

CASE AND COMMENTARY

How Should Health Care Professionals Address Social Determinants of Refugee Health?

Julie M. Aultman, PhD

Abstract

In the case scenario, RJ is a resettled refugee teenager who presents to his physician with vitamin B₁₂ deficiency, anemia, and symptoms of mental illness. This commentary considers social determinants of refugee health and the moral importance of freedom to achieve well-being. The capabilities framework is used to analyze this case because it offers an ethical framework for understanding and evaluating social determinants of refugee health that either promote or diminish freedom to achieve well-being. By using this framework to consider social isolation as a negative social determinant of refugee health, clinicians and institutions can be caregivers as well as advocates for social justice, fulfilling 2 core ethical obligations to refugee communities.

Case

Dr G is a physician who follows up with RJ, a 17-year-old resettled refugee, about his feelings of isolation and depression revealed in an earlier visit in which RJ needed a physical exam to get a work permit. RJ was subjected to psychological trauma during his early childhood and, from 2009 to 2013, lived in a refugee camp, where he learned English. After reviewing RJ's blood work from his last visit, Dr G explains to RJ that he is anemic and has a vitamin B₁₂ deficiency, probably due to poor nutrition. Dr G inquires about RJ's daily life, school, and work. RJ spends most of his free time working to help support his grandparents, mother, and sister. Job opportunities are scarce, and RJ is currently the only member of the household earning an income. After further conversation, RJ reveals that he still feels depressed and isolated. "I have to work, so I don't have time to go to the outreach programs you recommended. Besides, my family and I just don't seem to fit in. We don't belong here." He describes how his family members have similar feelings and how he is worried about their health.

Dr G and RJ discuss RJ's concerns and therapeutic options. RJ is not willing to take medication and says, "Why would I spend money on a drug just for me? It won't help. We are all so alone here."

Dr G hears similar concerns expressed by her other refugee patients and has described these patients as melancholy, fatigued, and malnourished. There are over 1000 refugees living in her city; roughly 60 receive care at Dr G's clinic. She knows that there are higher-than-average rates of mental illness and suicide among this local population. She does her best to serve these patients, but it doesn't seem to generate improved health outcomes in the community. Dr G wonders what to do.

Commentary

The hypothetical case of RJ is representative of the many refugees and asylum seekers who experience difficulty in assimilating to an unfamiliar culture while trying to manage health-related conditions attributable to the abuses, threats, and violence that they suffered within their country of origin. For RJ and other refugees, escaping persecution results in years confined to a refugee camp with a different set of problems and a lack of resources. RJ likely endured physical and emotional trauma both during his migration and his stay at the refugee camp. While refugee camps are often perceived as safe and secure environments, it is not uncommon for those living in them to experience trauma (eg, physical and sexual violence), insecurity (eg, theft of personal items), malnutrition, and loss of basic freedoms (eg, privacy).¹ However, even when refugees resettle in a safe environment, they continue to experience physical and emotional hardships, such as discrimination, isolation, and the inability to find work and housing, which forces them to resettle in different, often multiple, locations.²

Resettled refugees' ill health is contributed to by inaccessible public transportation, language barriers, inadequate housing, conflicting family commitments (eg, child care), and inflexible work schedules. Patients like RJ are unable to get the health care services they need without extensive support, flexible health care professionals and social services, and some creative ways to deliver care (eg, health care services offered during worship services at religious centers or primary care medical homes).^{1,2} Unless clinicians pay special attention to the [social determinants of health](#) (SDH) and make a deeper connection to refugee patients, these patients will be at increased risk of mental disorders and other harms, including self-harm.³⁻⁵ Thus, the journey to freedom for a refugee can be long, arduous, and harmful to his or her health and well-being.^{5,6}

In what follows, I look more closely at RJ's narrative and the therapeutic relationship that his physician, Dr G, is trying to establish in a broader social context. It is important to understand some of the general health conditions and SDH experienced by resettled refugees like RJ. Equally important is recognition of the rights of those who have sought asylum and how past abuses and violations of basic human rights have contributed to and perpetuate existing social, emotional, and physical conditions that require attention from health care professionals, the institutions they serve, and others in the community. I then show that a *capabilities approach*—a theoretical framework attributable to the work of economist-philosopher Amartya Sen and philosopher Martha Nussbaum^{7,8}—

would better equip Dr G to assess RJ's well-being, evaluate his environment or social arrangements, and have a better understanding about what it means to be a resettled refugee in a new environment. Before embarking on a discussion of the benefits of a capabilities approach in guiding refugee care, it is important to look more critically at RJ's health issues and the challenges of resettlement.

Addressing Refugee Health and the Challenges of Resettlement

With little or no income or financial support, RJ is likely unable to maintain proper nutrition or to acquire health care resources, postsecondary training, and necessary social support. He may find it difficult not only to find long-term employment and build a future career but also to be healthy enough to work. Thus, it is important for health care professionals to recognize not only SDH, or those conditions in the environment that affect health and functioning, but also how poor health outcomes can be magnified when persons resettle in unfamiliar environments and cultures.

Social determinants of health. Dr G—and all health professionals—should recognize the complex relationship of patients' environment to their health status. RJ's anemia, [B₁₂ deficiency](#), depression, and feelings of isolation may have started prior to his resettlement in the United States; however, these health conditions might only get worse when compounded by RJ's financial, familial, and social pressures and his inability to access social and economic opportunities. RJ does not want to spend money on a drug prescribed by Dr G, presumably because he is looking out for the financial welfare of his family rather than his own medical needs. Perhaps RJ even views the drug—and, by extension, his health—as a luxury. Hence, it is important for Dr G to openly discuss with RJ how valuing his own health can align with his other values and interests, such as supporting his family. Awareness of the relationship between health and work may help RJ realize that being “melancholy, fatigued, and malnourished” can negatively impact his employment opportunities and his ability to work. Furthermore, an integrated and coordinated team approach might provide Dr G with support and with additional information and resources to share with RJ. For example, social workers, case managers, and others could assist RJ and his family in securing long-term health care benefits, access to nutritious foods, and community support. Such coordinated efforts can be challenging, particularly when the patient's work life may prohibit health-based opportunities (eg, outreach programs). Thus, ongoing assessment by clinicians and flexibility within existing social structures and among community stakeholders (eg, employers) are needed to improve refugee health and to mitigate associated SDH.

Health insurance. Refugee resettlement in the United States has been described as a private-public enterprise that requires coordination among several federal agencies; national, state, and local resettlement offices and health care agencies; and primary care clinicians.⁹⁻¹² One example is [insurance coverage](#). Refugees in the United States currently get short-term health insurance, or refugee medical assistance, which is only available

for up to 8 months.^{9,10} Thereafter, some may qualify for Medicaid and the Children's Health Insurance Program (CHIP) in the state where they resettle,¹⁰ particularly pregnant women and children. Because RJ is only 17 years old, in many states he could qualify for CHIP or comparable programs up to a certain age (eg, 19 years of age in Ohio¹¹) if his family is within a designated percentage of the federal poverty line. Many refugees, however, may have to buy costly, private health insurance after the first 8 months of resettlement if they do not qualify for Medicaid. Some states will also provide cash assistance for refugees in their first 8 months living in the United States; however, such assistance may not be adequate for meeting basic needs such as housing and utilities and is inconsistent across states.⁹ In some states, such as Ohio, social services are available to refugees for up to 5 years that can assist with acculturation, language education and training, job training and placement, transportation, child care, elderly assistance, and citizenship classes.¹²

Although financial, social, and educational support may be available for refugees such as RJ and his family, the reality is that not all refugees are aware of these services, which may be poorly advertised, resource depleted, or simply ineffective. Thus, professionals like Dr G and the communities in which resettled refugees live may have to be innovative in reaching this population.

Mental health. Extensive or more complex mental health care (such as might be required to treat RJ's depression and feelings of isolation) may not be widely accessible, and medical professionals often lack expertise or understanding of refugees' perceptions of mental health and their (un)willingness to seek help. Refugees may experience symptoms consistent with major depressive disorder, posttraumatic stress disorder, or any number of mental health conditions that require specialized therapeutic interventions.^{4,5} It should give Dr G pause when RJ describes not fitting in and being unable to utilize outreach resources, as continued isolation is a risk factor for suicidal thoughts and acts.^{4,5} For some refugee populations, the stigma of mental illness serves as a barrier to seeking help, and, for others, mental illness may not be a concept understood within the population (eg, symptoms associated with mental disorders may be attributed to diet, religious beliefs, or some other external force).

Broaching the sensitive topic of mental illness can be a challenge for health care professionals and advocates due to language barriers (ie, there may not be a term for mental illness in some cultures), cultural differences in the meaning of mental illness, or fear of disrespecting or harming patients by inviting them to share their emotionally painful stories for diagnostic and treatment purposes. Sensitivity to SDH can improve mutual communication and understanding between health care professionals and patients who are refugees, such that mental health care can be delivered in ways that are more consistent with patients' values and beliefs. For example, depression can be explained in physiological and neurochemical terms rather than as a "mental" disorder

that some cultures attribute to an immaterial, often sinister, force or spirit (which is thus a topic to be discussed not with a health care professional but with a spiritual leader). Framing health and disease around what patients understand and value can contribute to a better therapeutic relationship and serve as a starting point for improving refugee health. However, acknowledging SDH and reframing concepts of health and disease may not be sufficient for promoting RJ's health and his other capabilities essential to preserving his dignity as a human being.

Guidance From a Capabilities Framework

The 1951 Convention Relating to the Status of Refugees, a United Nations treaty, identifies the rights of refugees—including, but not limited to, the right to safe asylum, freedom of thought and movement, and the right to education.¹³ When we look at these freedoms—and the ethical and social injustices impeding achievement of such freedoms—we can better understand the opportunities refugees such as RJ need in order to achieve full functioning or essential human capabilities, such as earning a living or caring for others. Part of a social justice analysis also includes identifying avoidable SDH that create unfortunate constraints on human capabilities. Through a capabilities framework, particularly one informed by Martha Nussbaum's liberal theory of justice and human rights, health care professionals can take "account of the space within which we make comparisons between individuals and across nations as to how well they are doing."¹⁴ That is, we can ask questions such as: What is RJ actually able to do and to be? How might the existing resources for resettlement work in enabling RJ to function in a fully human way? How might SDH inhibit RJ's functioning in a fully human way?

Many refugees' families have been killed in their war-torn countries of origin or continue to be housed in refugee camps and are unable to be resettled, but, even with family support, refugee patients such as RJ can feel isolated in their new environments. And while health care professionals are not obligated to reproduce such social support in their efforts to mitigate patients' feelings of isolation and promote their capabilities, acknowledging the circumstances surrounding patients' emotional and social needs is an important step. Dr G has offered outreach programs, which could be beneficial for RJ; however, due to RJ's work schedule, he is unable to access this opportunity. The conflict between 2 important commitments (work and social outreach) thus prevents RJ from functioning in a fully human way¹⁵; the need to financially support his family contributes to his social isolation and his being incapable of affiliation with others. While health care professionals and organizations can help alleviate social isolation by creating support groups based on cultural and supportive needs of refugees such as RJ, existing employment structures need to be more flexible to ensure that refugees can take advantage of opportunities that promote health and well-being.^{2,14} Without more flexible or alternative ways for refugee patients to earn a living while being part of a community, Dr G's efforts will be ineffectual in helping her patient.

To contribute to the change that is needed to promote human capabilities and overall patient health, health care professionals and organizations need to be advocates for their refugee patients by identifying barriers to care that compromise capabilities such as lack of transportation, health illiteracy, the inability to take time off work, and the high costs of quality care, especially if a patient does not qualify for supportive programs such as Medicaid or CHIP. Of course, such problems are experienced by many citizens within the United States and continue to be a barrier to preventive care and early detection of serious, costly health conditions. Nevertheless, it is equally important to recognize this vulnerable population of refugees that is trying to navigate a new environment, language, and culture, while surviving the trauma of unfathomable past circumstances and existing discrimination that continue to threaten their human capabilities. Advocacy can promote public awareness of SDH, refugee health, and social injustices that can be repaired through community commitment and a willingness to improve human functioning by breaking down barriers and biases and creating opportunities.

Recognizing trends in mental and physical illness among particular refugee populations is another obligation that health care professionals and organizations ought to consider. Careful medical record keeping, research and quality improvement studies, and ongoing communication with refugee patient populations and their communities are critical for identifying and understanding health-related trends including nutritional deficits, mental disorders and related high suicide rates, infant morbidity and mortality, and so forth. By recognizing trends such as poor nutrition, as RJ is likely experiencing, health care professionals and organizations will be better able to inform communities and community leaders about prevention, access to vitamin B₁₂-rich foods and supplements, and the risks associated with nutritional deficits.

With evidence of barriers to health, including SDH, we are better equipped to answer questions, such as: What is RJ actually able to do and to be? If RJ's anemia and possible subsequent lethargy prevent him from working and financially supporting himself and his family such that it is difficult to put nutritious food on the table—and in a house with working utilities within a safe, nurturing community—his depression could be exacerbated. His untreated, comorbid health issues and SDH prevent RJ from fulfilling his basic human capabilities. Providing medications for RJ's poor nutrition and depression is not a viable solution without a full understanding of RJ's history, current health status, and what he strives to do and be. RJ may ignore prescriptions and recommendations and his health may continue to decline without a conscientious physician, a dedicated health care system, and a caring community.

Finally, it is important for health care professionals and institutions to recognize their general ethical obligations not only to patients but to the community. The American Medical Association's Principles of Medical Ethics outlines guiding principles that are applicable to this case. Besides "providing competent medical care, with compassion and

respect for human dignity and rights," physicians should also recognize their "responsibility to participate in activities contributing to the improvement of the community and the betterment of public health," and "support access to medical care for all people."¹⁵ While these guiding principles do not specifically detail the obligations of physicians to refugee populations, the underlying message is to treat all persons with dignity and respect—which is consistent with the capabilities approach—and to make an effort at the bedside and within the community to improve the health and well-being of all people. It may take time to translate—or to recognize—a patient's cultural perspective and values, but with greater understanding of the social determinants contributing to population-specific illness and disability and by advocating for each RJ as a whole person with unique needs, health care professionals can best respond to those conditions that undermine their patients' health and improve those capabilities essential to all persons.

Conclusion

For refugees like RJ and his family, nutrition, mental health, child and elder care, education, employment, and social support systems to enhance well-being and mitigate isolation are all issues that can be pragmatically resolved with the help of refugee assistance programs, social workers, community leaders, and advocacy groups. Some of the more complex issues, such as identifying barriers to realization of capabilities, may require a deeper, theoretical analysis and ethical examination from a capabilities approach, which enables critical assessment of the degree to which human capabilities are compromised and personal freedoms are limited in cases such as RJ's. To trigger both community involvement and a deeper awareness of social justice issues requires the health care professional, team, and organization to identify barriers specific to the health and well-being of refugees and to those capabilities essential for them to thrive within their new communities. It may take that follow-up clinical encounter for Dr G to address RJ's immediate health needs (eg, B₁₂ deficiency) and to establish supportive connections (eg, community gardens) to alleviate, if not resolve, his isolation, nutritional deficiencies, and depression. However, it will take additional time and a therapeutic commitment to identify the unnecessary social burdens bestowed upon RJ, foster a trusting relationship, and come to a mutual understanding of RJ's needs in relation to what he is or is not capable of doing or being. If RJ's freedoms are limited by a lack of such opportunities, advocacy and a call to action to secure those freedoms is recommended.

References

1. Jacobsen K. A "safety-first" approach to physical safety in refugee camps. Massachusetts Institute of Technology. http://www.mit.edu/~cis/migration/pubs/rrwp/4_safety.html. Published 1999. Accessed December 13, 2018.

2. McNeely CA, Morland L. The health of the newest Americans: how US public health systems can support Syrian refugees. *Am J Public Health*. 2016;106(1):13-15.
3. Silove D, Ventevogel P, Rees S. The contemporary refugee crisis: an overview of mental health challenges. *World Psychiatry*. 2017;16(2):130-139.
4. Wasserman D. Suicide risk in refugees and asylum seekers. *Eur Psychiatry*. 2017;41(suppl):S35-S36.
5. Ao T, Shetty S, Sivilli T, et al. Suicidal ideation and mental health of Bhutanese refugees in the United States. *J Immigr Minor Health*. 2016;18(4):828-835.
6. Schilling T, Rauscher S, Menzel C, et al. Migrants and refugees in Europe: challenges, experiences and contributions. *Visc Med*. 2017;33(4):295-300.
7. Sen A. *The Idea of Justice*. London, UK: Allen Lane; 2009.
8. Nussbaum MC. *Frontiers of Justice: Disability, Nationality, Species Membership*. Cambridge, MA: Harvard University Press; 2006.
9. Bruno A. US refugee resettlement assistance. Congressional Research Service. <https://fas.org/sgp/crs/row/R41570.pdf>. Published January 4, 2011. Accessed November 18, 2018.
10. Office of Refugee Resettlement, US Department of Health and Human Services. Health insurance. <https://www.acf.hhs.gov/orr/health>. Reviewed October 19, 2015. Accessed November 10, 2018.
11. Ohio Department of Medicaid. Programs for children, families, and pregnant women. <https://medicaid.ohio.gov/FOR-OHIOANS/Programs/Children-Families-and-Women>. Accessed January 13, 2019.
12. Ohio Department of Job and Family Services. Ohio Refugee Services Program. <http://jfs.ohio.gov/refugee/index.stm>. Accessed November 11, 2018.
13. United Nations High Commissioner for Refugees. Convention and protocol relating to the status of refugees. <https://cms.emergency.unhcr.org/documents/11982/55726/Convention+relating+to+the+Status+of+Refugees+%28signed+28+July+1951%2C+entered+into+force+22+April+1954%29+189+UNTS+150+and+Protocol+relating+to+the+Status+of+Refugees+%28signed+31+January+1967%2C+entered+into+force+4+October+1967%29+606+UNTS+267/0bf3248a-cfa8-4a60-864d-65cdfce1d47>. Published December 2010. Accessed January 13, 2019.
14. Nussbaum MC. Capabilities and human rights. *Fordham Law Rev*. 1997;66(2):273-300.
15. Venkatapuram S. *Health Justice: An Argument from the Capabilities Approach*. Cambridge, UK: Polity Press; 2011.
16. American Medical Association. AMA principles of medical ethics. *Code of Medical Ethics*. <https://www.ama-assn.org/delivering-care/ama-principles-medical-ethics>. Accessed September 7, 2018.

Julie M. Aultman, PhD is the program director of the Medical Ethics and Humanities Program and a professor of medical ethics and humanities in the Department of Family and Community Medicine at Northeast Ohio Medical University in Rootstown, Ohio. Her research focuses on refugee health, mental health, and social justice.

Editor's Note

The case to which this commentary is a response was developed by the editorial staff. Background image by Annie Broutman.

Citation

AMA J Ethics. 2019;21(3):E223-231.

DOI

10.1001/amajethics.2019.223.

Conflict of Interest Disclosure

The author(s) had no conflicts of interest to disclose.

The people and events in this case are fictional. Resemblance to real events or to names of people, living or dead, is entirely coincidental. The viewpoints expressed in this article are those of the author(s) and do not necessarily reflect the views and policies of the AMA.