Background

The Karen people of Myanmar

The Karen are the largest minority in Myanmar. Internationally 1.5 million Karen live as refugees. They have suffered ethnic cleansing and human rights abuses now for more than 60 years.

Many were born in the jungle while escaping and some spent up to 20 years in remote jungle refugee camps in Thailand where it is difficult for aid workers to reach. The camps are overcrowded, food is rationed (rice, fish paste and coal to cook) and health care is minimal. Day to day survival is their priority. Many contract malaria, parasitic infections, Hepatitis B, Tuberculosis and other infectious diseases. Education beyond the primary level is the exception and they do not speak English.

Canada started to resettle the Karen in 2006 . Over 300 have come to Ottawa and many more continue to arrive. Upon their arrival in Canada and beyond resettlement, they live with housing, income and food insecurity. They have limited employment skills and knowledge of health care and the urban culture. Health is perceived as the absence of disease . Health promotion and disease prevention have never been discussed. The concept of hot and cold is used to describe symptoms and they rely on treatments from learned customs.

Karen are strong, resilient people. They smile a lot and will nod "yes" even if they do not understand as they are too polite to say so. They are very friendly and hospitable.

The Nurse Practitioner at the Primrose site of the Bruyere Academic FHT provides health care for 625 patients. 40% of her practice is dedicated to refugees.

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ÉQUIPE DE SANTÉ FAMILIALE UNIVERSITAIRE BRUYÈRE ACADEMIC FAMILY HEALTH TEAM

Family Health Team
Équipe Santé familiale

uOttawa
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Beyond Resettlement: Nurse Practitioner Practice Model
Addressing Social Determinants of Health for Karen Refugees

Manon Bouchard NPPHC, Bruyère Academic Family Health Team
Tha Pyrope Lar, Karen Interpreter, Cultural Interpretation Services for Our Communities (CISOC)
Deborah Sarre-McGregor, Executive Director, Bruyère Academic Family Health Team

Approach

Nurse Practitioner Practice Model

The NP role is centered on the expertise acquired on the principals of patient centered holistic care. We are ideally positioned to observe the patient's health as the product of their socioeconomic environment in addition to culture, lifestyle, and physiologic factors. Our compensation model allows us the capacity to schedule longer appointments. This results in adequate time for addressing acute health concerns as well as health promotion, disease prevention and chronic disease.

Access

Appointment are a minimum of 30 minutes. Follow up appointments, after-hours access and home visits are based on identified needs. There is increased availability for same day appointments. Patients are recalled at set intervals. Missed appointments are addressed and patients are recalled.

Language

A cultural interpreter attends most appointments and family members can help with translation as well. Non-attendance is addressed. Language literacy is promoted by filling a drawer with books for them to choose.

Cultural Sensitivity

Cultural differences and similarities of the Karen culture impact values, learning and patient behavior. Engaging in self directed learning and learning from patients improves the provider-patient relationship.

Social Determinants of Health /Social Prescribing

Assessed and addressed at each visit. Time is reserved for system navigation and development of health literacy skills. The focus is on patient's needs and education in order for them to obtain, communicate, process, and understand basic health information, empowering them to make appropriate health decisions. E.g. prevention and screening for cancers.

Writing letters to housing agencies, calls to social services, teachers, assisting them to complete forms for services such as energy rebates for hydro, healthy smiles, dental programs, city subsidies for recreation and physical activities are examples of interventions provided.

Discussion

Questionnaire limitations

Having access to an interpreter was an asset as we attempted to develop questions that were clear and reflected on the cultural characteristics of the group. The questionnaire was difficult to hand out (explanation by interpreter, extra time needed in appointment), often required 30 minutes to complete short questionnaire, and some patients were worried about giving a "bad answer".

Conclusion

Beyond Resettlement

During their first year, refugees have access to newcomer medical clinics, settlement counsellors and health care via the Interim Federal Health Program (IFH).

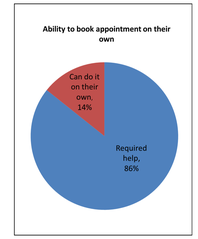
To provide comprehensive primary health care for refugees **beyond resettlement** requires enhanced accessibility and continuity of care due to their social gradient, high prevalence of infectious disease and the prevention and management of chronic diseases. The needs and priorities for these patients are influenced by the social determinants of health ; food and financial insecurity, housing, language and education.

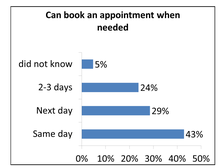
A pilot questionnaire provided some data on the continued assistance required to schedule appointments, health literacy, communication with the NP and the understanding of their health conditions and management plan.

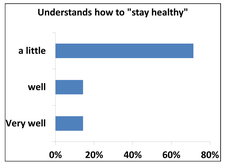
The Nurse Practitioner practice model, supported by access to a cultural interpreter, is well received by the Karen Community of Ottawa. Further research on this model and the impact on the social gradient of the refugee population is needed to support funding for Nurse Practitioners in Primary Care.

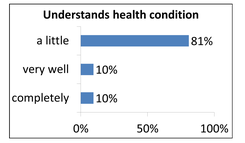
Measurement

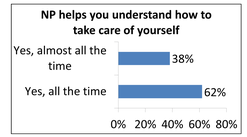
A pilot questionnaire was developed and translated in the Karen language to assess access to healthcare, health literacy and communication N=21 respondents

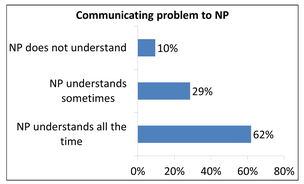












Data : Cancer screening prevention and access (appointment attendance rate)