A message from Medical Director, J. Carey Jackson, MD, MA, MPH:

Pre-travel counseling for persons visiting friends and relatives

Those of us who provide medical care for immigrants and refugees are familiar with their inevitable decision to return home for a visit. For many this is a momentous return. They left in terror, to return in safety for a long-imagined reunion. Now years have passed, many friends and family members have died, others have grown up, or grown old, and there are new family members to meet. I have had patients who returned home to Laos, Cambodia, or China for the first time after decades in exile. The excitement of return is overwhelming; to honor the dead, to see childhood landscapes one last time, to eat foods they have missed for years, to sit with a dying sibling in their illness. The exposures many risk upon return are sometimes minimized. Patients may shrug and say they lived there for years and not realize that now 20 years later they have congestive heart failure, breast cancer, and diabetes, and are elderly and cannot tolerate the insults to their immune system they might have weathered in their youth. In addition whatever residual immunity they had to endemic pathogens has waned in the intervening years. Others will want whatever treatment they can get but not realize the expenses may not be covered by medicaid or their insurance.

Public Health - Seattle & King County (PHSKC) provides useful tips as you discuss issues with traveling patients. These tips are based on the CDC’s Health information for international travel including detailed guidelines on pre-travel counseling specifically for persons visiting friends and relatives (VFRs). The decisions to immunize, prophylax, or treat when symptoms arise are a careful calculation based on the duration of the trip, geographic areas and the seasonal prevalences of disease, the urban, rural, or sylvan settings to be visited, and the condition and co-morbidities of the traveler. I would add a few caveats to the guidelines to discuss during the conversation with patients.

1) Calculate the duration of the trip and the actual percentage of time exposure to mosquito vectors of dengue and malaria may occur. This is where a decision to treat symptoms as they arise vs. take malaria prophylaxis will be decided. The risk of side-effects from mefloquin, or even doxycycline are not insignificant and have to be weighed.

2) Many devout and/or elderly patients are engaged in religious pilgrimages. I recently had several patients undertake a pilgrimage to the key sites of the Buddha’s life: birth, enlightenment, and death. Trips to Saudi Arabia for the Haj, or to Holy sites in Ethiopia are also familiar. At these times there may be special considerations around crowding and the need for meningococcal vaccine as for the Haj, or for Yellow Fever if the trip itinerary includes a country where the disease is endemic.
3) Unlike tourism which is usually a month or less, a trip home after years away may take 3-6 months. In these cases patients with chronic illnesses may decompensate if they do not plan a means to assure they have a steady supply of their chronic medications. This needs to be addressed and arranged in advance.

4) For individuals who are PPD negative or quantiferon negative the trip home may be another exposure to TB and require a reminder to re-screen after they have been back in the U.S. a few months. Similar arguments can be made for HIV if that is a reasonable concern in the traveler.

5) The biggest risk to health may not be infectious disease but motor vehicle accidents and traffic in settings where there are no emergency services. The recent pilgrims to India I mentioned were involved in a serious bus accident. Others have been pushed into, or killed by erratic traffic. A thoughtful reminder of these mundane risks may address the most real threat faced daily.

6) Finally, for many the emotional jubilation of return can be followed by renewed PTSD or depression. Screening again after reentry can be useful.

In any case, this is not adventure travel or tourism, but a trip home, often to remote locations for prolonged periods and the traveler must be well prepared.

Best,
Carey

OF INTEREST ON ETHNOMED

Cambodian Terms for Hypertension May Cause Misunderstandings about the Disease

A population-based survey conducted in Cambodia in 2007 by the Ministry of Health found self-reported rates of high blood pressure of about 50% were significantly higher than the actual prevalence of high blood pressure of about 12% (Saphonn & Prak, 2008). This raised a question about what the terms used for high blood pressure by health professionals meant to patients, and whether the surveyed population had a different perspective from health professionals. These terms, which suggest that hypertension is an illness related to blood volume—and not pressure—may influence patients’ understanding of the disease. If so, such confusion may increase the risk of poorer health outcomes if adequate education about the disease is not imparted. The Khmer terms for hypertension used by interpreters and patients in the Seattle area are the same as those in Cambodia. We explored whether the terminology used may be a source of confusion for Cambodian immigrants and found that indeed, the same misunderstandings exist among many Cambodians in our area. The article explores the misunderstandings and contains practical suggestions from patients, interpreters, and health care providers for education about hypertension.

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Patient education audio resources for blind or low literacy patient populations

Audio recordings were produced by the Utah Office of Health Disparities and are made available with permission on EthnoMed. Each audio recording has a corresponding English document to accompany it. Topics include: Cerebral Palsy, Diabetes, MS, Parkinsons and more.

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CALENDAR ITEMS OF INTEREST

Abiy Tsom (Lent): March 11 - May 5, 2013

This Great Holy Lent Fast observed by followers of the Ethiopian Orthodox Church lasts 55 days, culminating on Easter. The fast involves total abstention from meat, dairy products and eggs,
and only one meal a day is eaten, taken in the evening or after 3:00pm. Starting on Good Friday to Easter Sunday, there is total abstention from everything taken orally. Health care providers should be vigilant and question their patients whether they intend to observe regular or modified fasting and consider potential medical implications of fasting, including altered medication dosing that may occur and increased risks for diabetics.


8th National Conference on Quality Health Care for Culturally Diverse Populations, held this year in Oakland CA. EthnoMed staff are attending and would be glad to meet you there!

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SOMETHING WE'RE WORKING ON

Torture Survivor Resources

Lutheran Community Services Northwest has been funded through the Office of Refugee Resettlement to develop a coalition between organizations to identify and assist survivors of torture in the Puget Sound region. The coalition will initially include entities that have been doing this work for decades. Mental Health services will be provided by International Counseling and Community Services, a program of Lutheran Community Services. Legal services will be provided by Northwest Immigrant Rights Project. Medical evaluations and services will be provided by the Refugee and Immigrant Health Promotion Program at Harborview Medical Center. As the coalition evolves it will provide training and support throughout the region. Partnerships with and support from similar programs for torture survivors in other regions of the country undergird this coalition to provide depth and resources. Eventually relevant materials will be available on EthnoMed for those similarly providing varied services to survivors of torture.

EthnoMed welcomes input and review of the content we create. If you have experience related to any of the above topics and might have interest in being interviewed or reviewing drafts, please Contact Us. We look forward to sharing these materials with you in future newsletter editions.

ABOUT ETHNOMED

EthnoMed was founded in 1994 and is a joint program of the University of Washington Health Sciences Library and Harborview Medical Center in Seattle, Washington. EthnoMed grew out of another hospital program, Community House Calls, which was successfully bridging cultural and language barriers during medical visits, through interpretation, cultural mediation and advocacy with immigrant patients, families and communities. The website was created to reflect and support that experience. In recent years, our content has expanded to reflect many new communities that have settled in the Seattle area.

EthnoMed aims to address disparities in care through enhancing understanding between the medical culture and the culture of the patient. The program is grounded in relationships established with local ethnic communities and the providers who care for them. Our contributors come from a wide range of disciplines and experiences and include nurses, physicians, nutritionists, psychologists, academic faculty, medical interpreters, librarians, community members, and students. Health care providers and community members review content for clinical accuracy and cultural relevance.

We invite you to share your knowledge and educational materials with the EthnoMed audience. Consider being a content contributor, collaborator or reviewer. Contact Us.

We hope that every newsletter edition (approximately 6 a year) will lead you to something helpful to your work. Please help us spread the word by forwarding this newsletter to a colleague or two, using the button below. Thank you!
THIRD EDITION

This is the third edition of the EthnoMed newsletter. Click here to view previous editions.
http://ethnomed.org/about#section-12

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