Health care of refugee women

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BACKGROUND
Women refugees have endured major discrimination and poverty in their countries of origin or countries of displacement. This has had a major impact on their physical and psychological health. The experience of resettlement places a further burden on their health.

OBJECTIVE
This article aims to provide a simple approach to the health assessment and management of women refugees, taking into account specific issues related to migration and resettlement.

DISCUSSION
Because of the complexities of their realities related to gender, social and economic status, and premigration and resettlement experiences, women refugees need a multiplicity of health interventions. The identification of the major physical and psychological health issues with consideration of gender issues and premigration and resettlement experiences, represents more adequate basis for the assessment and management of the health care of women refugees.

The complex experiences of women refugees in their countries of origin and in refugee settings have a major impact on their health. In recent years, primary health care services in Australia and other countries of resettlement have addressed the specific health care needs of women refugees. The aspects of assessment and management described in this article are based on the experience of these services including the experience of a state funded medical service for women refugees in South Australia.[1–5]

This article incorporates some of the procedures developed by the service, a collaborative initiative between Women's Health Statewide and the Migrant Health Service, started in 1994.

Health issues

During life in their country of displacement, and in refugee camps where they may have spent protracted periods, women refugees have been routinely exposed to violence and extreme poverty. Furthermore, access to basic needs such as adequate food and water, education, and income generating and resettlement opportunities would have been limited. These factors, together with the relative lack of gender specific health care, have had a major impact on their physical and psychological health.[6–10]

At their point of entry in countries of resettlement women, like men, are likely to experience a large number of acute and chronic health problems.[11]

Health issues – physical

- Chronic diseases including diabetes, hypertension and heart disease
- Infectious and parasitic diseases such as hepatitis B and C, tuberculosis, malaria and schistosomiasis
- Nutritional deficiencies such as folate, iron and vitamin D deficiency
- Anaemia – which threatens women more than men because of chronic malnutrition and endemic deprivation. Common causes are:
  - iron deficiency due to chronic blood loss caused by intestinal parasitic infections, menstruation, malabsorption, multiple pregnancies close together and concurrent, prolonged breastfeeding
  - folate deficiency
  - hemoglobinopathies, commonly thalassaemias and sickle cell anaemia
- Reproductive health issues[12,13]
  - high rates of poor pregnancy outcomes (miscarriage, preterm labour, low birth weight babies), unsafe abortions
  - complications from gynaecological surgery
  - complications of female genital circumcision including vulval scarring and chronic vulva and pelvic pain, urinary tract infection, menstrual problems and complications during pregnancy and childbirth
- Sequelae of gender based violence
  - physical effects – mutilation and deformities leading to chronic musculoskeletal problems, sexually

transmitted infections (STIs), notably HIV, chlamydia, syphilis and gonorrhoea.
  - psychological effects – post-traumatic stress disorder (PTSD), anxiety, depression, low self esteem, relationship difficulties; somatic symptoms of fatigue, headaches, insomnia, generalised pain and anorexia
- General conditions including dental problems and incomplete immunisation.

Health issues – mental

Resettlement stress arises from dealing with pressing needs such as housing, transport, finances, social security and immigration. Increasingly, women head many newly arrived African families. Adjusting to a new culture brings about change in roles and the dynamic of relationships within the family, which can often become strained. As a result many women become more vulnerable to family violence.

Grief is experienced because of the loss of or traumatic separation from their loved ones whose whereabouts are often unknown. Women may also be in constant fear for the safety of their relatives left behind in the countries still stricken by conflict, or in refugee camps. As a result the memories of past trauma are kept alive.[5,14]

Health assessment

Assessment and management require understanding of the impact of culture and of migration and resettlement on the health of women refugees. The explanatory model approach proposed by Kleinman has provided a suitable framework to establish a culturally sensitive therapeutic relationship.[15]

The model emphasises a patient centred approach to explore the influence of culture on health, on the perceived causes of illness and on therapeutic relationships. Therefore, by following the woman's narrative of her presenting problem, the practitioner gains insight into how the woman 'understands, feels, perceives, and responds' to the problem and also what is at stake for her family and community. The model also provides the practitioner with self monitoring tools to critically reflect on the impact of his/her belief system and practices.

Important elements of the therapeutic encounter are the use of a qualified female interpreter and adequate allocation of time. The interpreter's role as the woman's 'voice', in the background, and bound, like the practitioner, by absolute respect of confidentiality must be stressed. The constant focus of the consultation must be between the practitioner and the woman. The request to involve a family member, in particular a spouse, often presents a cultural challenge. While sometimes it may be appropriate initially to do so, it is important to point out that accurate diagnosis and management require the language skills of a qualified interpreter who should be booked for future consultations.

Time has a cultural meaning. The time to greet, smile and involve family members can open new paths in developing trust and rapport.

History taking

- History of health problems and treatment before migration
- Migration and resettlement history detailing life in country of origin, country of displacement other host countries, or time spent in refugee camps.

It is also important to enquire about the woman's circumstances of seeking refuge and with whom she migrated, time separated from family, family left behind and if she is in touch with them, the current composition of her family, relationships and adjustment, how she deals with multiple resettlement demands, and links with her own community and support agencies (see *Case study 1*).

- Reproductive health history including:
  - obstetric and gynaecological history with specific attention to complications during pregnancy, delivery, abortion and menstrual problems
  - contraceptive history
  - sexual history including past history of STIs and level of awareness of safer sexual practices
  - female genital circumcision and related complications. As many women may not find it appropriate to talk directly about this issue, it is useful to start by enquiring about cultural/family practices. This issue may be further addressed as part of the preventive health examination (see *Resources*)
- Mental health history including:
  - details of experience of PTSD, anxiety, depression, grief and loss and somatic symptoms (see *Case study 2*).

Physical examination

It is important to consider that many women are unfamiliar with their anatomy, in particular

Case study 1

Mrs B migrated to Australia with her husband and five children after having spent 4 years in a refugee camp in Guinea. They lived in Liberia until the war broke out in 1996. She was assaulted and sustained major injuries to the pelvis and legs. Her son and brother were killed. The family was taken to the Ivory Coast by peacekeeping forces. In 2002, when another war erupted, while fleeing to Guinea, they become separated from the two older children. Soon after their arrival to Australia, the Red Cross located the children in a refugee camp in Kenya. With the support of the Australian Refugee Association, she applies for a resident visa for her children and patiently engages with the immigration department.

Case study 2

Mrs D and her two teenage daughters are refugees from Afghanistan. The Talibans killed her husband 7 years ago. For the past 12 months she has been suffering from constant headaches, generalised body aches, intermittent episodes of left sided chest pain, palpitations and shortness of breath. Apart from mild hypertension, no causes are found for her symptoms. Since coming to Australia, her appetite and sleep have been poor. She constantly thinks about her two sons left behind in Pakistan and spends most of her time at home, as she has stopped attending English classes because of difficulties with concentration. Above all, she fears that if she dies suddenly there will be no-one to look after her daughters.

their reproductive organs, and might never have had a physical, breast or internal examination performed. Many women experience embarrassment when asked to uncover their bodies, even in front of a woman practitioner (see *Case study 3*).

Investigations

In addition to routine screening tests to detect anaemia, nutritional deficiencies, and acute and chronic diseases,[11] it is necessary to perform preventive health screening tests including a Pap test, vaginal swabs for STIs (urine test for chlamydia may be a useful preliminary screening test if pelvic examination is not appropriate), and screening mammography where indicated.

Case study 3

Mrs G, 53 years of age, has recently arrived from Iran with her husband and three children. She is postmenopausal and has been treated in Iran for type 2 diabetes for the past 3 years. She has never had a Pap test or mammography screening. She presents accompanied by her eldest daughter who has persuaded her to seek treatment for a longstanding problem of vaginal pain and discharge. Mrs G discloses her embarrassment and is agreeable to having a vaginal examination.

Management

The management plan needs to be developed with consideration of the individual woman's needs and the practical, financial and cultural issues that impact on her life in the initial stage of resettlement. It must clearly outline practical aspects such as prescribing and follow up plans and referrals. Liasing with migrant health and support services facilitates the woman's introduction to the Australian health care system.

The management plan should include treatment of conditions found in the assessment phase. The complex interplay between nutritional deficiencies, poorly treated chronic conditions, and anaemia requires prompt attention, particularly in pregnancy. For example, pregnant women suffering from malaria, especially during their first pregnancy, are more vulnerable to the most severe manifestations and complications of this disease because of decreased immunity;[16] and addressing reproductive health issues and choices. This may include discussions about sexuality, body perception and cultural attitudes toward fertility and family size.[17]

Many African women have never received family planning counselling and contraception information. They tend to hold fertility and motherhood in high regard and as a result have short spacing between births. In discussing contraception it is preferable to explore attitudes and birth spacing practices rather than raising directly the issue of contraception.

A discussion about contraceptive options needs to take into account the woman's general physical state, as well as practical, financial and cultural considerations. For example the use of barrier methods such as condoms can be difficult because of lack of access or knowledge about condom use as well as cultural attitudes about women negotiating safer sex. Slow release long term contraception (such as depot-medroxyprogesterone) tends to decrease menstrual flow and may be suitable for anaemic women. Combined oral contraceptives are safe and effective in women undergoing treatment for malaria and schistosomiasis and are preferable to intrauterine devices for women suffering from sickle cell anaemia.[16]

In providing oral contraception it is important to give simple, clear information on pill taking, and to arrange for further visits to review the effectiveness and suitability of the contraceptive options.

The management of blood borne and STIs requires a sensitive approach. Explanations about how infection is spread, assurance regarding confidentiality, preparedness to deal with the uncovering of trauma and violence, clear explanation about treatment and outcome, and counselling regarding safer sexual practices are all important aspects of the consultation.

Women who have undergone female genital circumcision need specific care if they suffer from complications associated with this practice especially during pregnancy (*Table 1*).

Table 1. Resources – women affected by female genital mutilation

Information

- Female genital mutilation: information for Australian health professionals produced by the National Education Program on Female Genital Mutilation (FGM) and published by The Royal Australian College of Obstetricians and Gynaecologists Available at www.ranzcog.edu.au/publications/pdfs/FGM-booklet-sept2001.pdf
- Female genital mutilation: a self directed learning package for counsellors produced by the NSW Education Program on Female Genital Mutilation. Copies are available by contacting the Area Multicultural Health Unit, Cumberland Hospital, Locked Bag 7118, Parramatta BC 2150. Phone 9840 3910, fax 9840 3755

Programs

Victoria: FARREP (Family And Reproductive Rights Education Program). Program designed to support, advocate for, and inform African women and those affected by female genital mutilation attending the Royal Women's Hospital. Referrals are accepted from women, GPs, hospital and other community agencies. Phone 9344 2211

South Australia: Female Genital Mutilation Program includes education programs and resources for service providers. For information contact Women's Health Statewide on 08 8239 9600 or www.whs.sa.gov.au

Early intervention for mental health issues

Through the woman's narrative of her presenting problem and her journey, it is possible to explore the depth of her suffering, and develop therapeutic interventions and partnerships with specialist services.

Preventive health

Preventive health and health promotion interventions include:

- Pap test – before taking a cervical smear it is useful to explain, possibly with the aid

of a pelvic model or other visual material, about anatomy and to demonstrate the process and the purpose for taking a smear
- Breast examination and, during the perimenopausal and postmenopausal period, mammography
- Dietary and nutrition advice – for many newly arrived women finding traditional, affordable food can be difficult initially. This, in conjunction with eating disturbances linked with depression or PTSD can prolong nutritional deficiencies and anaemia, and lead to constipation and pain. Other women need to be alerted about the cardiovascular and metabolic risks of switching to a diet rich in simple carbohydrates and sugars, in particular soft drinks. Women of childbearing age should be counselled regarding folic acid supplementation
- Provision of immunisation
- Referral for further investigations and specialist services are often required. In the initial stage it is crucial to provide assistance with making appointments and linking with support resettlement agencies. Support may also be necessary for emergency housing, immigration and social security issues (see *Case study 4*).

Case study 4

Mrs C, 55 years of age, and her three children are the only family survivors from the Burundi 1993 war. They first migrate from a camp in Tanzania, where they lived for 13 years, to Darwin. There, the children are frequently harassed. Mrs C develops severe shoulder pain following a fractured arm for which she received only emergency treatment. The family move to Adelaide where they contact a resettlement service that provides the assistance of an African community worker who brings her to the migrant health service. The worker assists to attend medical appointments and trauma counselling, orientation with the public transport system, application for priority housing, communicating with Centrelink, and initially with English home tutoring.

Conclusion

A management plan for the health care of a refugee woman presents significant challenges for the general practitioner. However, there are increasing resources through the advocacy and commitment to quality of care of professional bodies (see *Resources*). The recently introduced Medicare Benefit Schedule items 714 and 716 for health assessment of refugees and humanitarian entrants will also assist GPs in this challenging task.

Resources

- Medicare Benefit Schedule Items 714 and 716 for health assessments for refugees and other humanitarian entrants: www.health.gov.au/mbs/
- The RACGP Refugee and Asylum Seeker Resource Centre: www.racgp.org.au/refugeehealth/
- Translating and Interpreting Service: 131 450, Doctor's Priority Line 1300 131 450, www.immi.gov.au/tis/
- Agencies providing integrated humanitarian settlement services: www.refugeecouncil.org.au/docs/general/IHSS_providers_0506.pdf
- The Victorian Foundation for Survivors of Torture and Trauma Inc: Phone 03 9388 0022, www.foundationhouse.org.au email info@foundationhouse.org.au
- Queensland Program of Assistance to Survivors of Torture and Trauma: www.qpastt.org.au
- Service for the Treatment and Rehabilitation of Torture and Trauma Survivors in New South Wales: www.startts.org
- Multicultural Mental Health Australia: www.mmha.org.au/
- Multicultural Health Resources – women's health: www.health.qld.gov.au/multicultural/cultdiv/womens_health.asp
- Refugee Council of Australia: www.refugeecouncil.org.au/
- Australian Refugee Association: www.ausref.net/
- New South Wales Refugee Health Service: www.refugeehealth.org.au
- Migrant Health Service (SA): Phone 08 8237 3900.

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