community.

V. Recommendations

The majority of recommendations made by assessment participants related to one of the following areas: how to improve utilization of existing services, areas that would benefit from increased education, and identification of new service needs. Below is a brief schematic of these suggestions.

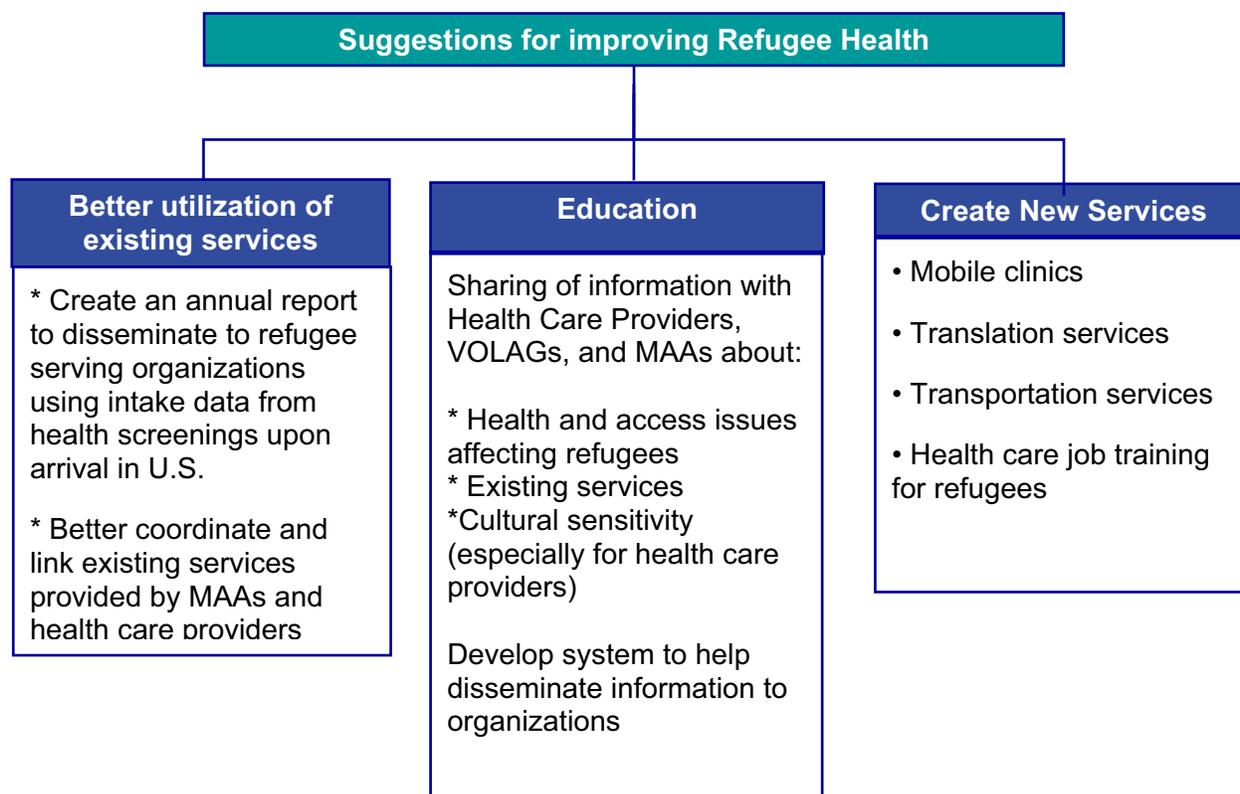


Figure 7: Participant’s suggestions for improving refugee health in San Diego

When asked how current services can be improved, the majority of service providers focused on improving translation and interpretation services – as language is intimately related to a variety of barriers faced by the refugee community. Participants suggested the need for **better access to current interpretation services** and **continued training of interpreters and translators within the field** to improve skills. Interpretation and translation services are directly related to suggestions for health promotion strategies.

Respondents overwhelmingly endorsed the idea of **additional transportation programs** to help bridge the transportation gap between refugees and existing services. Suggestions to existing services also included **more funding to improve programs** with high involvement rates and increased **collaboration among existing programs** to better serve the community

Several participants strongly suggested the need for programs to be developed to help support gaps in coverage that MediCal recipients experience when accessing medical care.

"Definitely more behavioral health and mental health services. [And] more supportive kinds of services, and domestic violence programs. Um, and you know translation and transportation..." – *Female, Clinic Director*

Health Promotion

- There is a need to **bring health promotion messages and educational materials directly to the community** either at the neighborhood level or to community events. This suggestion would help bridge the transportation gap faced by many recent refugee arrivals.
- Almost all participants who responded with how best to promote health within the refugee population suggested using **workshops** at the community level or **mobile clinics**. Mobile clinics can bring prevention services as well as health promotion efforts directly to neighborhoods with high concentrations of refugees.
- Refugee serving organizations also mentioned **holding workshops with case-managers or other representatives from these organizations**. The feeling was that the most effective way to promote health is to make sure those interacting with refugees on a daily basis are knowledgeable on refugee's health needs and can respond with effective prevention messages or referrals to existing resources.
- Participants reinforced the idea that **improving the literacy and English skills of refugees** will help improve their ability to receive current health promotion messages.

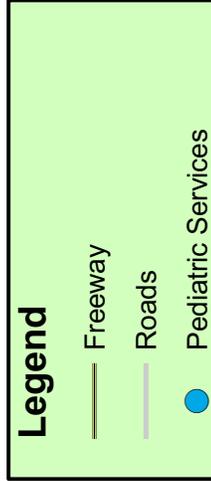
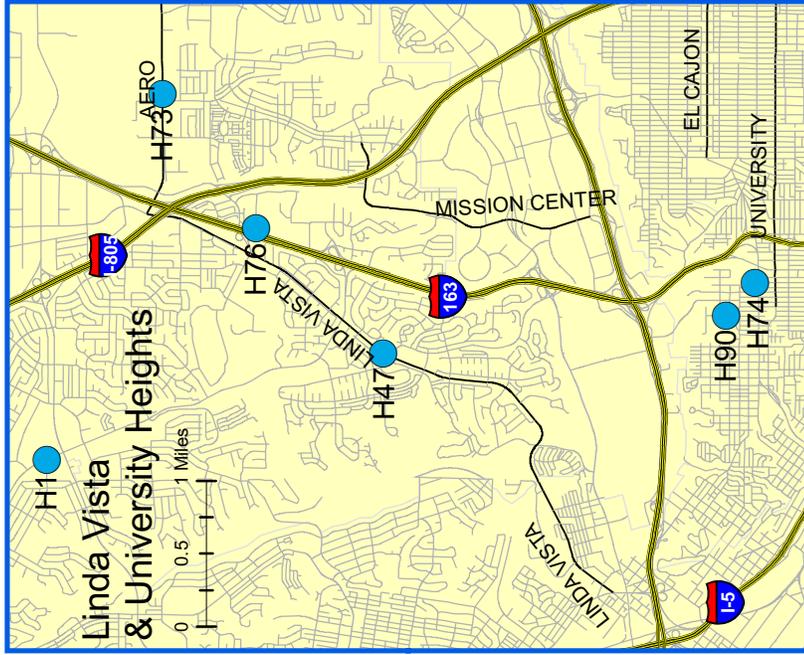
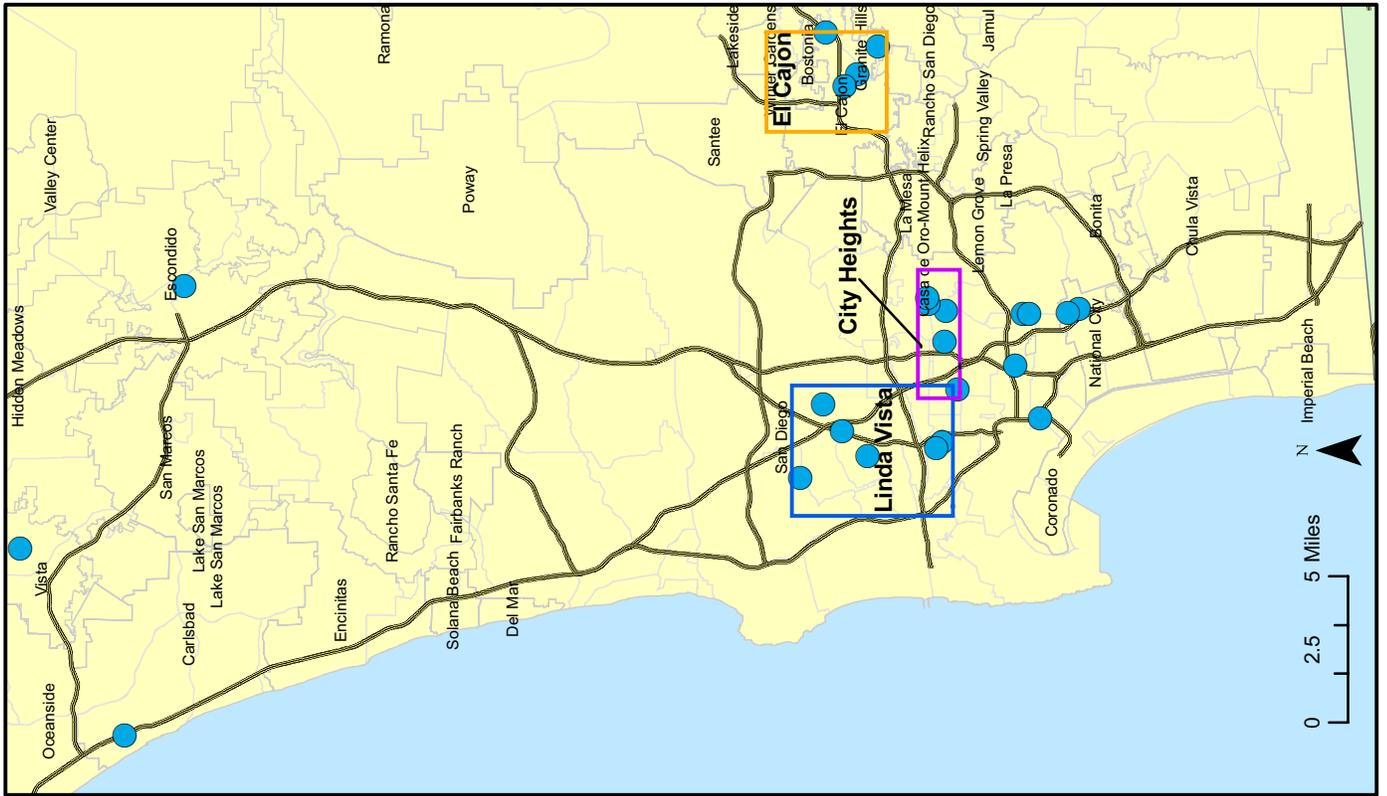
A complete list of suggestions and recommendations can be found at the end of each Health Condition section in the above Findings section; as mentioned previously, recommendations in the Findings section are noted by the 🗣️ icon.

VI. Resources Available

While the primary purpose of this assessment was to determine health care needs as well as barriers to health care in the San Diego refugee community, San Diego is fortunate to have a strong network of community-based and governmental institutions that can help address some of the issues identified. In an effort to help facilitate identification of and cooperation between these organizations, we have included in this report the following:

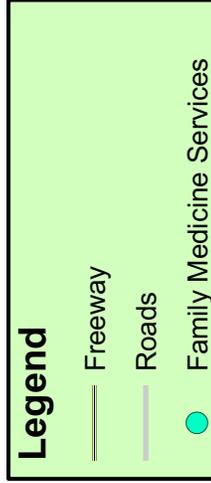
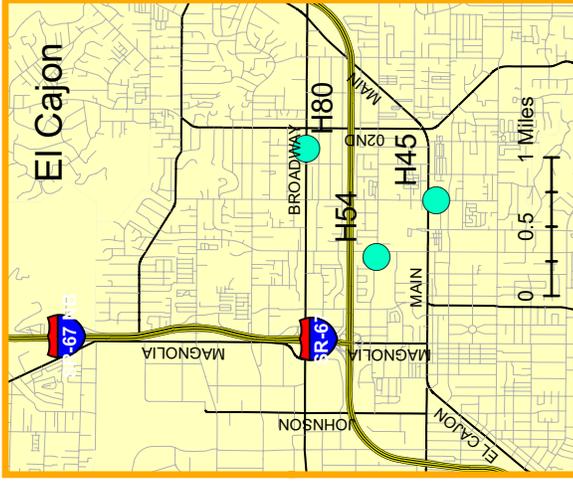
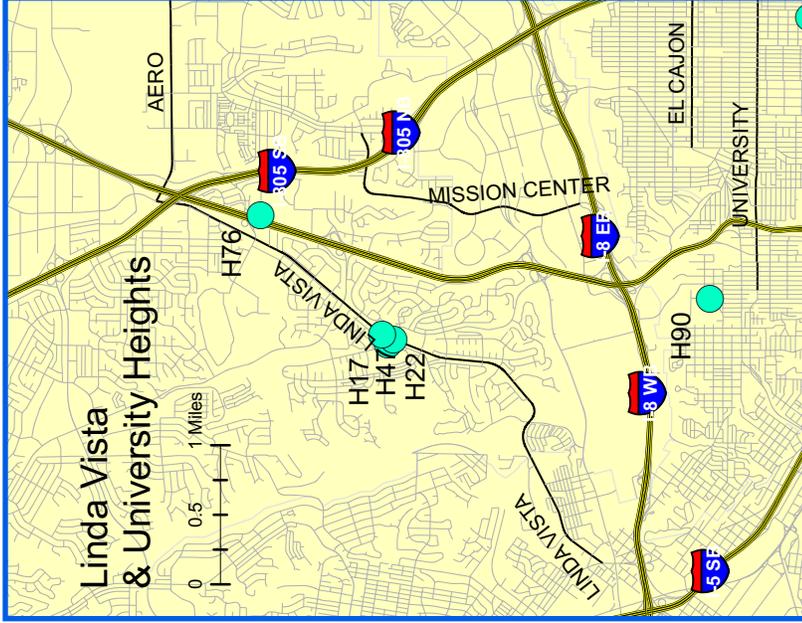
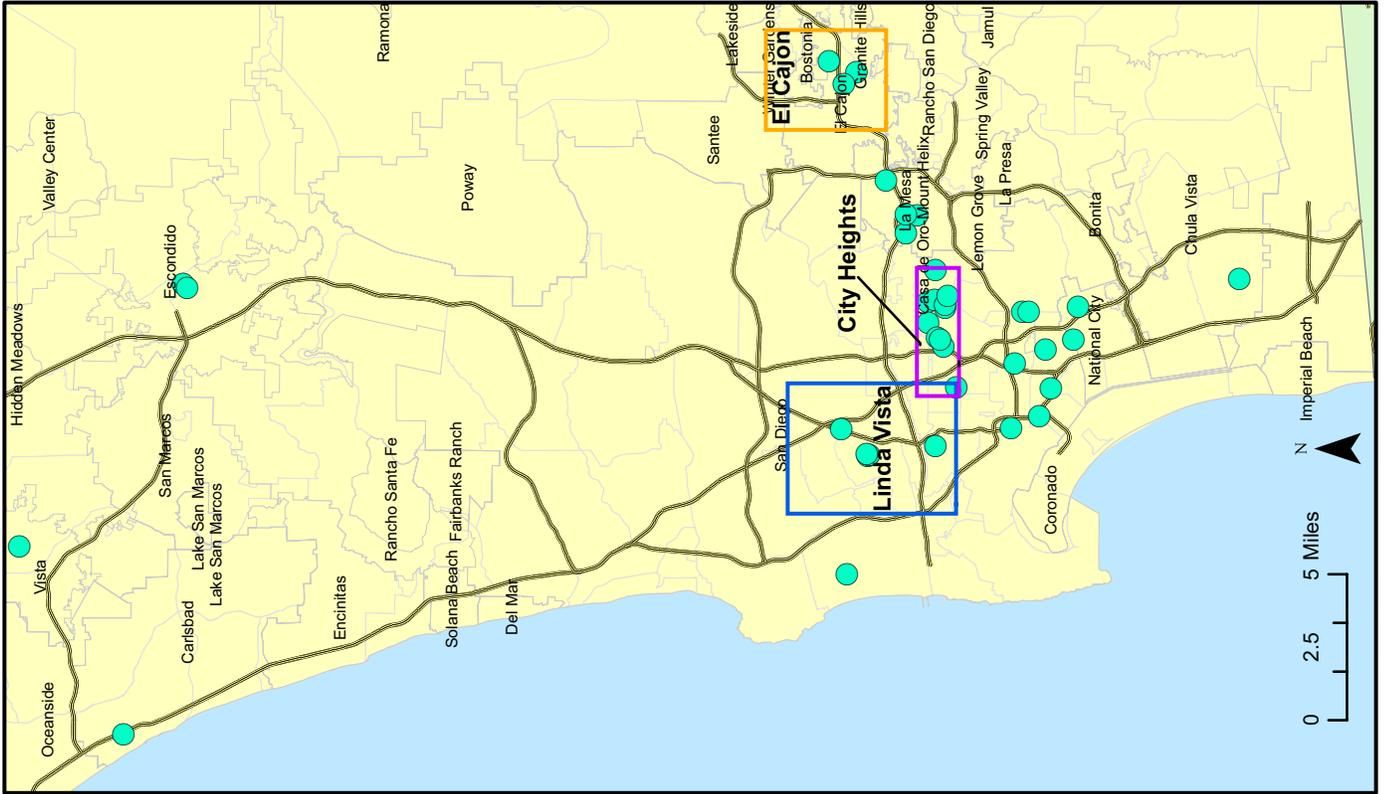
- **List of service organizations commonly serving refugees (Appendix 6):** This list was compiled from several existing lists as well as from the phone surveys we conducted. The list includes a column with common services offered by each organization. All addresses and phone numbers have been verified and updated as of March 2007.
- **Maps of Health and Service Facilities:** display where in San Diego County organizations commonly serving refugees are located in relation to high concentration of refugee populations. Labels within the map refer to rows on Appendix 6 where detailed contact information on each organization can be found.

PEDIATRIC SERVICES with large refugee clientele*



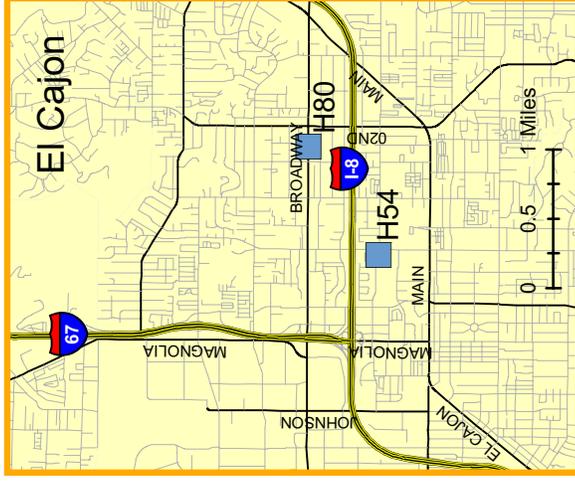
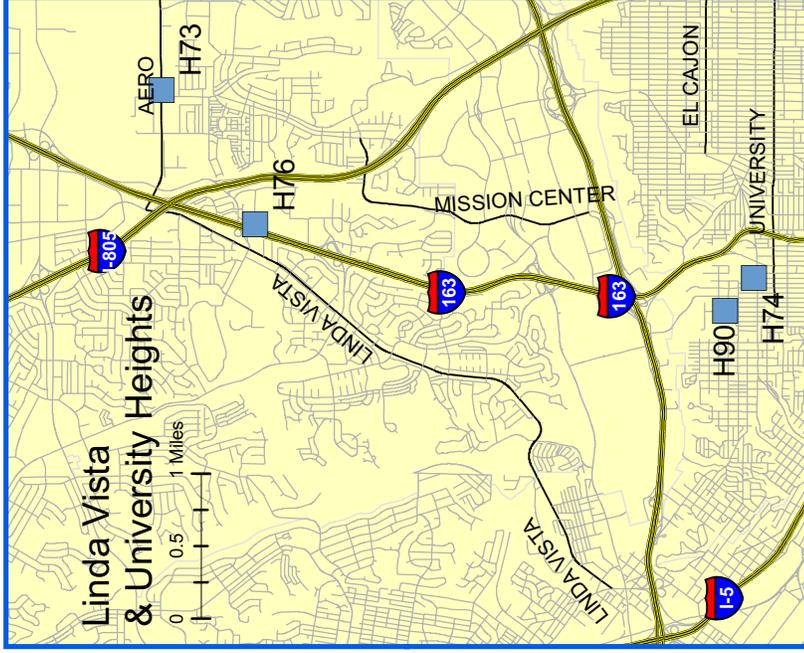
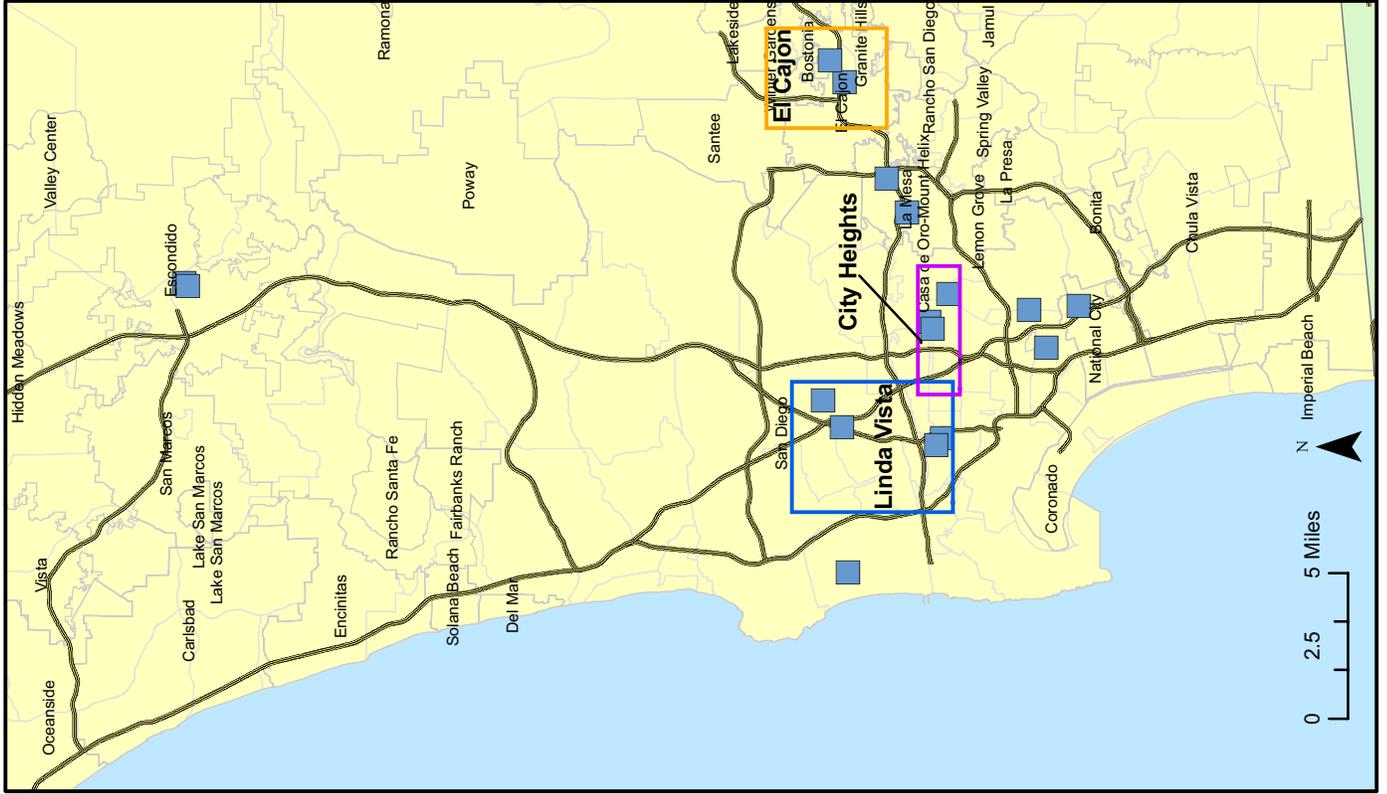
* Refer to Appendix 6 for details on specific service locations. Labels on service locations refer to rows in the Appendix 6 table.

FAMILY MEDICINE SERVICES with large refugee clientele*



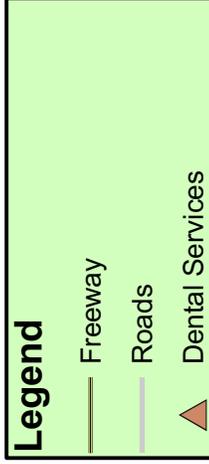
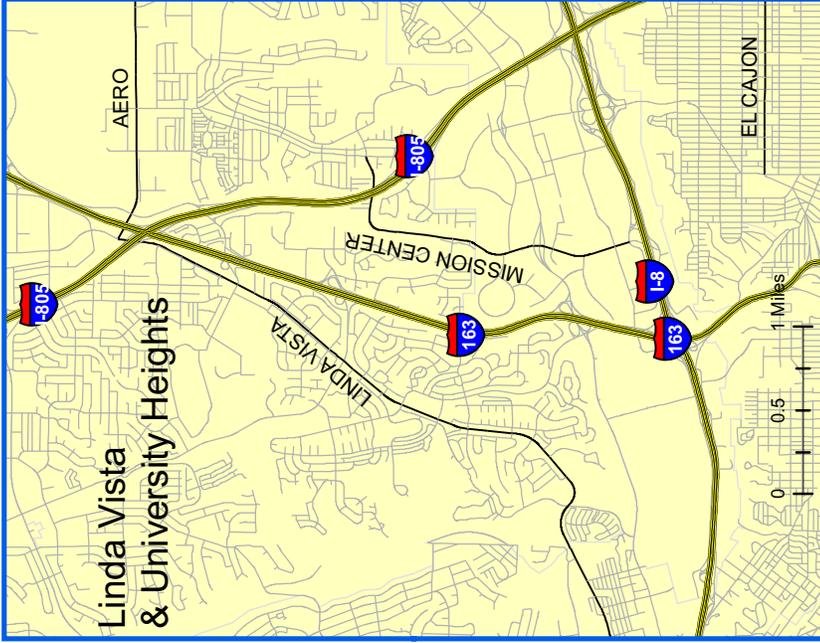
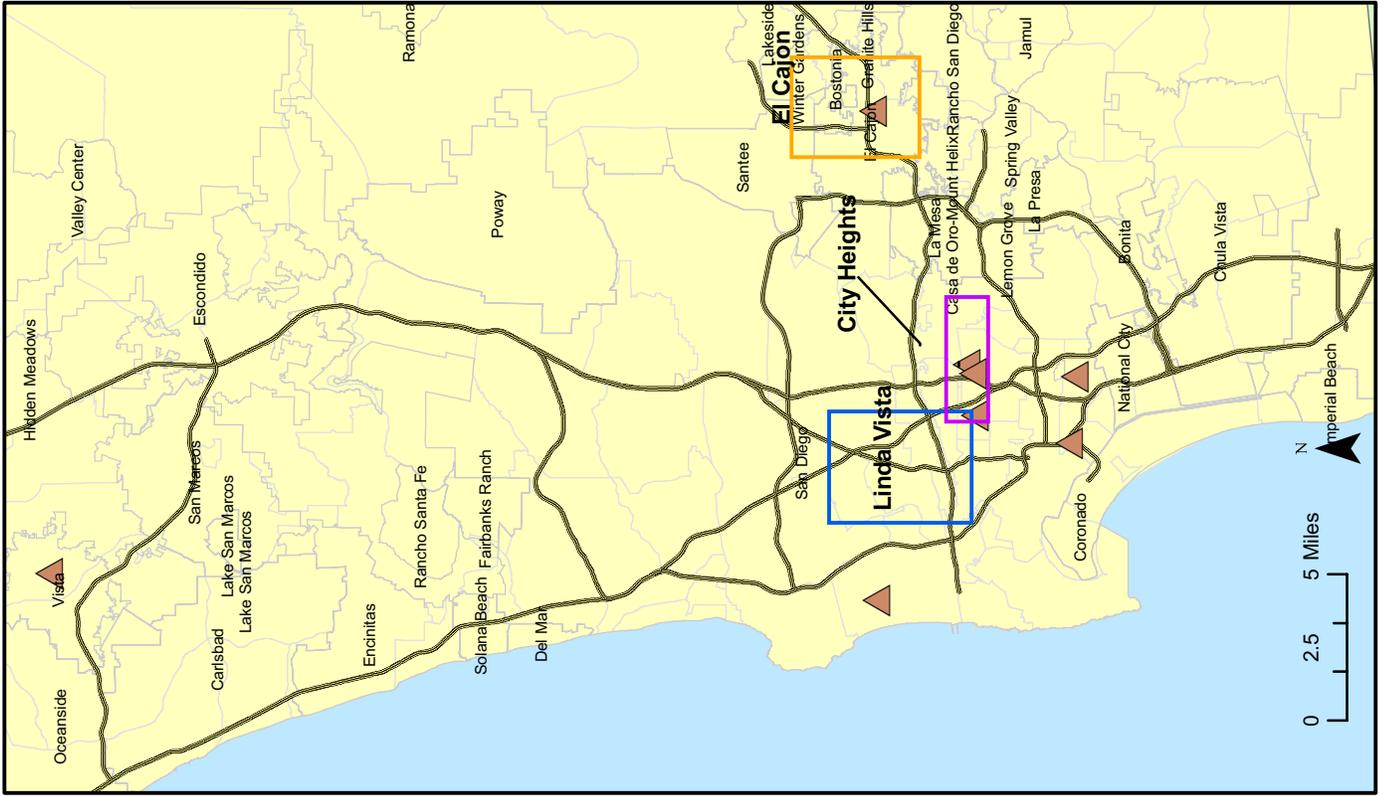
* Refer to Appendix 6 for details on specific service locations. Labels on service locations refer to rows in the Appendix 6 table.

INTERNAL MEDICINE SERVICES with large Refugee clientele*



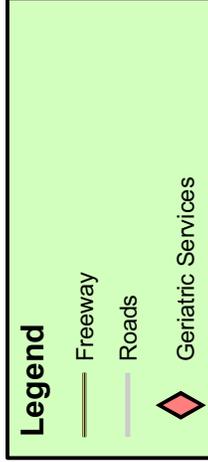
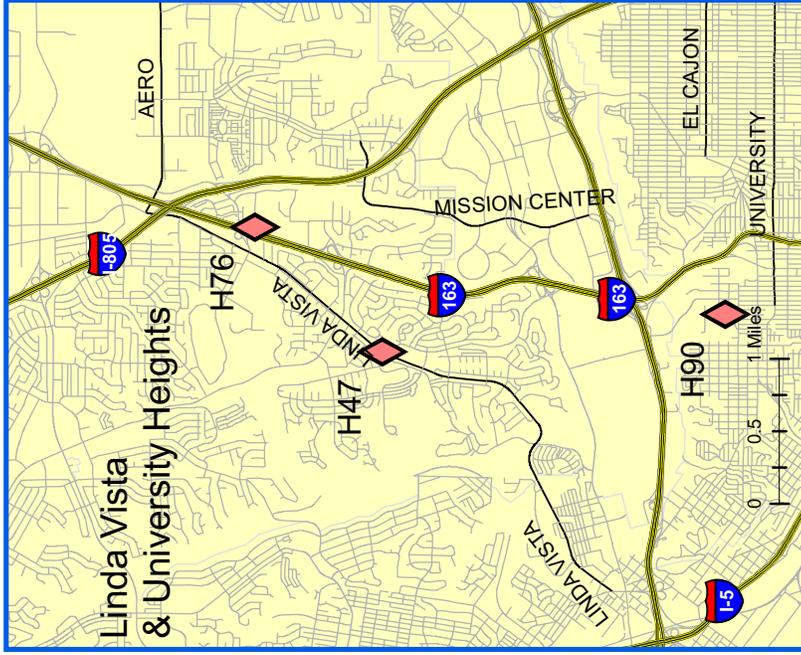
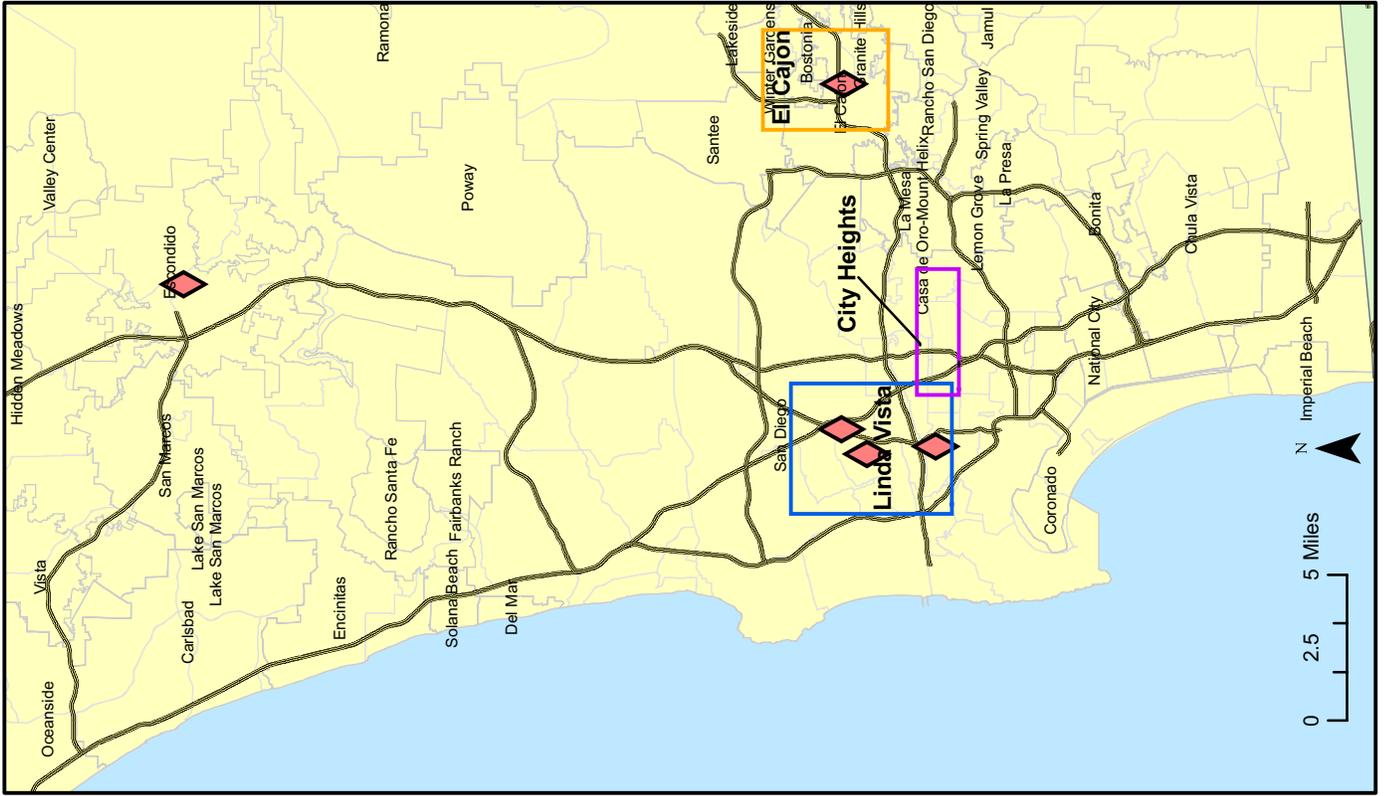
* Refer to Appendix 6 for details on specific locations. Labels on service locations refer to rows in Appendix 6 table.

DENTAL SERVICES with large refugee clientele*



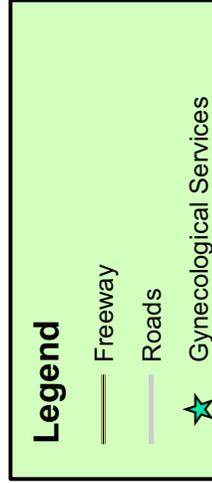
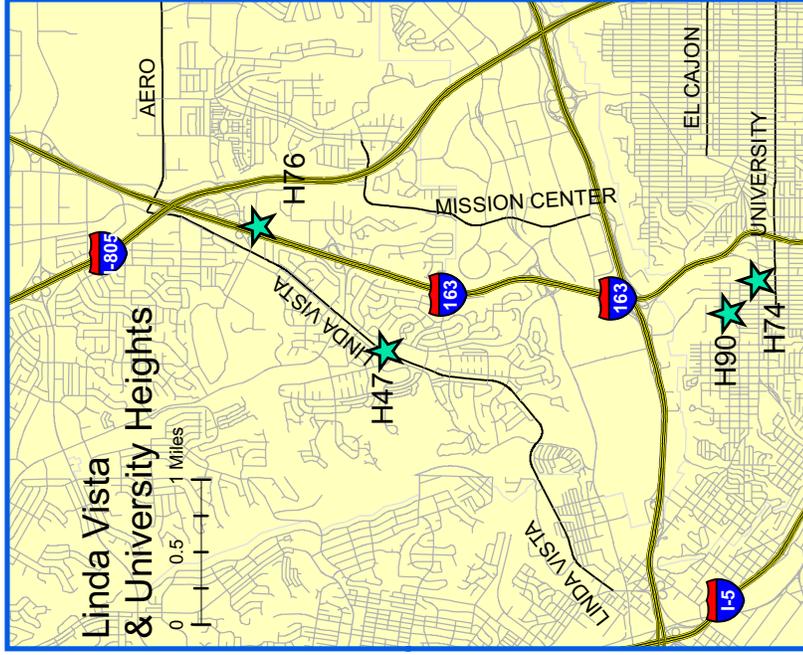
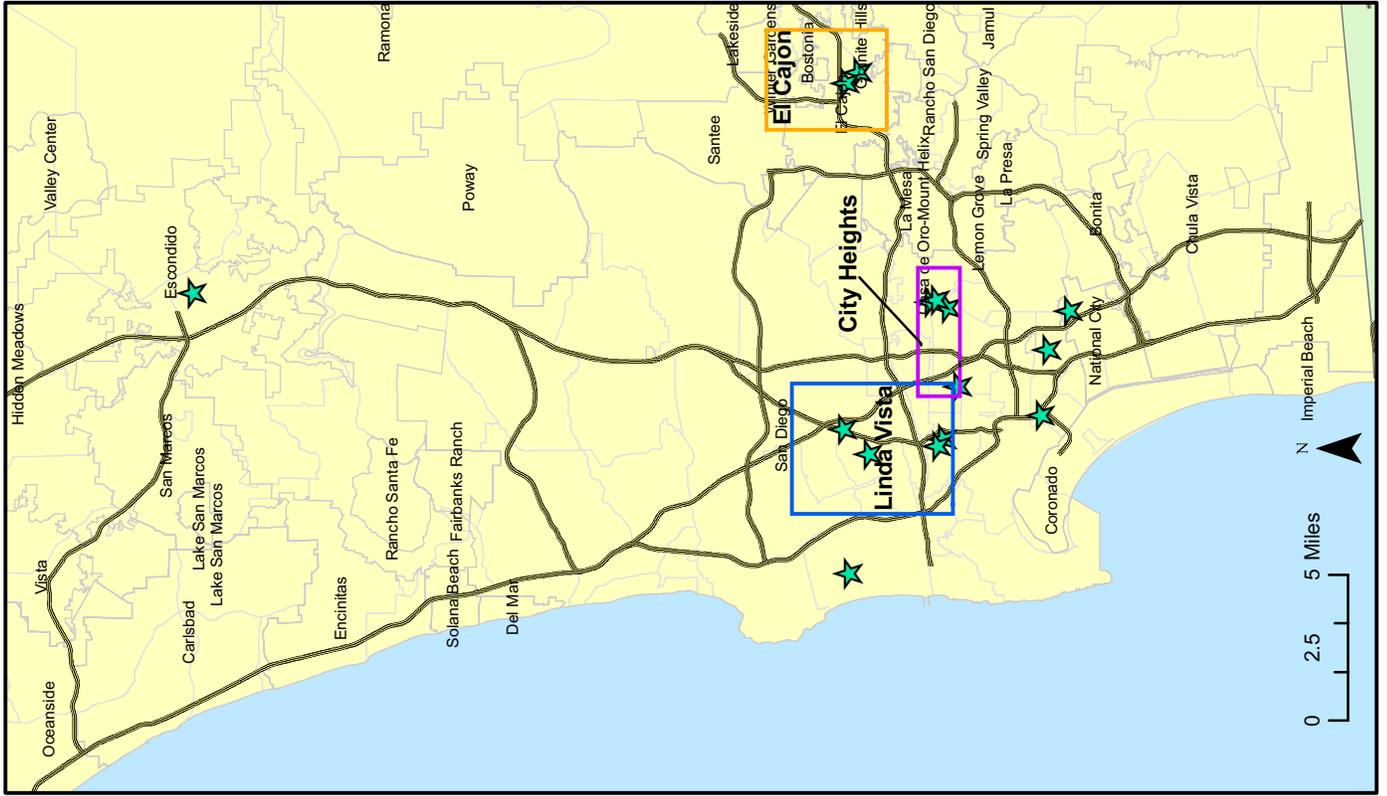
* Refer to Appendix 6 for details on specific service locations. Labels on service locations refer to rows in the Appendix 6 table.

GERIATRIC SERVICES with large refugee clientele*



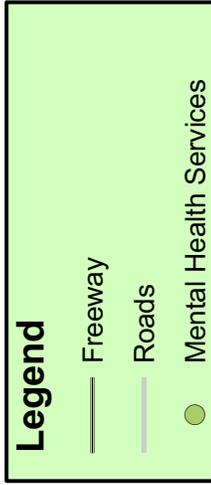
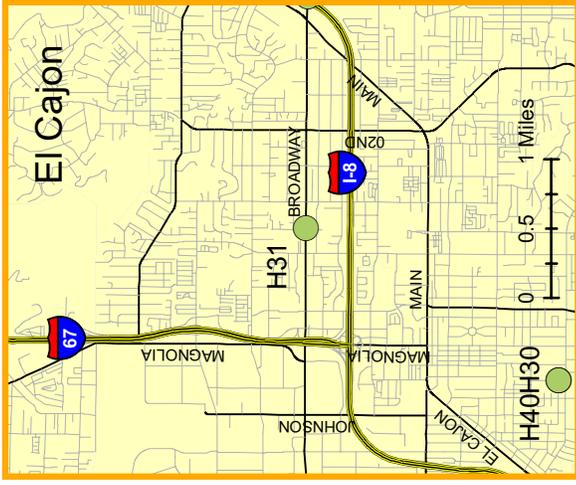
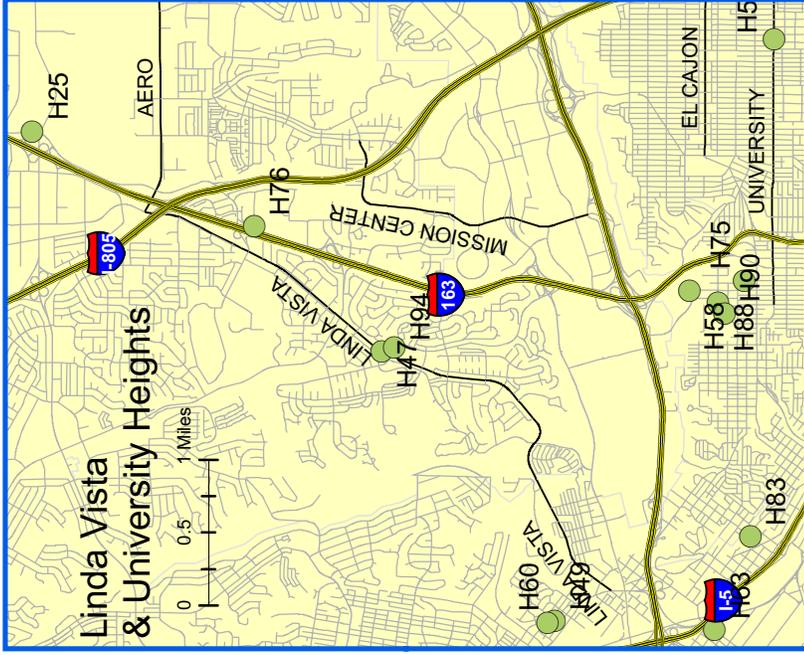
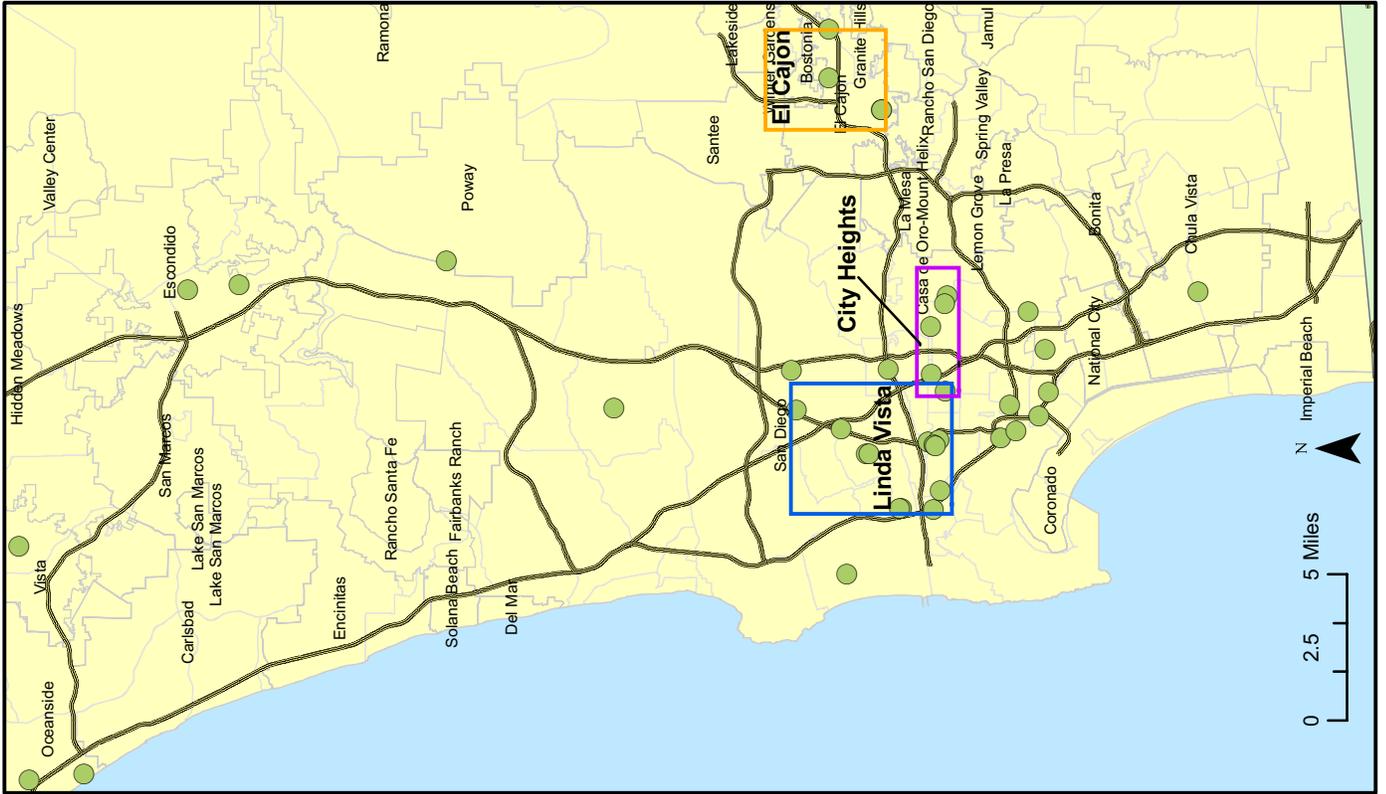
* Refer to Appendix 6 for details on specific service locations. Labels on service locations refer to rows in the Appendix 6 table.

GYNECOLOGICAL SERVICES with large refugee clientele*



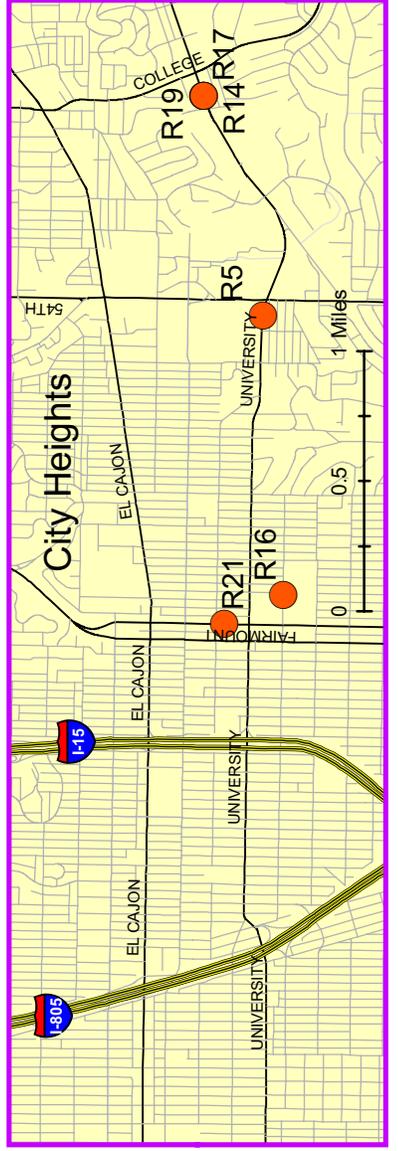
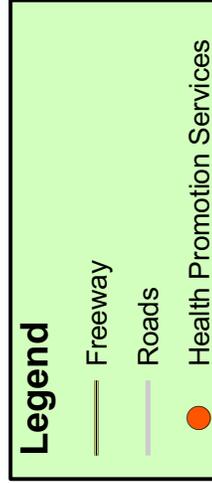
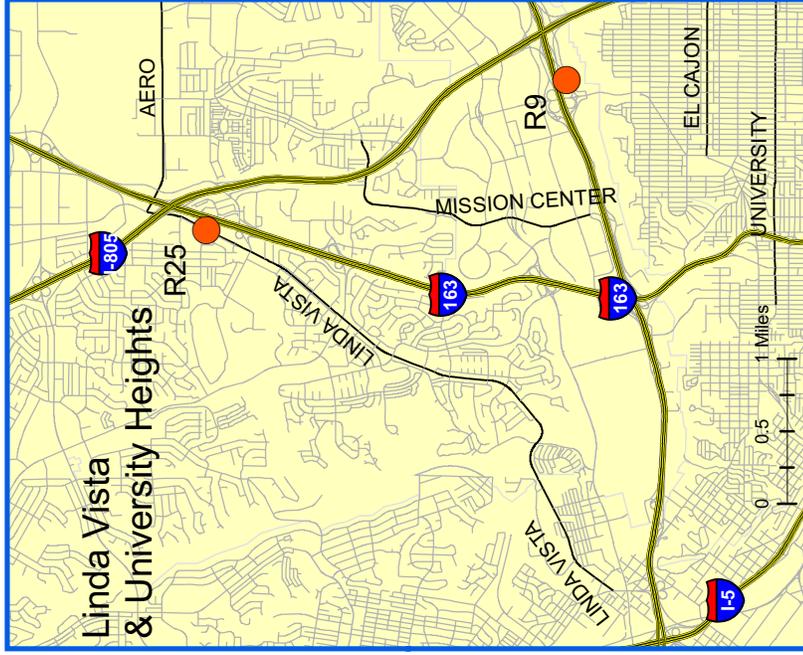
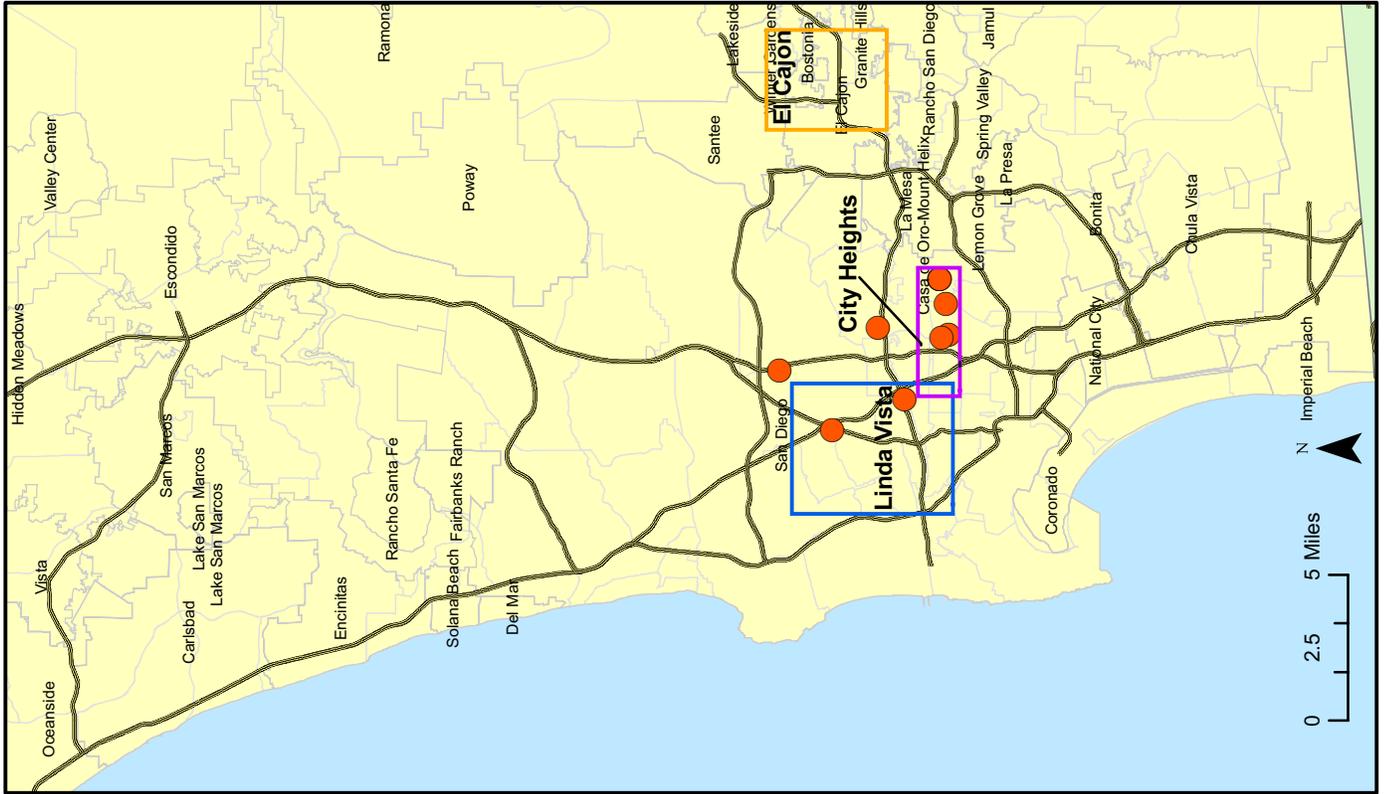
* Refer to Appendix 6 for details on specific locations. Labels on service locations refer to rows in the Appendix 6 table.

MENTAL HEALTH RESOURCES*



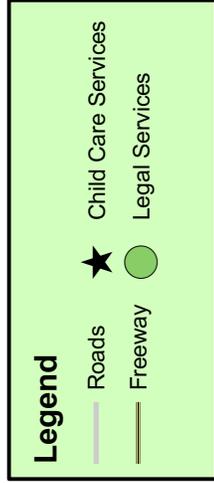
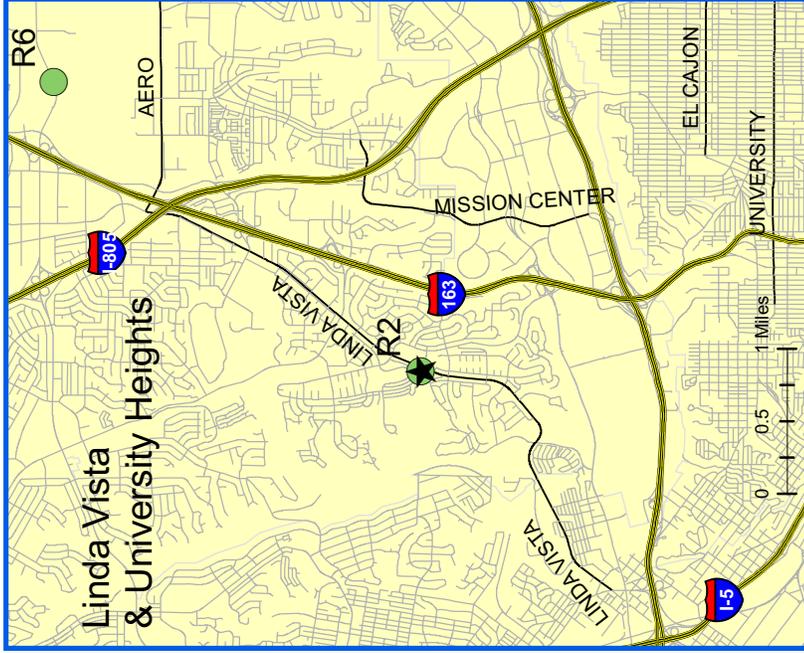
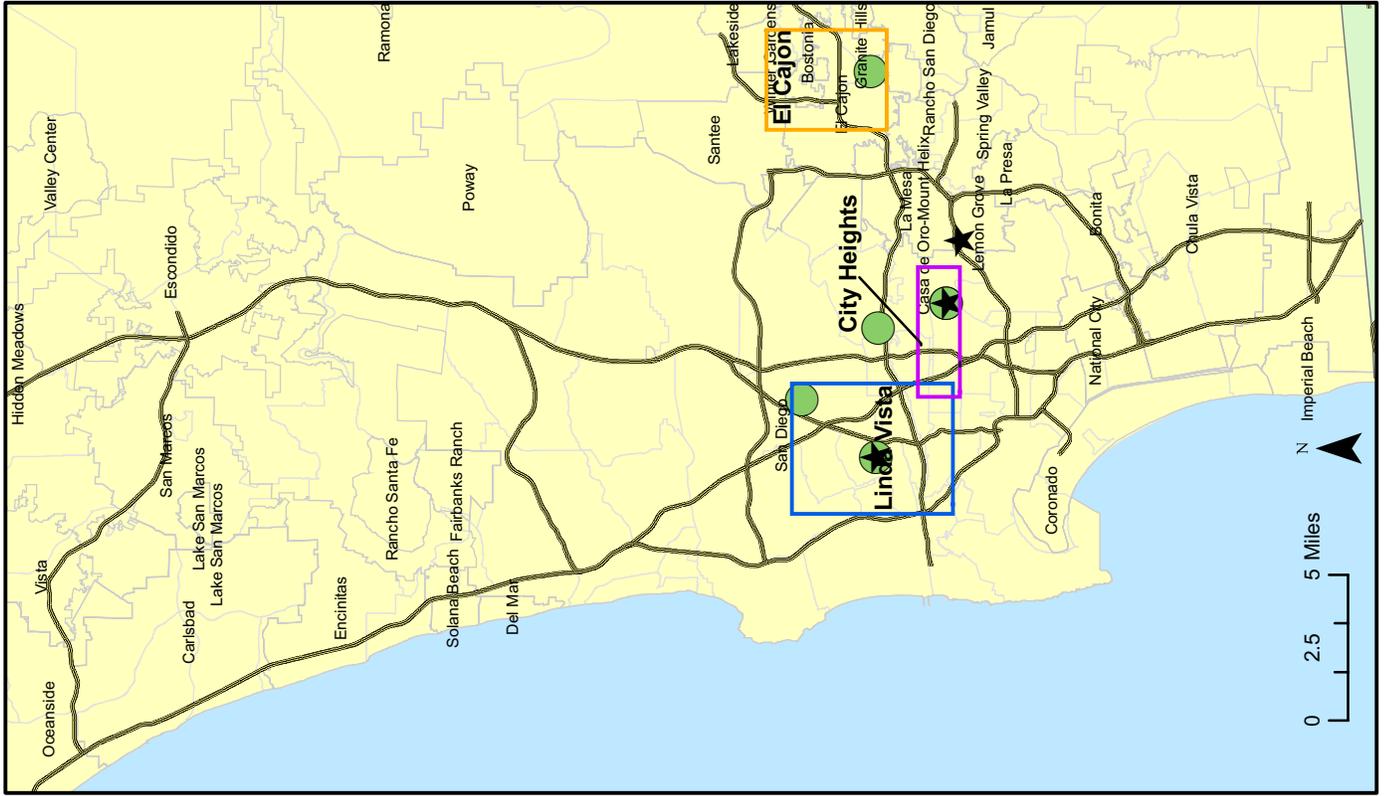
* Refer to Appendix 6 for details on specific service locations. Labels on service locations refer to rows in the Appendix 6 table.

HEALTH PROMOTION SERVICES with large refugee clientele*



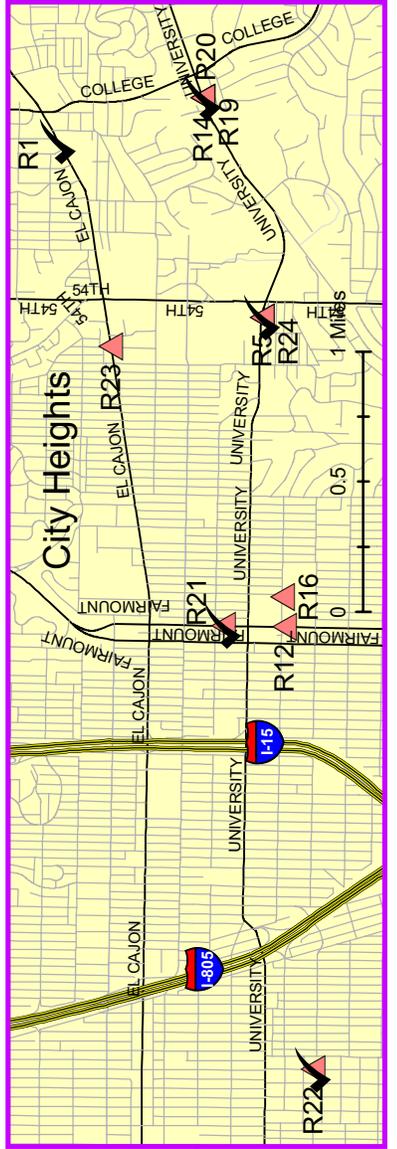
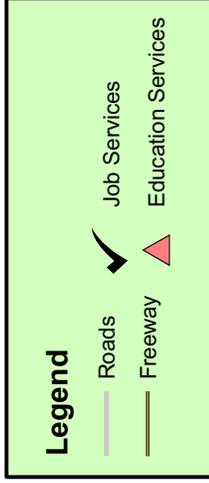
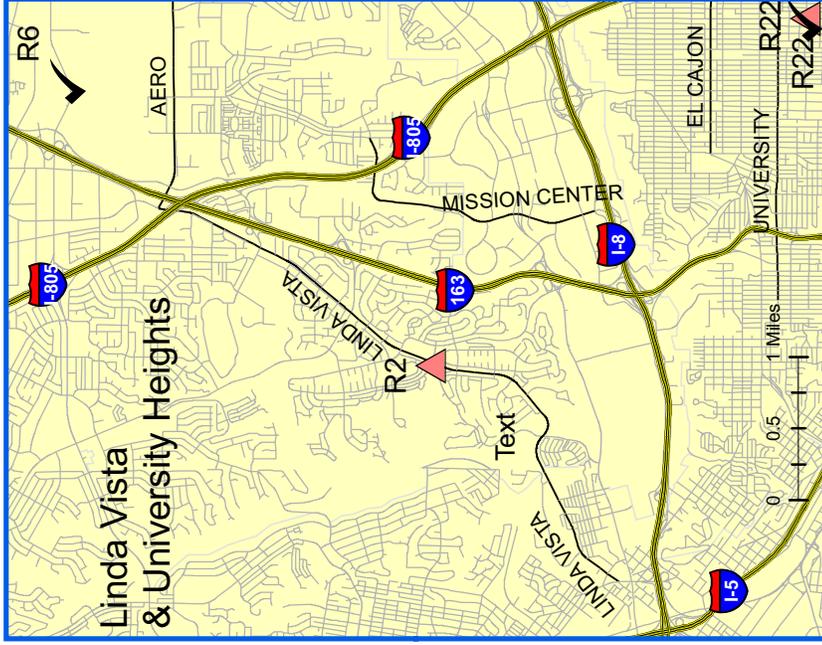
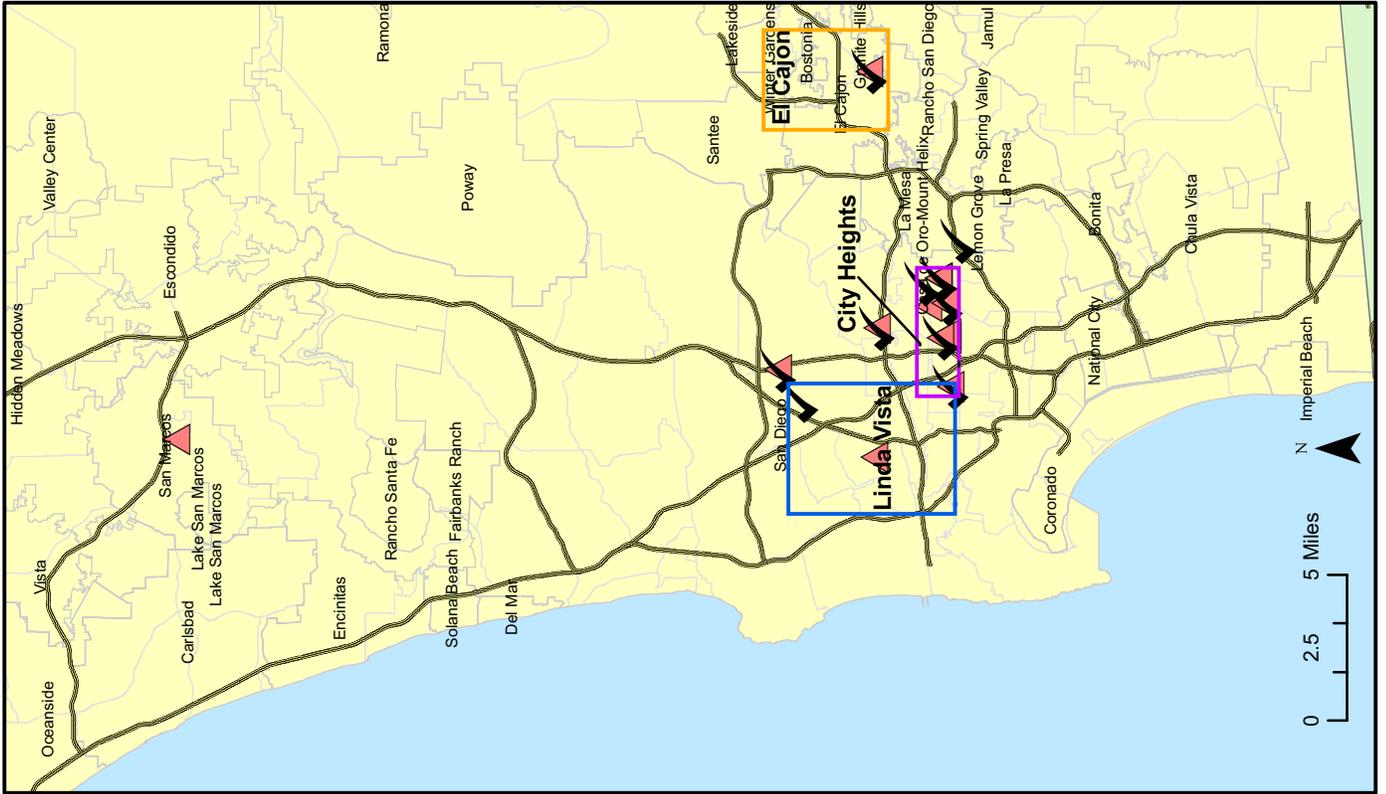
* Refer to Appendix 6 for details on specific service locations. Labels on service locations refer to rows in the Appendix 6 table.

LEGAL & CHILD CARE SERVICES with large refugee clientele*



* Refer to Appendix 6 for details on specific service locations. Labels on service locations refer to rows in the Appendix 6 table.

JOB & EDUCATION SERVICES with large refugee clientele*



* Refer to Appendix 6 for details on specific locations. Labels on service locations refer to rows in the Appendix 6 table.

VII. Conclusion and Future Assessments

The overall sentiment across all groups interviewed was that the refugee community in San Diego is prepared for and open to educational programs to help bridge the health access gap. We summarize below some of the main conditions affecting health that were identified in the present assessment as well as ideas and advice from participants on how best to conduct future health promotion and assessment activities.

A. Conclusion

Mental health was the most common long-term health issue in San Diego's refugee community. Many of the other long-term health issues of concern to participants closely parallel major health concerns of the public at large (e.g. hypertension, diabetes, nutrition, and obesity), but were met with increased concern as they were emerging upon resettlement.

- Awareness of and attitudes towards **mental health** were discussed in the vast majority of interviews. Cultural and structural barriers to getting treatment for mental health problems were a common theme.
- Health conditions such as **hypertension** and **diabetes** that are affected by diet were the top long-term health concerns in the San Diego refugee community.
- While few children were considered obese, nutritious foods weren't often included in **diets** and **weight gain** was thought to be increasingly common. Quantitative understanding of these issues is lacking.
- In addition to diet, a change to a more **sedentary lifestyle**, for a variety of reasons, was considered an important component to the nutrition/obesity issue.
- Refugee women were most affected by **reproductive health** issues including pre- and postnatal care. Nutrition and obesity were the greatest long-term health concerns among refugee children. Although several health conditions affected elderly refugees, the issue most important for their long-term health was improving their **access to care**.

Top health care access barriers that affect the long-term health of San Diego's refugee community are language and transportation. These barriers often had the effect of reducing the use of preventive services and delaying a visit to a health care provider.

- Refugee groups lacking representation among health care providers are much more likely to face language barriers. Services currently available such as AT&T's language line are inadequate for addressing the need for professional interpretation and translation; refugees who have to bring their own interpreter to health care providers offices often turn to family members or interpreters with insufficient medical translation training or expertise.
- Transportation is another large unmet need. Of those refugees who have access to public transportation through MediCal, many are not using such services.

B. Ways of reaching communities

In an effort to develop recommendations for future assessments of health issues in the San Diego refugee community, refugee populations' health, most respondents provided advice on the best way to communicate with and find recent refugee arrivals.

- Contact with refugee communities should be arranged in the community where the refugee resides. Thus, **in person contact** was almost always preferred over phone or mail surveys. One participant recommended that interviewers get to know community members before attempting a survey:

“Interact with them. Show them that you are one of them and not someone who is observing them from behind a glass wall. People respond to compassion and this is the way you will get the most honest answers.” *Male, 54, Middle Eastern Refugee*
- Of the few who recommended contact by mail or written material, all suggested that **materials be translated into refugees’ languages**.
- Ethnic groups with large populations in Southern California, including Russians, Persians and Vietnamese, mentioned their **community’s newspapers as ways of finding and identifying refugees**.
- Across all groups – refugees, service providers and health care providers – respondents recommended that, in addition to speaking refugees’ languages, **interviewers should ideally belong to the same ethnic group as the refugee population**. Among all groups surveyed only 2 respondents emphasized that the interviewer should be of the same gender as the refugee being surveyed.
- Most refugees expressed a **willingness to participate in future health surveys** in a meaningful and substantial way.
- Interventions or future projects should take place near **group settings where refugee community members gather**. Churches, mosques, community meeting halls, and community celebrations were the most common suggestions of venues in which to reach refugees.

C. Issues to Consider when designing health campaigns and assessments

- Broad health assessments of diverse refugee communities require the involvement of mutual assistance agencies working in each community. Refugee communities are often diverse, and the MAAs representing them dispersed widely. Communicating with these organizations in efforts to recruit both staff and interviewees can be challenging.
- Any health assessment or campaign working with refugees who have been here for less than five years needs to have staff fluent in the language of each refugee group. As mentioned, it is also preferable to have staff representing each gender. Thus, either interpreters must be on hand for interviews, or bi-lingual staff must be hired and trained to interview and translate documents.
- For the present assessment, once staff members, especially bi-lingual interviewers, were recruited, it was often difficult to retain them. Understandably, they were hired for very few hours for a short-term task; nonetheless, in designing future assessments use of professional interpretation services would be more efficient. The additional cost of professional interpreters is small compared to the time project coordinators must spend in order to find, train, and hire independent interpreters.
- If getting a representative sample of various refugee ethnicities is an important factor in design of future assessments, strong ties with each community must be established in order to increase the likelihood of getting an unbiased sample of willing participants from each group.

E. Sample size calculations

Sample Size **TO BE UPDATED by kcb**

Any health promotion interventions implemented in the refugee community should be monitored for effectiveness. For instance, if one would like to know if an anti-smoking campaign resulted in at least a 5% decrease in smoking, and the prevalence of smoking prior to the campaign was 25% ...

Table 3. Power to detect differences in smoking prevalence

Smoking prevalence n1	Smoking prevalence n2	Odds Ratio	Power n1=n2=266	Power n1=400;n2=100
0.20	0.03	2.43	0.562	0.273
0.07	0.02	3.69	0.796	0.457
0.08	0.02	4.26	0.890	0.598
0.08	0.01	8.61	0.975	0.823
0.09	0.01	9.79	0.989	0.903
0.10	0.01	11.0	0.996	0.952

F. Future Assessments

- Pilot findings demonstrate the need for additional investigations into how to improve access to care and a structured intervention to increase knowledge of services.
- Some members of the refugee community either live in areas without refugee serving organizations or are unsure where services are located. Further attention regarding best allocation of resources to these services is needed.
- Larger, population-based assessments are needed to focus on specific health conditions and develop appropriate health promotion programs to address them.

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Appendices

Appendix 1
Phone Survey for Health Care
Providers

Health Care Providers:

1) Name and phone of office or, if single physician, name of doctor:

2) Address(es)

3) What are the main ethnic groups/nationalities your agency most often serves?

1. All groups – including non-refugees
2. All refugee groups
3. Afghanis
4. Ethiopians
5. Iranians
6. Iraqis
7. Russians
8. Somalis
9. Sudanese
10. Vietnamese
11. Other *Specify* _____

4) Languages spoken by staff: (circle) Amharic Arabic Farsi Kiziguia Maimai Russian Somali Swahili Vietnamese

Other: _____

5) Translation services provided?

- 1) Yes
- 2) No
- 3) Don't know

6) Approximately how many refugees does your agency serve each month? (and/or "number of patients served" if records aren't kept on nationality/refugee status)

_____ /month _____ /year

7) What services are provided? (**read out list and check all that apply**)

1. Family medicine
2. Internal medicine
3. Dental
4. Gynecological
5. Mental health
6. Geriatrics
7. Pediatrics
8. Other *Specify* _____

8) What insurance do you accept? (**Ask specifically about MediCal**)

MediCal Y? N? (circle one)

Others _____

9) Email contact: _____

Appendix 2

Phone survey for Refugee Service Providers

Refugee Service Providers:

- 1) Name and Phone Number of organization _____
- 2) Address including zip code (***if they have several, ask for the address(es) where refugees would actually go to get services – in addition to their office address***)

- 3) Type of agency
VOLAG 1
MAA 2
Other 3 Specify: _____
- 4) What are the main ethnic groups/nationalities your agency most often serves?
 1. All groups – including non-refugees
 2. All refugee groups
 3. Afghanis
 4. Ethiopians
 5. Iranians
 6. Iraqis
 7. Russians
 8. Somalia's
 9. Sudanese
 10. Vietnamese
 11. Other Specify _____
- 5) Languages spoken by staff (circle) Amharic Arabic Farsi Kiziguia Maimai Russian Somali Swahili Vietnamese
Other: _____
- 6) Approximately how many refugees does your agency serve each month? (or year)
_____ /month _____ /year
- 7) What specific services do you provide refugees?
 1. Resettlement (housing etc.)
 2. Education (language classes, tutoring etc.)
 3. Job training/employment assistance
 4. Legal assistance
 5. Child care
 6. Health promotion Specify _____
 7. Other Specify _____
- 8) Are there any restrictions on receiving services from your agency?
 1. Income restriction
 2. Restriction on how long a person has lived in the U.S.
 3. Other Specify _____
- 9) How long has your agency been serving refugees? ____ years ____ months
- 10) Are you a 501 c3 non-profit organization? Yes No Other status/funding: _____
- 11) Email contact: _____

Appendix 3

In-depth Interview Guide for Refugee Interviews

REFUGEE INTERVIEW GUIDE

INTERVIEW GUIDE COVERING MAIN HEALTH TOPIC THEMES TO BE BROUGHT UP IN IN-DEPTH INTERVIEWS

REFUGEE HEALTH NEEDS ASSESSMENT: **Assessment of Community Member Attitudes towards Health Needs of** **Refugees in San Diego**

PARTICIPANT ID: _____ INTERVIEWER INITIALS: _____

DATE OF INTERVIEW: ____ / ____ / _____

M M D D Y Y Y Y

Section 1.01 INTERVIEW START TIME: _____ : _____

Section 1.02 INTERVIEW END TIME: _____ : _____

Notes: _____

Please read the following before proceeding with the questionnaire:

Hello, my name is _____ and I am part of the University of California San Diego Division of International Health & Cross-Cultural Medicine. Thank you so much for agreeing to participate in this project. This study is part of a cooperative agreement between our group and the San Diego County Health and Human Services Agency, Refugee Health Program.

We are conducting a refugee health needs assessment survey to identify refugees' unmet health needs, health concerns, and health care access issues. The first step in this work is to speak with refugees and refugee-serving groups in San Diego County to identify their opinions of health needs of San Diego refugees. An eventual goal of this work is to help refugee service organizations to improve long-term health services for refugees. Your ideas and suggestions are extremely important to help us learn what types of health issues are important.

As mentioned in the consent documents, the interview will last approximately 1 hour and will be taped. This is to avoid note-taking errors and to make the interview smoother. If you have any questions before we begin, feel free to ask them now. If you would like to contact someone from the study after we complete the interview today, you can call the principal investigator, Dr. Kimberly Brouwer, at (858) 822-6467.

Thank you again for your participation in this project and the time that you are going to spend with us today. Do you have any questions you would like to address before we begin?

I. SocioDemographics

1. **(Interviewer) Record gender as observed.**

Male 1
Female 2

2. **(Interviewer): Record type of interviewee.**

Health care provider 1
VOLAG representative 2
MAAS representative 3
Refugee..... 4
Other 5 Specify: _____

3. **What is the highest level of education that you have completed?**

None, no formal education..... 1
Incomplete Primary School..... 2
Completed Elementary/Primary school..... 3
Middle School..... 4
Some high school..... 5
High school graduate..... 6
Technical/Trade..... 7
Some college..... 8
College graduate..... 9
Masters..... 10
PhD/MD/JD 11
Other..... 12 Specify _____
Don't know..... 13
Refuse to answer..... 14

4. **How old are you? (if interviewee unsure, probe for a best guess)**

___ ___ years old

5. **In what country and city were you born? _____**

5. **To what ethnic group do you belong? _____**

6. **Under what immigration status were you admitted to the U.S. (e.g., as a refugee, asylee, parolee, Victim of Trafficking)?**

1. Refugee
2. Asylee
3. Parolee
4. Victim of human trafficking
5. Other Specify _____
6. Doesn't know
7. Refuse to answer

7. Where were you originally resettled in the U.S.?

Specify City: _____

Specify State: _____

8. How long have you lived in the United States?

___ ___ years ___ ___ months *(if less than 1 year or more than 5 years, end interview)*

9. How long have you lived in San Diego?

___ ___ years ___ ___ months

9 b. [If response to 9 < response to 8] Why did you relocate to San Diego?

10. What is your occupation? _____

II. Health Conditions

The following questions refer to health conditions affecting refugees who settled in the United States 1-5 years ago. Please answer based on your own experiences or the experiences of the San Diego refugee groups you know best.

1. **How do you feel about your overall health?**

Probes:

How do you think they compare to the rest of the population?

How does your health now compare to when you first arrived in the U.S.?

2. ****What do you think are the most serious or common health conditions affecting refugees in San Diego?**

Probes:

What are the top five?

The most urgent one that needs attention?

****Subquestion: Are there infectious diseases affecting the refugees within San Diego?**

****Subquestion: Are there current chronic diseases affecting the refugees within San Diego?**

Probe: How common is high blood pressure? Chronic pain? Heart-attacks?

How do these diseases affect your daily life?

3. ****Are there issues affecting the health of refugee children that you feel are important?**

Probes:

Are there any differences between health issues affecting young children versus teenagers? Which ones affect children? Which ones affect teenagers?

Is obesity (health issues connected to weight) an issue for children in your community?

4. **What are the main issues affecting the health of elderly refugees that you feel are important?**

Probes:

Is there a difference between health problems of recent elderly refugees and ones that have lived in the U.S. since young adulthood?

5. ****Are there current common or serious health problems affecting women in your community? (problems that affect refugee women specifically)**

Probes:

Is there any difference between those who have been in the U.S. 1 year versus those who have already been here 5 years? Are there any differences between refugee groups?

6. **Do you or refugees who you know access health care to deal with stress, anger, or depression?

Probes:

What populations or age groups are most affected?

Is there any difference between those who have lived in the U.S. for a short time (less than a year) and those who have lived in the U.S. for a long time (more than 5 years)?

7. Is dental health a problem for refugees you know?

Probes:

What are the main problems?

Are there any differences by age?

8. Do you have any problems with your sight or ability to see clearly?

Probe: Did you go to an eye doctor to get this problem corrected? If no, why not?

How common are eye problems with refugees that you know?

III. Socio-cultural Issues

1. When thinking about cultural practices and traditions from your home country are there any that you or refugees you know use here to treat illness or to improve health?

Probe:

Do you or those you know visit spiritual healers or use herbal preparations? Please tell me about the last time this happened.

How do you pay for these services?

2. **What are some changes in behavior that you or refugees you know have adopted while living in the United States that have affected health?

Probe:

Could you please tell me why these behavior changes were made?

Have you noticed any differences in your health after these changes?

3. Are there current health-related behaviors (e.g., smoking, drinking, drug use, diet, exercise, violence, physical activity, etc.) affecting the refugees in San Diego that you feel are important?

How do these behaviors affect your health?

IV. Access to Health care

1. **What types of places do you or people you know go for health care?

Probes:

For emergency care only or for regular doctor visits?

Do you have a doctor that you regularly see?

How easy is it to make an appointment?

Subquestion: Thinking about emergency situations, what types of care are available to you?

Probes:

Do you know about 911? How is it to be used?

Have there been any problems in quickly getting medical care?

2. Do you or recent immigrants you know seek medical care only when you're sick or on a regular (e.g. annual) basis for prevention services?

Probes:

What do people think about vaccinating their children?

Is it common for young children to regularly see a doctor, even if they feel well?

Are there any differences in likelihood of getting preventive help for children versus adults?

When you receive a prescription for medicine from your physician, do you always fill it?

Do you understand how, when and why you are taking it? Why/whynot?

3. **Do you know of any refugees who needed to see a doctor for a physical or emotional problem but did not go?

Probes:

What were the reasons they did not go?

What are the main reasons for refugees not accessing care when it is available?

4. How is the quality of care at doctor's offices and hospitals?

Probes:

Is there any differences between the care you received before or after you came to the US?

5. Do most community members you know have health insurance? Do you have health insurance? What kind of insurance?

Probe:

Has anyone you know received help to pay for treatment of a health problem? Can you tell me about this experience?

6. **What improvements can be made so that health care is more accessible and used by refugees?

Probe:* Do changes need to be made in translation services?

*Hours that clinics are open?

*Do we need improvements in existing services?

Do we need more affordable treatment?

Do we need new services?

*What kind of services do we need?

7. What types of care do pregnant mothers seek before and after giving birth?

Probe: Where do most refugee women give birth?

Do women receive regular checkups after giving birth? What about the child?

What improvements or changes can you suggest to improve services for pregnant women both before, during and after childbirth?

8. Do the mothers you know plan when to become pregnant?

Probe: Do refugees you know use family planning services such as? Where? What types?

Is it usually the role of the husband or wife to decide about family planning issues?
When do families usually stop having children?

9. Do members of your community use contraception?

Probes: What types?

Where do refugees get information about contraception?

Where do refugees get contraception?

In this next section I would like you to think about your own experiences or experiences of those close to you in relation to accessing health care. Please remember, if you do not want to answer any specific question or do not want to share personal experiences, that is okay.

1. **Tell me about the last time you (or someone you know) tried to get health care services.

Probe:

Was there any delay between getting the health problem and going to seek health care services? What was the reason for the delay?

Was care sought elsewhere before going to a health clinic?

2. Do you or someone you know ever have any trouble communicating with health care providers or feel uncomfortable talking about certain issues?

Probe.

Please tell me about the last time this happened.

V. Health Promotion

1. **Please tell me what you think would be the most effective way to promote health and safety among refugees.

Sub question: Are there any programs that you know about which promote the health of refugees in San Diego?

Probes:

Is it easy or difficult to use these programs?

Have you used them? Why or why not?

How could they be improved?

2. Do you think health information and promotion measures (such as warning labels on products, health fairs, public service messages on the radio) directed towards the general U.S. population are having an effect on the refugee community?

Probe: Why or why not?

VI. Future Studies

In the future, we plan to do a more detailed survey of refugees who have lived in the U.S. more than 1 year but not more than 5 years.

1. **In trying to reach a representative sample of the refugee community, what are your suggestions of the best way to communicate with refugees (e.g. telephone, in-person, mail etc.)**
2. **Do you have any suggestions on how to find recent refugee arrivals (e.g. door-to-door surveys, through refugee service organizations)**
Probe: What times of the day would this population be most available?
What days of the week are best to reach this population?
What types of locations are best to reach this population?
3. **What advice would you give to someone planning to conduct a survey of refugees in San Diego?**
4. **Do you think the refugee community would be receptive to the idea of a health behavior/health status survey?**
Probe:
Are there any topics that might be difficult to discuss?
Are there any settings/places in which it might be difficult to ask health-related questions?
Are there any special difficulties in reaching women or talking about these subjects with women?
Are there any special difficulties in reaching men or talking about these subjects with men?

VII. Wrap Up

1. **Would you like to add any special considerations to your responses above for a particular ethnic group?**
2. **Are there any other health conditions or health care-related issues affecting the refugees you would like to add?**
3. **Is there anyone that you think is particularly connected with your community that we should interview? How do we contact them?**

Thank you for participating in our study.
The information that you gave me will be very helpful to us.
We really appreciate you doing the interview today.

DO NOT FORGET TO WRITE THE FINISHING TIME AND ANY FIELD NOTES

Appendix 4

In-depth Interview Guide for Service Provider Interviews

**Health care providers, Representatives of Voluntary Agencies,
Employees/Volunteers from Mutual Assistance Agencies**

INTERVIEW GUIDE COVERING MAIN HEALTH TOPIC THEMES TO BE BROUGHT UP IN IN-DEPTH INTERVIEWS

**REFUGEE HEALTH NEEDS ASSESSMENT:
Assessment of Community Member Attitudes towards Health Needs of
Refugees in San Diego**

Fill in the following completely:

PARTICIPANT ID: _____ INTERVIEWER INITIALS: _____

DATE OF INTERVIEW: ____ / ____ / _____

M M D D Y Y Y Y

Section 1.03 INTERVIEW START TIME: _____ : _____

Section 1.04 INTERVIEW END TIME: _____ : _____

Notes: _____

Please read the following before proceeding with the questionnaire:

Hello, my name is _____ and I am part of the University of California San Diego Division of International Health & Cross-Cultural Medicine. Thank you so much for agreeing to participate in this project. This study is part of a cooperative agreement between our group and the San Diego County Health and Human Services Agency, Refugee Health Program.

We are conducting a refugee health needs assessment survey to identify refugees' unmet health needs, health concerns, and health care access issues. The first step in this work is to speak with refugees and refugee-serving groups in San Diego County to identify their opinions of health needs of San Diego refugees. An eventual goal of this work is to help refugee service organizations to improve long-term health services for refugees. Due to your experience and knowledge of these issues, your ideas and suggestions are extremely important to help us learn what types of health issues are important.

As mentioned in the consent documents, the interview will last approximately 1 hour and will be taped. This is to avoid note-taking errors and to make the interview smoother. If you have any questions before we begin, feel free to ask them now. If you would like to contact someone from the study after we complete the interview today, you can call the principal investigator, Dr. Kimberly Brouwer. at (858) 822-6467.

I. SocioDemographics

1. (Interviewer): Record gender as observed.

- Male 1
- Female 2

2. (Interviewer): Record type of interviewee.

- Health care provider 1
- VOLAG representative 2
- MAA representative 3
- Refugee 4
- Other 5 Specify: _____

3. What are the main ethnic groups your agency serves? Circle all that apply

- 12. All groups – including non-refugees
- 13. All refugee groups
- 14. Afghanis
- 15. Ethiopians
- 16. Iranians
- 17. Iraqis
- 18. Russians
- 19. Somalia's
- 20. Sudanese
- 21. Vietnamese
- 22. Other Specify _____

**4. For MAAs: Approximately how many refugees does your agency serve each month?
For VOLAGs: approximately how many refugees does your agency resettle per month?**

FOR VOLAGs/MAAs

5. What specific services do you provide refugees? (read out list and check all that apply)

- 1. Resettlement (housing etc.)
- 2. Education (language classes, tutoring etc.)
- 3. Job training/employment assistance
- 4. Legal assistance
- 5. Child care
- 6. Health promotion Specify _____
- 7. Other Specify _____

FOR HEALTH CARE PROVIDERS

6. What services does your clinic provide? (*read out list and check all that apply*)

- 1. Family medicine
- 2. Internal medicine
- 3. Dental
- 4. Gynecological
- 5. Mental health
- 6. Geriatrics
- 7. Pediatrics
- 8. Other Specify _____

7. How long has your agency been serving refugees? ____ years ____ months

8. How old are you?

____ years old

9. What is the highest level of education that you have completed?

- None, no formal education.....1
- Incomplete Primary School.....2
- Completed Elementary/Primary school.....3
- Middle School.....4
- Some high school.....5
- High school graduate.....6
- Technical/Trade.....7
- Some college.....8
- College graduate.....9
- Masters.....10
- PhD/MD/JD11
- Other.....12 Specify _____
- Don't know.....13
- Refuse to answer.....14

10. What is the title of your position? _____

11. What are your general job responsibilities?

12. How long have you been working in the refugee field (or working with refugees)? ____
____ years ____ months

13. Were you born in the U.S.?

1 Yes (*skip to section II*)

0 No

14. Did you originally come to the U.S. as a refugee?

1 Yes

0 No (*skip to section II*)

15a. In what country were you born? _____

15b. In what city were you born? _____

16. To what ethnic group do you belong? _____

17. How long have you lived in the United States?

___ ___ years ___ ___ months

****Check question 8: stop interview if participant is less than 18 years old. Explain that they do not meet the criteria necessary to proceed with the research interview.**

For the purpose of this survey, the term Refugee is defined as a person outside of his or her country of nationality who is unable or unwilling to return because of persecution. This includes Refugees, Asylees, Parolees, and Victims of Trafficking.

The following questions refer to health conditions affecting refugees who settled in the United States 1-5 years ago. Please answer based on your own experiences or the experiences of the San Diego refugee groups you know best.

II. Health Conditions

1. In your opinion, how do the refugee communities in San Diego feel about their overall health?

Probes:

How do you think they compare to the rest of the U.S. population?
How does it compare to when they first arrived in the U.S.?

2. **What do you think are the most serious or common current health conditions affecting refugees in San Diego?

Probes:

What are the top five health conditions?
The most urgent one?
The most overlooked health condition?

3. Are there infectious diseases affecting the refugees that you feel are important?

Probe: How about STIs?

Are there left-over effects from past infections?

4. **Are there current chronic diseases affecting the refugees that you feel are important?

Probe: How common is high blood pressure?

How common is heart-attacks?

Obesity?

Chronic pain?

5. **Are there issues affecting the health of refugee children that you feel are important?

Probes:

Are there any differences between health issues affecting young children versus teenagers?

Are there health issues related to child birth that affect the refugee community?

6. **What are the main issues affecting the health of elderly refugees that you feel are important?

Probes:

Are there any differences between refugee groups?

Is there any difference between those who have been in the U.S. just 1 year versus those who have already been here 5 years?

7. **Are there current common or serious women's health conditions affecting the refugees?

Probes:

Are there any differences between nationalities or ethnic groups?

Is there any difference between those who have been in the U.S. 1 year versus those who have already been here 5 years?

8. **Are there current mental health conditions affecting refugees in San Diego that you feel are important?

Probes:

Do refugees often complain of feeling down, or depressed?

What populations or age groups are most affected?

Is domestic violence an issue for the refugee populations you serve? What are your observations/experiences with the refugee population regarding domestic violence?

Is there any difference between those who have been in the U.S. 1 year versus those who have already been here 5 years?

9. Are there dental health problems affecting refugees you serve?

Probes:

Are there any differences by age?

10. How common would you say uncorrected vision or hearing problems are in the refugee community?

III. Socio-cultural Issues

1. **In thinking about the refugee groups you are familiar with, are there any cultural practices or traditions that refugees have brought from their home countries that are affecting their health?

Probe:

What are the effects on health of these cultural practices/traditions?

Do many refugees visit spiritual healers or use herbal preparations to treat health problems?

2. **What are some changes in behavior that refugees have adopted while living in the United States that have affected their health?

Probe:

Why do you think these changes have been made?
Has the health of these refugees been affected by these changes?

3. **Are there current health-related behaviors (e.g., smoking, drinking, drug use, diet, exercise, violence, physical activity, etc.) affecting the refugees in San Diego that you feel affect refugee health?**

IV. Access to Health care

1. **What types of places do refugees go for health care?**

Probes:

Where do they go most often?
How easy is it to make an appointment?
How easy is it for refugees to be seen at these places?
What about traditional/faith healers?

2. ****Do you know of any refugees who needed to see a doctor for a physical or emotional problem but did not go?**

Probes:

What were the reasons they did not go?

3. ***What is your experience with refugees filling prescription medication when prescribed by a doctor?**

Probes: do they typically fill their prescriptions?

Do the refugees you serve understand what their medications are used for?

4. ****Thinking of the refugees you are familiar with, do they usually go to the doctor when they are sick or on a regular (e.g. annual) basis for prevention services?**

Probes:

*How well are pediatric vaccinations accepted by the community?
Is it common for young children to regularly see a doctor, even if they feel well?
Are there any differences in likelihood of getting preventive help for children versus adults?

5. ****What are important issues limiting refugees from using health care (or causing refugees not to seek care *even though the services are available*)?**

How do refugees you know feel about the quality of their health care?

6. ****What are important issues limiting health care access of the refugees you know best?**

7. **Ask all VOLAGs: What percentage of refugees you serve/know have health insurance?**

What kind of insurance: private and public?

Why do some not have insurance?

What happens when refugee patients are not able to pay for health care?

8. Thinking about emergency situations, what are the most common issues affecting how refugees get care in emergencies?

Probes:

****Do they know about and/or use/misuse 911?**

Have there been any problems in quickly getting medical care?

9. **Thinking about reproductive health, what are the most common barriers affecting how refugees access pre-partum and postpartum care?****

Probe:

What types of services do pregnant women access most?

Where do women primarily give birth?

Do women access health care for their children once they are born?

10. **Do the refugees you serve access family planning services?****

What services do they access?

11. **What is your experience with refugees' attitude toward contraception use?****

What types of contraception do they utilize (any form of contraception)?

Do they use contraception properly?

In this next section, I would like you to think about your own experiences or experiences of those close to you in relation to accessing health care. Please remember, if you do not want to answer any specific question or do not want to share personal experiences, that is your choice.

(Identify which professional category the informant falls under and proceed with questions in that row only.)

<p><u>Health Care Provider</u></p>	<p>Are there certain health topics that you feel are especially difficult to talk about with your refugee patients?</p> <p>Are there any behavioral issues that are of special concern with your refugee patients?</p>
<p><u>VOLAG /MAA Representative</u></p>	<p>Have you ever had to give health care advice to the refugees you serve? Tell me about this.</p> <p>Were you able to respond to the refugee's concerns?</p> <p>Why did refugees come to you for health advice?</p> <p>On what health-related topics did refugees ask for your help? Have you ever had to accompany refugees to an appointment with a health care provider? Tell me about this.</p>

V. Health Promotion

1. **What improvements or changes can you suggest for existing services or programs for refugees?

Probe: Do changes need to be made in translation services?

Do we need improvements in existing services?

Do we need more affordable treatment?

Do we need new services?

What kind of services do we need?

What would you consider as a successful outcome in addressing the health issues of refugees in San Diego?

2. **Using your experiences, what would be the most effective way to promote health and safety among refugees?

3. Do you think health information and promotion measures (such as warning labels on products, health fairs, public service messages on the radio) directed towards the general U.S. population are effective in the refugee community?

Probe:

Why or why not?

VI. Future Studies

In the future, we plan to do a more detailed survey of refugees who have lived more than 1 year but not more than 5 years in the United States.

1. **In trying to reach a representative sample of the refugee community, what are your suggestions of the best way to communicate with refugees (e.g. telephone, in-person, mail etc.)

2. Do you have any suggestions on how to find recent refugee arrivals (e.g. door-to-door surveys, through refugee service organizations)

Probe: What times of the day would this population be most available?

What days of the week are best to reach this population?

What locations are best to reach certain populations?

3. **What advice would you give to someone planning to conduct a survey of refugees in San Diego?

4. Do you think the refugee community would be receptive to the idea of a health behavior/health status survey?

Probe:

Are there any topics that might be difficult to discuss?

Are there any settings/places in which it might be difficult to ask health-related

questions?

Are there any special difficulties in reaching women or talking about these subjects with women?

Are there any special difficulties in reaching men or talking about these subjects with men?

5. **What other agencies or health care providers do you recommend we talk to about San Diego County refugee health needs?

*******Show interviewee our latest list (get from Steve ahead of time) to see if they have any additions*******

6. We will be interviewing refugees who have lived in the U.S. between 1 and 5 years for this research project. Do you have any suggestions for refugees to interview within the community? What is the best way to contact them?

VII. Wrap Up

7. Would you like to add any special considerations to your responses above for a particular ethnic group?

8. Are there any other health conditions or health care-related issues affecting the refugees you would like to add?

9. Do you have any last questions or suggestions about the current refugee health situation in San Diego?

Thank you for participating in our study.
The information that you gave me will be very helpful to us.
We really appreciate you doing the interview today.

DO NOT FORGET TO WRITE THE FINISHING TIME AND ANY FIELD NOTES

Please refer to the first page 'Checklist' to complete all remaining tasks before excusing interviewer.

Please offer the interviewee payment and give them a receipt. Log payment in book.

Appendix 5

Consent Form

University of California, San Diego
Consent to Act as a Research Subject

In-Depth Interview Consent Form

Title of Research Project:

Assessment of Community Member Attitudes towards Health Needs of Refugees in San Diego

PURPOSE OF STUDY:

Kimberly C. Brouwer, Ph.D., is carrying out a research study to find out more about health needs in the refugee population of San Diego. She is interested in knowledge and opinions of community members about the main health problems affecting refugees and any difficulties in getting health care for the refugee population. Approximately 40 people in San Diego will be enrolled in the study. You have been asked to take part because you are familiar with refugee issues in San Diego and fall into one of the following categories: 1) health care provider who sees refugees on a regular basis, 2) employee/volunteer of an agency that helps refugees settle in the United States, 3) employee/volunteer of an agency that works with refugees on a personal basis (Mutual Assistance Agency), or 4) recent refugee who has lived in the United States for at least 1 year, but not more than 5 years. We look forward to learning from your knowledge and opinions of refugee health in San Diego.

The study will be carried out over the course of 9 months. Your participation in the study will only involve a 1 hour interview conducted at a single meeting session.

PROCEDURES

If you agree to participate, you will be interviewed by one of our study staff members. As part of this project, an audiotape recording will be made of the interview. This is completely voluntary and up to you. In any use of the audiotapes, your name will not be identified. You have the right to request that the tape be stopped or erased during the recording. The interview will last about 1 hour. The tapes will be destroyed within 120 days of the interview and no copies will be stored.

Do you give permission that the audiotapes can be studied by the research team for use in this project?

I give my permission; I do not give my permission_____ (initials)

The questions that you will be asked will be about where refugees get health care, any difficulties in getting health care, health needs of refugees, and common health problems. We will also ask you for your ideas on how best to reach the refugee community for future health studies. You do not have to answer any question that you do not want to answer. You may be asked your opinion on certain things like relevance of questions or ways to improve access to health services and basic care of refugees in San Diego.

RISKS/DISCOMFORTS

There are no physical risks of participation in this study.

The main risk of this study is to your privacy, because you will be providing your opinion and, if you wish to share them, possibly sharing personal experiences. Although study forms, written transcripts of the interview, and tapes will not contain your name, there is a small chance that someone may discover that you participated in this study. It is also your choice whether or not to tell people that you have taken part in this study.

There may be questions that you find hard to answer or that may make you feel uncomfortable. You may refuse to answer any question that you do not want to answer. The interviewer will try to answer questions you have and discuss any concerns you may have about any of the questions.

If you are injured as a direct result of participation in this research, the University of California will provide any medical care you need to treat those injuries. The University of California will not provide any other form of compensation to you if you are injured. You may call the Human Research Protections Program at (858) 455-5050 for further information about this, to find out about your rights as a research subject, or to report research related problems.

PAYMENT

You will receive 15 U.S. dollars for participating in this study, to compensate you for your time. You will receive this money even if you choose not to answer all of the questions. If you do not wish to receive this payment directly, we will use the funds towards conducting a more in-depth health study of refugees in the coming months.

BENEFITS

There are no direct benefits to you for taking part in this study. However, your participation in this study will help us to learn about the needs of refugees in San Diego and how to better serve them. Through oral presentations in public forums in San Diego and a written report, we hope to share this information with the refugee community, those who are trying to design better programs for refugee health needs, and any participants interested in finding out the results of our study.

CONFIDENTIALITY

Your experiences and opinions are personal. Every effort will be made to protect the confidentiality of the information that you provide.

To ensure this:

- Everyone working on this study has been trained to respect the privacy of study participants. They will never discuss what you have told them in a way that could identify you.

- Your name or other identifying information will not be on any notes or data. This consent form will be the only form with your name on it. It will be stored at the University of California, San Diego, in the USA in a locked drawer.
- We will never reveal that you participated or any other information about your visit to anyone else as far as the law will allow us.

CONTACT INFORMATION

A member of the research team has explained this study to you and answered your questions. If you have other questions or research-related problems, you may speak confidentially with Dr. Brouwer at (858)822-6467 or send her an e-mail at kbrouwer@ucsd.edu?.

It is your decision to join the study or not. You can drop out of this study at any time. If you ever do not want to answer a specific question you do not have to. If you withdraw from the study you will be asked whether you wish to take back your consent to use information gathered up to that point. You may inspect and make a copy of the records of your participation in this project.

Due to the nature of scientific research, the researcher also may withdraw you from the study at any moment.

You have received a copy of this consent document and the "Experimental Subject's Bill of Rights" to keep if you so desire.

If you agree to be in this study, please sign your name below:

Subject's signature

Witness to Consent Procedures

Translator's Signature (when applicable)

Date

CHR No.

Appendix 6

List of organizations from phone surveys

Map Link	Organization	Telephone	Address	City	Zipcode	Services Identified*
Resettlement and Voluntary Agencies Assisting Refugees						
R1	Alliance for African Assistance	(619) 286-9052	5952 El Cajon Blvd.	San Diego	92115	Rstl, JobPlc
R2	Bayside Community Center	(858) 278-0771	2202 Comstock St.	San Diego	92111	Edu, Lgl, ChldCre, Health
R3	Catholic Charities of the Diocese of San Diego	(619) 287-9454	4575 Mission Gorge Place	San Diego	92120	Rstl, Edu, JobPlc, Lgl, HP, Health
R4	Episcopal Community Services	(619) 228-2800	4305 University Ave.	San Diego	92105	
R5	Horn of Africa	(619) 583-0532	5348 University Ave., Ste. 108	San Diego	92105	Rstl, Edu, Lgl, HP, Health, maternal health/families together school readiness
R6	Jewish Family Services	(858) 637-3030	8804 Balboa Ave.	San Diego	92123	Rstl, JobPlc, Lgl
R7	Kurdish Human Rights Watch	(619) 447-9933	1109 E. Washington Ave.	El Cajon	92016	Rstl, Edu, JobPlc, Lgl
R8	License to Freedom	(619) 286-3789	5348 University Ave., Ste. 107	San Diego	92105	Domestic Violence/Crisint HP, SS, PT, OT, Psych (PTSD, Anxiety, Depression), MD (1/Month)
R9	Loving Care Adult Day center	(619) 718-9778	2565 Camino Del Rio South	San Diego	92108	
R10	MAXIMUS - El Cajon (Calworks Cash Assistance Program)	(619) 937-4406	1300 N. Johnson Ave., Ste. 100	El Cajon	92020	Welfare to Work Program
R11	MAXIMUS - Lemon Grove (Calworks Cash Assistance Program)	(619) 937-4524	7150 Broadway	Lemon Grove	91945	Welfare to work program, JP, ChldCre, Clothing, Transportation, Books for School
R12	Mid-City Adult Education Center	(619) 388-4500	3792 Fairmount Ave.	San Diego	92105	Edu, ESL, computer, High School Programs
R13	National Latino Research Center	(760) 750-3504	333 South Twin Oaks Valley Rd.	San Marcos	92096	Edu
R14	Nile Sisters Development Initiative	(619) 265-2959	6035 University Ave.	San Diego	92115	Edu, HP, Translation, Prenatal care Edu, Medical application, food stamps, choosing PCP, diapers, sanitary supplies, Health plans

Map Link	Organization	Telephone	Address	City	Zipcode	Services Identified*
R15	Project Concern International	(858) 279-9690	5151 Murphy Canyon Rd.	San Diego	92123	Edu, JobPlc, HP
R16	Scripps Mercy City Heights Wellness Center, Hooyo Health Program	(619) 321-2924	4440 Wightman St.	San Diego	92105	Edu, HP, WIC
R17	Somali Bantu Community of San Diego	(858) 610-6144	6035 University Ave., #25	San Diego	92105	JP, HP, Home visits
R18	Somali Families of San Diego	(619) 277-0402	5150 University Ave.	San Diego	92105	
R19	Somali Family Service	(619) 265-5821	6035 University Ave.	San Diego	92115	Edu, JP, HP, Transportation
R20	South Sudan Christian Youth	(619) 858-1861	6035 University Ave.	San Diego	92115	Edu, JP, Welfare to work
R21	Southern Sudanese Community Center	(858) 405-6120	4077 Fairmount Ave.	San Diego	92105	Edu, JP, HP, Cultural awareness/domestic violence Edu
R22	St. Luke Refugee Network	(619) 757-8514	3725 30th St.	San Diego	92104	Edi, JP, transportation to work
R23	The Aja Project	(619) 223-7001	5253 El Cajon Blvd.	San Diego	92115	Edu
R24	The International Rescue Committee	(619) 641-7510	5348 University Ave.	San Diego	92105	Rstl, Edu, JobPlc, Lgl, ChldCre
R25	Vietnamese Federation of San Diego	(858) 292-1778 (858) 967-0035	7833 Linda Vista Rd.	San Diego	92111	HP, Cultural events, Free health care screening
Health care Providers						
H1	Advanced Pediatric Medical Group	(858) 268-0702	4282 Genessee Ave.	San Diego	92117	Peds
H2	Areta Crowell Center	(619) 233-3432	531 16th St.	San Diego	92101	MH, MedMgmt, Soc
H3	Asian Pacific Health Center	(619) 582-2360	5871 University Ave., Ste. 334	San Diego	92115	Family care and prevention services
H4	Broadway Medical Center	(619) 590-0097	1160 Broadway	El Cajon	92021	FM
H5	Central Adult Center (Douglas Young Satellite)	(619) 291-9611	2864 University Ave.	San Diego	92104	MH, MedMgmt
H6	Central Region PHC	(619) 229-5400	5202 University Ave.	San Diego	92105	FM, Gyn, Peds
H7	Children's Primary Care Medical group	(619) 442-3560	1662 East Main St.	El Cajon	92021	Peds
H8	City Heights Family Health Center	(619) 515-2400	5379 El Cajon Blvd.	San Diego	92115	FM, Gyn, Peds
H9	Clairemont Villa Adult Day Health Center	(858) 576-8575	5150 Murphy Canyon Road, Ste. 101	San Diego	92123	Health

Map Link	Organization	Telephone	Address	City	Zipcode	Services Identified*
H10	Community Health Systems, Inc.	(760) 728-3816	617 E. Alvarado St.	Fallbrook	92028	FM
H11	Consumer Center for Health Education & Advocacy (CCHEA)	(877) 734-3258	1475 Sixth Ave., 4th Floor	San Diego	92101	MH, County Resident Beneficiaries of the Managed Care or Fee-for-Services System
H12	Destia Digestive Dise	(619) 266-3332	292 Euclid Ave.	San Diego	92114	Gastroenterology
H13	Douglas Young Clinic	(858) 695-2211	10717 Camino Ruiz, #207	San Diego	92126	MH, Med. Manag., CrisInt, Crisis & Comm. Support, Psych Testing
H14	Dr. Angela Panah	(619) 447-6001	1319 E. Main St.	El Cajon	92020	
H15	Dr. Boris Khamishon	(619) 582-2595	6699 Alvarado Rd., Ste. 2301	San Diego	92120	
H16	Dr. Deena Tajran	(858) 578-9600	10737 Camino Ruiz	San Diego	92126	
H17	Dr. Duc Dinh Vo	(858) 560-1226	2418 Ulric St.	San Diego	92111	FM
H18	Dr. Freydoun Alavi (retired); Dr. Bakster Jones	(858) 277-1113	8008 Frost St.	San Diego	92123	
H19	Dr. Gertser	(619) 582-8055	6367 Alvarado Ct. #202	San Diego	92120	
H20	Dr. Ibrahim	(619) 515-2300	1809 National Ave.	San Diego	92113	MH
H21	Dr. Joanna Nawroski-Wozniak	(619) 584-3215	4440 Euclid Ave.	San Diego	92115	FM, IM
H22	Dr. Khang Van Tran	(858) 569-8537	6947 Linda Vista Rd.	San Diego	92111	FM
H23	Dr. Lieu Nguyen	(619) 265-2262	5296 University Ave. #1	San Diego	92115	
H24	Dr. Mohammad Bailony	(619) 470-1945	502 Euclid Ave., #104	National City	91950	FM, Peds
H25	Dr. Nagmo Fatukara	(858) 279-1223 ext. 455	4550 Kearny Villa Rd.	San Diego	92123	MH
H26	Dr. Nguyen Le	(619) 582-8814	5507 El Cajon Blvd.	San Diego	92115	Peds
H27	Dr. Oleg Gavrilyuk	(619) 287-9730	5555 Reservoir Dr.	San Diego	92120	
H28	Dr. Tim Gurtch	(619) 265-1070	4276 54th Place	San Diego	92115	FM, Gyn, minor surgeries
H29	Dr. Trung Q. Tran	(619) 281-3443	4139 University Ave.	San Diego	92105	FM
H30	East Corner Clubhouse	(619) 440-5133	1060 Estes St.	El Cajon	92020	MH, JobServ, Peer & Social Support Prog, other

Map Link	Organization	Telephone	Address	City	Zipcode	Services Identified*
H31	East County Mental Health Clinic	(619) 401-5500	1000 Broadway Ave., Ste. 210	El Cajon	92021	MH, Med. Manag., Crisis Interv.
H32	El Cajon Family Medical Center	(619) 280-7185	4551 El Cajon Blvd.	San Diego	92115	IM
H33	El Cajon Pediatric Medical Group, Inc.	(619) 442-0945	860 Jamacha Rd.	El Cajon	92019	Peds
H34	Family Medical Clinic	(619) 230-8810	2980 National Ave.	San Diego	92113	FM, Psychiatric, Nutrition
H35	Gateway Pediatrics and Family Care	(619) 264-1934	995 Gateway Center Way	San Diego	92103	FM, Peds
H36	Golden House Adult Day Health Care	(619) 667-0996	7373 University Ave., Ste. 110	La Mesa	91941	Health, Skilled Nursing, Occupational Therapy
H37	Grossmont Hospital	(619) 465-0711	5555 Grossmont Center Dr.	La Mesa	91942	Emergency Department
H38	Halcyon Center	(619) 579-8685	1664 E. Broadway	El Cajon	92021	MH, START
H39	Harmony Medical Group	(619) 667-0055	7839 University Ave.	La Mesa	91941	FM
H40	Heartland Center (BPSR East)	(619) 440-5133	1060 Estes St.	El Cajon	92020	MH, MedMgmt, Crisis interv., Case mang., Soc, JobServ
H41	Imperial Beach Community Clinic	(619) 429-3733	949 Palm Ave.	Imperial Beach	91932	FM, Peds
H42	Jary Barreto Crisis Center	(619) 232-4357	2865 Logan Ave.	San Diego	92113	MH, START
H43	Johnson Medical Group	(619) 267-4255	2400 E. 8th St.	National City	91950	FM, IM, Peds
H44	La Maestra Community Health Center-Women's Clinic	(619) 434-7308	101 N. Highland Ave., Ste. A	National City	91950	FM
H45	La Maestra Community Health Center-El Cajon City Medical Clinic	(619) 312-0347	165 South First St.	El Cajon	92019	FM, Gyn, Peds, Health, N, Social Services, JobServ
H46	La Maestra Community Health Center-Medical Main Clinic	(619) 280-1105	4185 Fairmount Ave.	San Diego	92105	FM, Dental, Transportation, Health, SS, JobServ, N
H47	Linda Vista Health care Center or San Diego Family Care	(858) 279-0925	6973 Linda Vista Rd.	San Diego	92111	FM, Gyn, MH, Ger, Peds
H48	Logan Heights Family Health Center	(619) 515-2526	1809 National Ave.	San Diego	92113-2196	FM, Dental, Gyn, Peds
H49	MHS, Inc./Case Management-Dual Diagnosis	(619) 276-2157	1202 Morena Blvd., Ste. 301	San Diego	92110	MH

Map Link	Organization	Telephone	Address	City	Zipcode	Services Identified*
H50	MHS, Inc./Case Management-North	(760) 743-3312	474 W. Vermont Ave., Ste. 101	Escondido	92025	MH
H51	Mid-City Community Clinic-Adults or San Diego Family Care	(619) 563-0250	4290 Polk Ave.	San Diego	92105	FM
H52	Mid-City Community Clinic-Pediatrics or San Diego Family Care	(619) 280-2058	4305 University Ave.	San Diego	92105	Peds
H53	Multi-Cultural Primary Care Group	(619) 262-7523	286 Euclid Ave.	San Diego	92114	FM, IM, Peds
H54	Neighborhood Health Care El Cajon	(619) 440-2751	855 E. Madison Ave.	El Cajon	92020	FM, IM, Dental, Gyn, Ger, Peds
H55	Neighborhood Health Care Escondido	(760) 520-8100	460 N. Elm St.	Escondido	92025	FM, IM, Ger, Peds
H56	Neighborhood Health Care Pennsylvania Ave.	(760) 520-8200	641 E. Pennsylvania #102	Escondido	92025	FM, IM
H57	Neighborhood Health Care Women's Center	(760) 737-2020	401 E. Valley Parkway	Escondido	92025	Gyn
H58	New Alternatives, Inc. Cabrillo	(619) 224-4642	4307 Third Ave.	San Diego	92103	MH, Day treatment
H59	New Vistas Crisis Center	(619) 239-4663	734 Tenth Ave.	San Diego	92101	MH, START
H60	North Central Mental Health Center	(619) 692-8750	1250 Morena Blvd.	San Diego	92110	MH, MedMgmt, CrisInt
H61	North Coastal Mental Health Center	(760) 967-4475	1701 Mission Ave., Ste. A	Oceanside	92054	MH, MedMgmt, CrisInt
H62	North Park Family Health Center	(619) 515-2424	3544 30th St.	San Diego	92104	FM, Gyn, Peds, General Practice, Adult Practice, HIV Clinic
H63	Office of the Public Conservator	(619) 692-5664	3851 Rosecrans St.	San Diego	92110	MH, Investigation and Related Services
H64	Palomar Medical Center-Mental Health Unit	(760) 739-3240	555 E. Valley Pkwy.	Escondido	92025	MH, Acute Psychiatric Inpatient Care
H65	Paradise Valley Family Health Center	(619) 470-4321	655 S. Euclid Ave.	National City	91950	
H66	Paradise Valley Hospital (Emergency Room)	(619) 470-4321	2400 E. First St.	San Diego	91950	Gyn, Peds, Acute Care Hospital, Rehab
H67	Pham and Tuong MDS	(619) 287-7835	5296 University Ave.	San Diego	92105	FM
H68	Physicians Health Care Medical Group	(619) 668-1515	7339 El Cajon Blvd., Ste. H	La Mesa	91941	FM, one doc specializes in Cardio/Internal med.

Map Link	Organization	Telephone	Address	City	Zipcode	Services Identified*
H69	Pomerado Hospital-Behavioral Medicine Center	(858) 613-5640	15615 Pomerado Rd.	Poway	92064	MH, Acute Psychiatric Inpatient Care
H70	Project Enable	(619) 263-6155 ext113	286 Euclid Ave., Ste. 102	San Diego	92114	MH, MedMgmt, CrisInt, JobServ
H71	Project ESSEA	(858) 829-8735	3435 Camino Del Rio South	San Diego	92108	MH, SS, Domestic Violence, Cultural Training
H72	Providence Community Services (EPSDT)	(619) 640-3266	4660 El Cajon Blvd., Ste. 210	San Diego	92115	MH, Individual, Group & Family Therapy, Clinic & School-based services
H73	San Diego Internists and Pediatric	(858) 541-0181	8765 Aero Dr.	San Diego	92117	IM, Peds
H74	Scripps Mercy Clinic	(619) 686-3630	4020 Fifth Ave.	San Diego	92103	IM, Gyn, Peds, Podiatry
H75	Scripps Mercy Hospital-Behavioral Health	(619) 260-7005	4077 Fifth Ave.	San Diego	92103	MH, Acute Psychiatric Inpatient Care, Psychiatric Assessment
H76	Sharp Memorial Hospital	(858) 499-4652	7930 Frost St.	San Diego	92123	FM, IM, Gyn, MH, Ger, Peds, Oncology, Alcohol & Drug Dependency
H77	Sharp Mission Park Urgent Care	(760) 806-5400	130 Cedar Rd.	Vista	92083	Emergency department
H78	Sharp Rees-Stealy La Mesa Family Medicine	(619) 644-6974	5525 Grossmont Center Dr.	La Mesa	91941	FM, IM, Podiatry, Surgery
H79	Sharp Rees-Stealy La Mesa West Family Medicine	(619) 644-6974	7862 El Cajon Blvd.	La Mesa	91941	FM, IM, Podiatry, Surgery
H80	Sharps Rees-Stealy El Cajon Family Medicine	(619) 644-6974	1240 Broadway Ave.	El Cajon	92021	FM, IM, Podiatry, Surgery
H81	South Bay Guidance Center	(619) 427-4661	835 Third Ave., Ste. C	Chula Vista	91911	MH, MedMgmt, CrisInt
H82	STEPS III	(858) 467-1418	4830 Viewridge Ave.	San Diego	92123	MH, Day Treatment Intensive, Limited Outpatient, Intensive Case Management
H83	Survivors of Torture International	(619) 278-2404	3990 Oldtown Ave., Building C, Ste. 201	San Diego	92175	MH
H84	Turning Point Crisis Center	(760) 439-2800	1738 S. Tremont St.	Oceanside	92054	MH, START

Map Link	Organization	Telephone	Address	City	Zipcode	Services Identified*
H85	UCSD Free Clinic for Sudanese	(619) 219-9446	First Lutheran Church, 1420 Third Ave.	San Diego	92101	FM
H86	UCSD Free Clinic, Baker Clinic	(858) 534-6110	Baker Elementary, 4041 T St.	San Diego	92113	FM, IM, Dental, Gyn, MH, Diabetes Clinic, Cardiovascular Clinic
H87	UCSD Free Clinic, Pacific Beach	(858) 534-6110	Pacific Beach United Methodist Church, 1561 Thomas Ave.	San Diego	92109	FM, IM, Dental, Gyn, MH, Diabetes Clinic, Cardiovascular Clinic
H88	UCSD Gifford Clinic- Outpatient Psychiatric Services	(619) 299-3510	140 Arbor Dr.	San Diego	92103	MH, MedMgmt, CrisInt, SS
H89	UCSD Medical Center Emergency Department	(619) 543-6217	200 West Arbor Dr.	San Diego	92101	Emergency department
H90	UCSD Medical Group, UCSD Ambulatory	(619) 543-6794	4168 Front St.	San Diego	92103	FM, IM, Gyn, MH, Ger, Peds, Neurology, Neurosurgery, Audiology, Infusion, Cancer, Owen Clinic for HIV/AIDS, Cardiology
H91	UCSD Mother, Child and Adolescent HIV Program	(619) 543-8080	150 W. Washington St.	San Diego	92103	MH, HIV and AIDS care
H92	University Community Medical Center (Promise Hospital of San Diego)	(619) 582-3516 ext.8001 (619) 582-3800	5550 University Ave.	San Diego	92905	FM, IM, MH
H93	UPAC Counseling and Treatment Center	(619) 299-2999	5348 University Ave., Ste. 101	San Diego	92105	MH, MedMgmt, CrisInt
H94	UPAC East Wind Socialization Center	(858) 268-4933	2359 Ulric St.	San Diego	92111	MH, MedMgmt, CrisInt, Soc
H95	UPAC Economic Development Services	(619) 286-8880	3288 El Cajon Blvd., Ste. 5	San Diego	92104	MH, Addiction/Treatment Recovery Services, Economic Development; MH Child & Adult
H96	UPAC Multi-Cultural Family Services	(619) 232-6454	1031 25th St.	San Diego	92102	MH, Indiv., Group & family therapy, CrisInt, Case management
H97	Vietnamese Refugee Relief Committee	(858) 292-1778	6255 University Ave.	San Diego	92115	FM
H98	Villa View Community Hospital	(619) 265-9976	5550 University Ave.	San Diego	92105	

Map Link	Organization	Telephone	Address	City	Zipcode	Services Identified*
H99	Villa View Community Hospital	(619) 585-3000	709 Third Ave.	Chula Vista	91910	Psychiatry FM, Dental, MH, Peds, Women's Center, Nurses Clinic, Teen Clinic, HP, Smoking Cessation
H100	Vista Community Clinic	(760) 631-5000 ext.1135	1000 Vale Terrace	Vista	92084	
H101	Western Dental Center	(619) 294-4500	2948 University Ave.	San Diego	92104	Dental
H102	Western Dental Center	(619) 521-0012	4123 University Ave.	San Diego	92105	Dental
	Key to Abbreviations:					
	* ChldCre=Child Care, CrisInt=Crisis Intervention, D=Dental, Edu=Education, FM=Family Medicine, Ger=Geriatrics, Gyn=Gynecological, HP=Health Promotion, Health=Health Education, IM=Internal Medicine, JobPlc=Job Placement, JobServ=Vocational Services, Lgl=Legal Services, MedMgmt=Medication Management, MH=Mental Health, N=Nutrition, Peds=Pediatrics, Rssl=Resettlement, SS=Social Services, Soc=Socialization, STAR=Short – Term Acute Residential Treatment					

Appendix 7

Glossary of Terms

Glossary of Terms

- ❖ **Acculturation:** a merging and adoption of behavior patterns between cultures as a result of prolonged contact
- ❖ **Hypertension:** hypertension is an arterial disease characterized by high blood pressure, especially the diastolic blood pressure.
- ❖ **Latent Tuberculosis:** Latent tuberculosis or Latent TB infection or LTBI all refer to tuberculosis infection where the disease is not active. Someone with latent TB is not contagious. The major concern with Latent TB is that a small number of people with Latent TB will later develop an active infection.
- ❖ **MAA:** is an acronym for Mutual Assistance Agency or Mutual Assistance Association. The term is used to describe community-based organizations serving refugees that often have refugees or former refugees on their staff. In contrast to VOLAGs, Mutual Assistance Agencies often focus on issues occurring after initial refugee resettlement.
- ❖ **Refugee:** According to the UN Convention on Refugees, "any person who is outside any country of such person's nationality... and who is unwilling or unable to return... because of persecution or a well-founded fear of persecution on account of race, religion, nationality, membership in a particular social group, or political opinion."² In this assessment the term refugees also includes secondary refugees, asylees and parolees.
- ❖ **Sexually Transmitted Infections (STIs):** Sexually transmitted infections are infections that are usually passed from person to person by sexual contact, but can also be passed by child birth, breastfeeding or contaminated blood or syringes.
- ❖ **Somatization:** is a diagnosis applied by doctors to patients who suffer from physical symptoms but no underlying physical problem. The physical symptoms are usually caused by psychological problems.
- ❖ **Triangulate (look in text for definition):** Using multiple methods to explore and evaluate a question in order to maximize reliability and validity of the results.
- ❖ **UCSD:** University of California San Diego.
- ❖ **VOLAG:** Voluntary Agencies, or refugee resettlement agencies who are contracted by the Office of Refugee Resettlement to resettle refugees over their first 8 months in the United States.