Third World Health Care in Urban Utah

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Many physicians have the perception that to be involved in the health care of underserved or Third World people, it would be necessary to leave the country or at least go to a remote area of the United States for an extended period of time. In actuality, there are many Third World people now living in most urban areas of the United States. The most recently arrived group is the Southeast Asian refugee population. Since the fall of the American-backed government in Vietnam, some 600,000 Southeast Asian refugees have entered this country. In Utah there are about 10,000 Southeast Asian refugees, and most of them live along the Wasatch Front. Salt Lake County ranks seventh in the nation for the highest number of refugees per capita, with about 7,500 Asian refugees. Furthermore, some 70 new refugees per month continue to enter the state. This immigration by Southeast Asians is projected to continue for several more years.

Other significant disadvantaged groups or Third World populations in Utah include native Americans, Hispanic groups, and South Pacific Islanders. In the 1980 census, there were some 30,000 people who identified themselves as being of Hispanic origin. The county officials working with migrant Mexican populations in the state believe there are another 7,000 to 10,000 migrant Mexicans not officially listed in the

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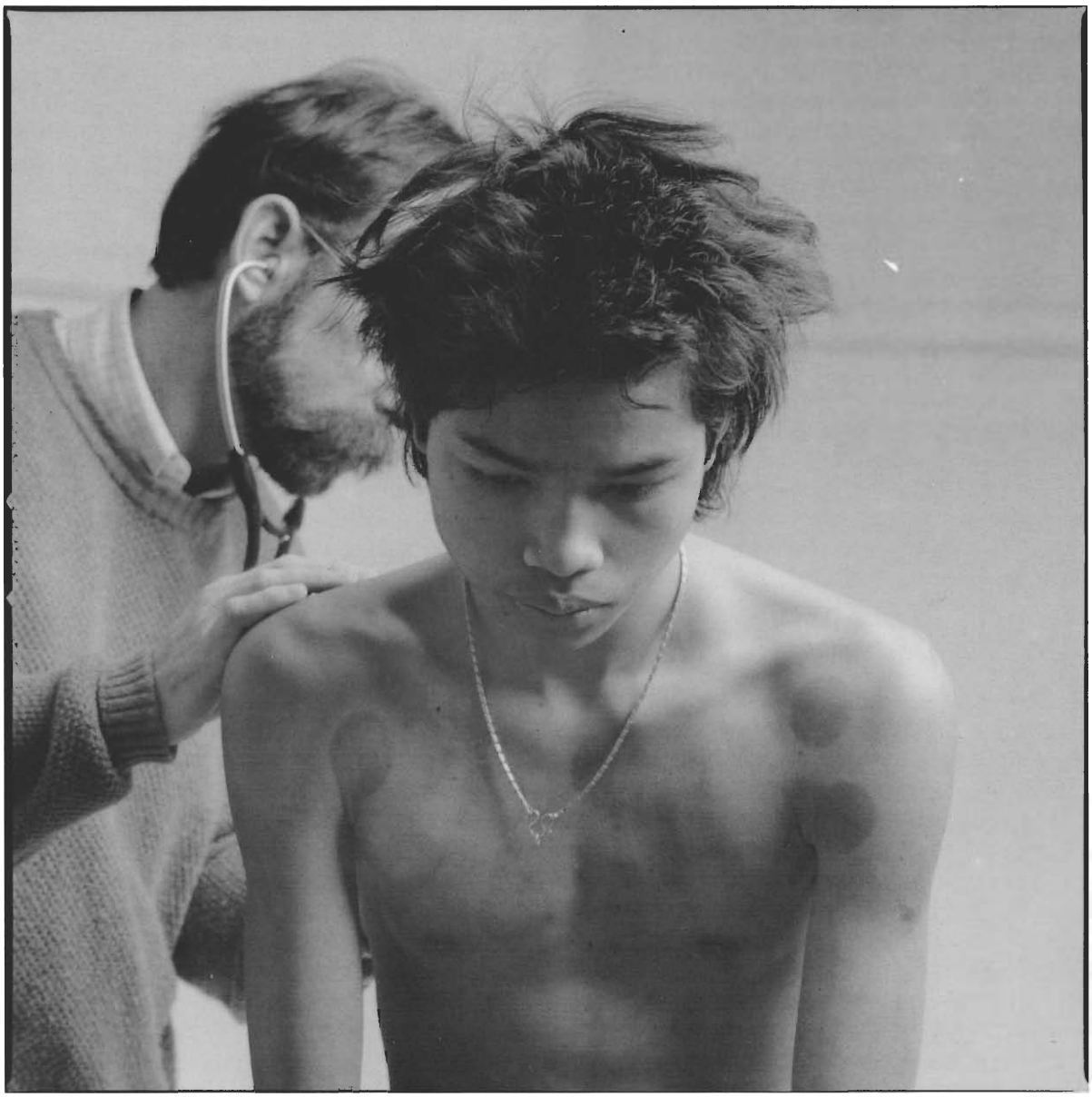

CAMBODIAN YOUTH *visits New Hope Clinic after hot-coin folk remedy failed. Below,* MICHAEL ENGELBERT-FENTON, P.A., *writes prescription*

census. This population varies according to the season. In addition, there are about 5,000 Pacific Islanders living along the Wasatch Front.

Each of these populations has unique health problems. Since the Southeast Asian group is the most recently arrived and many physicians have had the least experience with them, I would like to comment briefly about their particular health problems, as well as a few of their unique health beliefs.

All Southeast Asian refugees are screened for health problems while in resettlement camps. By law they must be screened for tuberculosis, leprosy, venereal disease, and mental illness before they enter those refugee camps. Despite this requirement, many refugees arrive with health problems not previously discovered. For example, in the resettlement camps in California and Washington states, 1 to 2 percent of refugees had "active" tuberculosis, and about half of the refugees had positive skin test for tuberculosis. Although many refugees have received BCG vaccination, any with positive skin tests should have chest x-rays. Local or state health departments should be notified of refugees found to have tuberculosis to

facilitate further epidemiologic studies among family members or other contacts. The Center for Disease Control also recommends bacteriologic examination, with smear, culture, and susceptibility studies for suspected or follow-up cases. Multidrug regimens for active cases are recommended because of the possibility of isoniazid-resistant organisms.[1]

Malaria has traditionally been a serious health problem in the indigenous countries of refugee origin. There are no exact figures documenting the prevalence of malaria among Southeast Asian refugees, but it appears to be significant. In our practice we have seen ten documented cases of malaria in the last four years. Any refugee who presents with unexplained fever and chills should be suspected of having malaria. Other signs and symptoms include splenomegally, anemia, headaches, backaches, and malaise. The diagnosis of malaria is established using both thick and thin blood smears, looking for endoerythrocyte parasites. This usually requires the expertise of a trained hemopathologist or experienced technician.

Malaria infestations with exoerythrocytic cycles, such as *P. Vivax* and *P. Ovale*, may not make themselves clinically apparent for months or years. Therefore, malaria must be considered as a possible diagnosis for the febrile refugee for some time after resettlement in this country. Falciparum malaria is a medical emergency because of the overwhelming parasitism that may occur with subsequent massive hemolysis. Treatment varies according to the particular parasite identified. Guidelines for treatment have been outlined in *Morbidity and Mortality Weekly Reports*.[2]

Another problem that is prevalent among refugees but decreasing inversely as to the length of time they have been in this country is that of intestinal parasites. Intestinal parasites do not pose a significant public health hazard because adequate sewage disposal interrupts transmission of the helminths, which require several days' incubation in the soil before becoming infectious. However, ascaris and hookworm may be transmitted in areas of poor sanitation and cause significant illness in affected patients. In one study ascaris constituted 41 percent of intestinal parasites among infected refugees with trichuris in 30 percent, hookworms in 26 percent, and giardia in 15 percent.[3] The CDC does not recommend screening of all refugees for intestinal parasites; however, testing should be part of a complete examination of the individual refugee with abdominal or lower gastrointestinal problems in which the diagnosis is uncertain. Presenting symptoms often include both constipation and diarrhea, malaise, vague abdominal pain, and weight loss. Treatment varies and is specific according to the type of parasite found.

Hepatitis B is extremely common in the countries of Southeast Asia. Carrier rates have been reported between 12 percent to 20 percent in refugee populations. This is 50 to 100 times the prevalence found in the United States population. Health care workers (e.g., physicians, dentists, and nurses) and the newborn child are at highest risk for exposure to this disease. Health workers that commonly care for Asian refugee populations should probably be vaccinated with Hepatitis B vaccine. All prenatal refugee patients should be screened for Hepatitis B surface antigen. Infants born of mothers with positive serology for Hepatitis B should receive prophylactic Hepatitis B immune globulin immediately postpartum and at three and at six months of age.[4]

Thalassemia and other hemoglobinopathies are commonly encountered among the Southeast Asian refugee groups. In one population of Khmer (Cambodian) refugees, 47 percent were noted to have microcytosis. Of this group, 19 percent had alpha thalassemia, 25 percent had hemoglobin 4, while only 3 percent with microcytosis were identified as iron deficient. Similar rates of thalassemia and microcytosis were found among the Hmong and Vietnamese groups.[5] Hemoglobin electrophoresis done on patients with alpha thalassemia is normal, unlike beta thalassemia in patients of Mediterranean descent. Therefore, alpha thalassemia becomes a diagnosis of exclusion in which other causes of hypochromia and microcytosis should be ruled out.

There are three particular problems that physicians dealing with the pediatric refugee group should be aware of. Our experience, as well as current indications from the CDC, reveal that refugee children are not adequately immunized before leaving resettlement camps. There continues to be a significant health education gap in which refugee parents have no

New Hope Clinic provides daycare while mothers learn English.

HMONG WOMAN *describes, through an interpreter, her ailment to* DR. ROBERT BEREN, *an M.D. volunteer from Tooele with experience in Indochinese refugee camps.*

concept of the need for preventive immunizations. This presents a real challenge to encourage parents to have their children immunized and also provide the health education necessary for them to understand the reasons for preventive immunizations. Another problem identified by the CDC has been the increased prevalence of lead toxicity among Hmong refugee children. Apparently a folk remedy that is fed children to treat fever or rash contains harmful amounts of lead. Similar situations have been documented in the Mexican-Hispanic communities. Screening for lead toxicity in these groups should be done as indicated.[6]

A study of 1,650 refugee children noted that the mean weights and heights for age as a group were two standard deviations below the U.S. mean values. The authors of the study concluded that the marked differences in growth status was due to nutritional factors rather than to a genetic background. It was also noted that the United States growth standards can continue to serve as reference tools for this group; however, it should be realized that the refugee children will have a different distribution on the U.S. growth curves.[7]

Even though the aforementioned health conditions are unique to refugees, it is the common health problems that are seen in most of our patients that occur most commonly among refugees also. In our practice we are beginning to see increasing numbers of elderly Asian refugees who are finally accepting Western medicine and who have uncontrolled hypertension, diabetes, and depression. Even with the luxury of good translator services, there is a strong tendency to underestimate the amount of psychiatric disease among this group. It has been estimated that for every refugee who left his or her native country for freedom, another paid the ultimate price (death) in the attempt. Needless to say, therefore, many refugees who were able to come to this country suffer from guilt and depression because of this great loss. In addition, the stress of resettlement, language barriers, and having to acquire new skills for employment, has placed a large psychological burden upon these people.

I would briefly like to mention a few of the folk beliefs that create health behavior seen among this group. An excellent, more exhaustive discussion can be found on the subject in the *Journal of American Medical Association* article entitled "Guidelines for Providing Medical Care to Southeast Asian Refugees," August 13, 1982.[8] This article notes the effect of Western medicine and its amalgamation with traditional medicine practiced in the Southeast Asian countries during the last decade. The modern medicine practice in Southeast Asia is typified by an empiric approach and relies more on clinical findings than on elaborate laboratory technology. "Shotgun therapy" and "placebo effect" are two common therapeutic modalities. Therefore, many Southeast Asian patients when seeking physicians trained in the West expect to receive one or more injections and/or prescriptions containing a long list of combined medicines.

Traditional folk medicine continues to be practiced in many parts of Southeast Asia and is largely influenced by Chinese medicine. It is derived from the Chinese concept of Yang and Yin, which claims that the universe, and consequently a human being, is made up of two opposing forces: masculine or Yang, represented by light, heat, and dryness; and feminine or Yin, represented by darkness, cold, and wetness. Any imbalance in the content or flow of these forces will produce disease. To cure disease, balance has to be restored either by internal medicines (herbs or animal or vegetable extracts, etc.) or resorting to acupuncture.

Many folk medicines combine folklore with Chinese and medieval French beliefs. Much of the understanding of disease is either supernaturalistic (the influence of gods, demons, spirits) or naturalistic (blaming bad weather) or metaphysical (hot or cold theory) or a combination of these three. A variety of techniques are employed for the cure of disease, including the following:

1. skin rubbing, which is either done by a coin or a spoon;
2. skin pinching;
3. cup suction, in which a cup is heated and placed on the skin and as it cools causes a suction on the skin;
4. herbal steam inhalation while the whole body is covered by a heavy blanket;
5. balm application;
6. inhalation of aromatic oils or liniment; and
7. ingestion of herbal concoctions.

Herbal folk medicine continues to be practiced here in the United States, but it is somewhat limited by the availability of herbal medicine. Therefore, we see more

use of physical abrasion or cup suction in an effort to relieve symptoms and cure health problems. The use of dual systems of health care is not uncommon. Refugee patients often use their own systems of care before resorting to Western medicine. One study in Denver found that refugees relied on self-care before seeking professional help. In this study 80 percent waited at least five days after the manifestation of illness before seeking physician care, and some 73 percent of those failed to return for follow-up care.[9]

Southeast Asians represent only a portion of Third World people who encounter significant barriers obtaining health care in urban areas. Other groups, such as American Indians, Hispanics, and Pacific Islanders, as well as indigent Caucasian groups, also have tremendous difficulties accessing good health care. There are several barriers these groups face. Of course, language and culture are major factors. For this reason certain health care groups have attempted to provide medical care in a cultural milieu acceptable to particular groups. For example, the Salt Lake Indian Health Center has attempted to create an atmosphere in which urban Indians feel comfortable in obtaining medical care. Similarly, the Utah Rural Development Corporation, formerly the Utah Migrant Council, has tried to make health care available in a setting where Hispanic

culture and health beliefs are taken into consideration. The Salt Lake County Urban Health Initiative (commonly called community health centers) in which I was involved as a family practitioner, serves as an umbrella agency for many of these groups in providing physician and other midlevel health care expertise. The staff has people fluent in Spanish and Navajo and have recently secured translators for Laotian, Cambodian, and Vietnamese languages. It is the community health centers, as well as the City-County Health Department, that particularly target the Asian refugees for medical care.

The most imposing barrier to health care for these groups is financial. Southeast Asian refugees do receive Medicaid coverage for their first 18 months in the country, but afterwards they must become self-payers. Most urban Indians also do not have third-party coverage and are usually low-income groups. The health care groups previously mentioned do receive some federal support to provide primary care services to these groups; however, little or no monies are available to cover specialty physician care. What is sorely needed by these disadvantaged groups are physician volunteers willing to provide consultation services at a reduced or individualized fee structure. In addition, there is urgent need for pediatric services at the Salt Lake Indian Health Center, which would entail minimal time commitment. Let me further emphasize that similar agencies exist in most urban areas throughout the United States, and volunteers would be warmly received at community health centers, Indian health centers, and migrant health centers throughout the country.

Left, Laotian refugee JAMESPOON, *New Hope Multicultural Center director, saw the need for care before small medical problems became major ones. Above, located in a donated LDS Church in West Salt Lake, the New Hope Clinic opens two days weekly with support and personnel from Intermountain Health Care, Salt Lake Community Health Centers, and other volunteers.*

It is my sincere hope that among a group such as Collegium Aesculapium in which there are many who speak different languages and have had exposure to many different cultures, there would be some who would like to become involved in volunteering their services. Certainly, the opportunity is at hand to exercise Christian brotherhood toward individuals who are sorely in need of the skills with which we are richly blessed.

NOTES

1. Center for Disease Control: Health status of Indochinese refugees. *Morbidity and Mortality Weekly Report* 28:385–398, August 24, 1979.

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3. Lindes C: Intestinal parasites in Laotian refugees. *Journal of Family Practice* 5:819–822, 1979.

4. Centers for Disease Control: Health status of Indochinese refugees: Malaria and hepatitis. *Morbidity and Mortality Weekly Report* 28:463–470, October 5, 1979.

5. Monzon CM, Fairbanks VF, Burgett EO, et al.: Hematologic and genetic disorders of Southeast Asian refugees. Abstract *Blood* 58 (supplement):55a, 1981

6. Centers for Disease Control: Lead poisoning from Mexican folk remedies—California. *Morbidity and Mortality Weekly Report* 32:554, October 28, 1983.

7. Olness K, Yip R, Indutz A, et al.: Height and weight status of Indochinese refugee children. *American Journal of Disease of Children* 138:544–547, 1984.

8. Hoang G, Erickson R: Guidelines for providing medical care to Southeast Asian refugees. *Journal of American Medical Association* 248:710–714, 1982.

9. Silverman ML: Vietnamese in Denver: Cultural conflicts in health care. Presented at the Conference on Indochinese Refugees, George Mason University, Arlington, VA, March 29, 1980.