

Traditional Medicine Use Among Refugees in Charlottesville

August 2011

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Abstract

Objective: This study aimed to determine the extent of traditional medicine use among refugees who moved to Charlottesville and now receive care at UVA's International Family Medicine Clinic (IFMC). The patient populations chosen for this study were Iraqi and Afghan refugees.

Methods: Subjects were interviewed using a semi-structured protocol covering topics including patient demographics, the extent of their therapy and product use and their thoughts on healthcare.

Results: 10 Iraqi and 9 Afghan refugees were interviewed. Some patients said they only used health treatments recommended by their providers at UVA, while others mentioned using personal remedies at home. Most common was the use of teas, often purchased from a local Afghan grocery store.

Discussion: While some patients mentioned using their own remedies when mildly ill, most seemed comfortable turning to the IFMC for treatment of their health problems. Analysis is still in progress, so themes in their answers may yet to be discovered.

Brief project description

Refugees receiving care at the IFMC come from a number of countries where complementary and alternative medicine (CAM) use is not uncommon. These countries include Iraq, Afghanistan, Burma, and Nepal. Herbs, animal products¹, and religious healing² are used in the Middle East, and Asian countries also see the use of natural narcotics like betel nut³. It is possible that patients continue such practices upon arrival to the US, as shown when a patient brought betel nut to an appointment with Dr. Hauck at the IFMC. CAM use can sometimes have safety implications, but it is also important to know what therapy modes patients prefer or will use first when faced with health problems. By increasing our understanding of what traditionally-rooted care patients may use, we hope to help better care for these patients at the IFMC. We chose to focus on Iraqis and Afghans because these groups differ in how recently they immigrated to Charlottesville; we reasoned that the length of time an ethnic group had lived in the US might influence their attitudes towards health care.

Methods employed

Potential participants were selected for their Iraqi or Afghan background from the IFMC patient database,

which is compiled from refugees' initial visits to the IFMC as part of the resettlement protocol when relocating to Charlottesville. Only refugees 18 and older were eligible for our study. Permission to contact patients was granted by Dr. Hauck, the director of the clinic, and IRB approval was obtained for the project. Potential participants were contacted by telephone, with assistance from CyraCom interpreters. A recruitment script, detailing the goals of the project and available compensation, was read and translated to the patient. Any questions they had were answered and if patients agreed to participate, interview dates were set and reminder calls were given. A semi-structured interview protocol covered topics including patient demographics, the extent of their therapy and product use, and their thoughts on healthcare. Interviews lasted 20 to 45 minutes and were audio recorded. CyraCom interpreters were used when necessary. Participants were given a \$20 gift-certificate to a local grocery store after completing their interviews. Interviews are currently being transcribed from the recordings. Participant answers will be analyzed for the frequency and extent of traditional medicine use among the various refugee populations, as well as any patterns that might relate to their demographics. A visit to a local Afghan store and an outside literature review helped confirm details given by the interviewees.

Discussion

10 Iraqi and 9 Afghan individuals showed up for their appointments. Their ages ranged from 18 to 72, and the number of years spent in the United States ranged from a few months to over 10 years. The breakdown among the sexes (10 females, 9 males) was equal in both refugee groups.

Transcription and analysis of the interviews are still in progress, but there were some general observations made during the interview process. Interviewees' answers indicated that refugees generally treated mild sickness as many people do. A number of patients said they used products at home, like making soups and eating lots of nutrient rich fruits and vegetables when sick. There was a sense that warm foods and drinks were considered beneficial. Teas consumed daily (a cultural tradition for many Afghans and Iranians) were thought to be good for one's health. Honey and various teas were said to help treat or prevent colds and coughs at home before going to the doctor. The teas mentioned included *babunij* (camomile), *za'tar* (a mixture of thyme, sumac and sesame seeds), anise, and cinnamon tea. One person

mentioned using eggplant slices rubbed on the skin to heal bone spurs. When asked about betel nut, the vast majority of patients were not familiar with the product, even when an equivalent term was given in Arabic or Dari. The few patients who did know of betel had never used it before. Smokeless tobacco was not used by any patients. Some patients said they smoked cigarettes or hookah, but the majority did not.

There was some evidence for the past use of traditional healers among a minority of both the Iraqi and Afghan refugees interviewed. The healing was described as involving the reading of curative passages from the Koran by an *imam* or other respected member of the clergy while the healer holds his hands over the body of an ill person. One lady said an imam cured her husband's diabetes while living back in Iraq, although she did not know of any such healers here in the US. In fact, no interviewees reported seeing another healer outside of the UVa health system. A very small number described knowing of traditional healers back in their home country, mostly in rural areas of Iraq and Afghanistan, although they had never visited such healers personally.

The majority of those interviewed believed compliance with physicians' orders and prescriptions was very important to maintaining their health. When asked about the difference between the practice of medicine in the US and in their home countries, patients expressed the idea that medicine and drugs were generally better here because of manufacturing and allocation problems back home. A few interviewees even said that some acquaintances expect pharmaceuticals to work faster and more effectively here because American drugs should just be better somehow. In general, the patients interviewed expressed satisfaction with their medical care in the United States. To improve refugee care, they advised offering devout Muslims the choice of gender of their doctors or making the Medicaid and insurance system easier to understand for newly arrived refugees.

We made a trip to the local Afghan store in Charlottesville, where interviewees said they shopped for products like tea that could not be purchased at national grocery stores. The store proprietor pointed out teas and products purchased by his clientele for health purposes, corroborating the interview responses. The teas discussed were easily located and seemed reasonably priced.

The limiting factor of this study's ability to generalize about the health behaviors of Afghan and Iraqi populations in Charlottesville is our small sample size. Using political refugees limited us to a certain type of immigrant. These were people who were persecuted in their home countries because of social prominence or political opinion. In general, the patients we interviewed

were well-educated, middle-class citizens in their home countries who came from big cities. Patients indicated that biomedicine was readily available and widely used in the cities in Iraq and Afghanistan, with traditional medicine more a rural phenomenon. The difficulty in taking time off for appointments may have also biased our sample to a particular personality type, as many patients who interviewed expressed their desire to help us. Some patients were young and had lived in the US for many years, possibly producing a generational effect that could have influenced their responses. For these reasons, it is possible that our study is under-estimating the prevalence and extent of traditional medicine use and benefits in these two populations. Future analysis of the data may determine the effect of these variables.

Conclusions of research

We found little evidence of traditional medicine use among Afghan and Iraqi refugees in Charlottesville. Aside from a few folk remedies and the perception of soups and teas having healing properties, interviewees embraced biomedicine and did not hesitate to make appointments at the IFMC. We did not find any evidence of alternative healers or betel nut use. Patients' advice for improving care centered on gender-matching physicians and patients, and improving insurance accessibility. We hope further analysis of the data will uncover more themes in the data.

References

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