

The Medical Evaluation of the Newly Resettled Female Refugee: A Narrative Review

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Abstract

The number of forcibly displaced individuals worldwide is increasing each year, reaching 65 million persons by the end of 2015, half of which were women and children. As the population of displaced persons grows, it is every physician's responsibility to understand these patients and their health needs. Refugee patients and the providers who care for them face many barriers to effective patient care, including language barriers, cultural differences, and systematic inequalities. Female refugees commonly experience gender-based violence, repetitive trauma, stigmatized mental illness, and cultural barriers to women's healthcare. This review is intended to be a comprehensive guide for the provider caring for the recently resettled female refugee patient. It addresses general considerations for working with refugee patients, initial medical evaluation guidelines, specific women's health issues, and mental health care of female refugee patients.

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Introduction

According to the U.S. Citizenship and Immigration Services, a refugee is a person who has been forced to flee his or her country due to persecution or fear of persecution based on race, religion, nationality, political opinion, or membership in a particular social group (U.S. Citizenship and Immigration Services). Due to the increasing number and duration of conflicts worldwide, the number of refugees has increased drastically; there were 65.3 million forcibly displaced persons worldwide in 2015 (UN High Commissioner for Refugees, 2015). In the United States alone, there has been a significant influx of refugees, with 69,933 refugees resettling in the U.S. in 2015 and 84,994 in 2016 (UNHCR, 2015). Approximately half of these refugees are women and children (UNHCR, 2015). As the population of displaced persons grows, it is every physician's responsibility to be able to understand these patients and their health needs (Mirza *et al.* 2014).

Several articles and guidelines have been published to inform us of how to care for resettled refugees (Centers for Disease Control and Prevention; Pottie *et al.* 2011). Infectious diseases, cultural differences, and language barriers make refugees a unique population. In addition, emerging research has highlighted the burden of chronic disease, trauma, and ongoing health disparities among refugee patients. In order to effectively address all health needs of refugees and surmount the barriers they face, a holistic approach to care is required.

In this review, we will provide a general framework to approach the evaluation of a newly resettled female refugee patient. We combine new research and up-to-date guidelines to give physicians a thorough and culturally-sensitive guide to caring for refugee patients and addressing their unique needs. This review is intended to address a gap in the literature and serve as a definitive resource for providers caring for refugee patients.

Caring for Refugee Patients: General Considerations

The United States accepted refugees from approximately 82 countries last year, with most refugees originating in Burma, Iraq, Somalia, Democratic Republic of Congo, or Bhutan (Office of Admissions, Refugee Processing Center, 2016). While their countries of origin vary widely, refugees face many common barriers to healthcare, including language, cultural beliefs, perception of healthcare, and lack of experience with a western healthcare system.

Language is the most commonly identified barrier to refugee care, as most refugees speak little to no English. Language barriers are frustrating for both patient and provider, and can lead to adverse patient outcomes (Mirza *et al.* 2014; Flores, 2005). In general, the use of professional interpreters is recommended over the use of untrained ad hoc interpreters (such as patient family or friends), as professional interpreters provide more accurate translation and confidentiality (Flores, 2005; Flores, Abreu, Barone, Bachur & Lin, 2012; Karliner, Jacobs, Chen, Mutha, 2007). Studies have demonstrated that female patients feel more comfortable with female interpreters, especially when discussing women's health topics (Odunukan *et al.*, 2015). While using interpreters, the provider should

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Table 1 Screening Tests for Communicable and Non-Communicable Diseases (CDC, 2014b)

Population	Disease or Condition	Test	Notes
All Refugees	General screen	CBC	
	General screen	Urinalysis	
	Varicella immunity	Varicella serology	If vaccine records are not available
	Pregnancy	Urine Pregnancy	For all female refugees of reproductive age
	Hyperlipidemia	Cholesterol	If indicated by ACC/AHA guidelines (CDC, 2014c)
	Diabetes	Hemoglobin A1C	If indicated by ADA guidelines (CDC, 2016)
	Hepatitis B	Hepatitis B serology	Check for active infection and immunization status; In countries with virus infection >2% (almost all refugee countries)
	Hepatitis C	anti-HCV antibody testing	Born 1945-1965, with risk factors (HIV, IVDU, blood products, chronic hemodialysis, abnormal ATL)
	HIV		No longer performed before arrival in the US; recommended for all patients
	Strongyloides	Serology or stool culture, O and P for those having symptoms	Only for those with no history of pre-departure therapy. Treat with ivermectin if positive. Do not need to re-treat patients from a country that routinely practices pre-departure therapy. List available at CDC. (Ahmed, Li, Liu, & Tsui, 2012)
	Syphilis	RPR or VDRL	
	Gonorrhea	Urine NAAT	For female refugees <25 years, those with a history of sexual assault, + leukesterase, or symptoms
	Chlamydia	Urine NAAT	For female refugees <25 years, those with a history of sexual assault, + leukesterase, or symptoms
	Tuberculosis	Quanterferon Gold, T-spot, or TST	If positive, follow up with chest x-ray; if indeterminate, repeat test
	Schistosomiasis	Serology or stool culture, O and P for those having symptoms	Only for those with no history of pre-departure therapy. Treat with praziquantel if positive. Do not need to re-treat patients from a country that routinely practices pre-departure therapy. List available at CDC. (Ahmed, Li, Liu, & Tsui, 2012)
Sub-Saharan African Refugees	Malaria	Smear	
Bhutanese	Vitamin deficiency	Vitamin B12/Folate	

continue to talk directly to the patient, using first person terms and maintaining eye contact with the patient (Juckett & Unger, 2014). These simple gestures better allow the patient and provider to connect, even when there is a third-party providing interpretation.

Refugees and other immigrant patients often have perceptions of health and illness that differ from those of Western medicine. For example, a study of Iraqi women found that health was highly valued and closely tied to religion, God, and fate (Salman & Resick, 2015). Familiarity with the patient's perspectives and cultural beliefs can help guide appropriate care plans and improve the doctor-patient relationship (Simmelink, Lighfoot, Dube, Blevins & Lum, 2013). There are several resources available, such as the Cultural Orientation Resource Center (<http://www.culturalorientation.net/learning/backgrounders>), to help physicians learn about cultural beliefs (Cultural Orientation Resource Center). It is also important for the physician to emphasize doctor-patient confidentiality, as many refugees come to the United States without prior contact with a medical system and may not understand their rights as patients (Murray, Mohamed & Ndunduyenge, 2013).

Another common barrier to healthcare is a lack of understanding of our insurance system by both providers and refugee patients. Newly-arrived refugees are given 8 months of health insurance through the Refugee Medical Assistance (RMA) program (Office of Refugee Resettlement). This brief coverage allows patients to see a physician for their initial evaluation and any necessary follow up. After 8 months, refugees are eligible to apply for health insurance through the Affordable Care Act (as of July 2017) or their employers (Terasaki, Ahrenholz & Haider, 2015). While RMA provides urgent and necessary coverage for recently resettled refugees, there are often significant lapses in coverage once the first 8 months have passed. Clinician awareness of this time limit ensures that all necessary tests, procedures, and preventative care are done well within the first 8 months of arrival. In addition, medical problems that usually

are treated through a "wait-and-see" approach, such as inguinal hernias, should be approached with more caution and quicker intervention while insurance is guaranteed.

General Medical Evaluation of Refugee Patients

Before entering the United States, all refugees undergo a health evaluation. The purpose of this evaluation is largely to screen for communicable diseases, such as tuberculosis (TB), syphilis, intestinal parasites, and sexually transmitted diseases (Terasaki, Ahrenholz & Haider, 2015; CDC, 2014c). Physicians should review the documentation from the overseas exam, if available. Once refugees have arrived in the U.S., guidelines put forward by the CDC and other organizations direct further testing, much of which varies by country of origin. These guidelines are frequently updated based on current epidemiologic data, and can be accessed online. The most recent CDC guidelines for health screening of refugee patients newly arrived in the U.S. are summarized in **Table 1** (CDC, 2014b).

A special note must be made about tuberculosis (TB), which continues to be prevalent among refugee populations. All immigrants and refugees are thoroughly screened for active TB prior to arrival to the U.S. However, there are high rates of latent TB among refugees, as well as an elevated risk of reactivation TB within the first year of resettlement. Tuberculosis screening should be repeated once refugees are resettled, unless prior infection and treatment is documented in the patient's records. Patients with a positive TB screen should be referred for chest x-ray to rule out active TB and immediately enrolled in appropriate treatment for either latent or active disease (ORR Health Insurance; Terasaki, Ahrenholz & Haider, 2015). Immunization records should also be examined on the first domestic visit of refugee patients. If incomplete or unavailable, serologic evaluation should be done for hepatitis B and varicella before initiating the vaccine catch-up schedule. Once vaccination

status is identified, refugees can catch up on vaccines via the vaccination schedule provided by the CDC (CDC, 2016; Kim, Riley, Harriman, Hunter & Bridges 2017; Merrett, Schwartzman, Rivest & Greenaway, 2007).

Chronic Disease

While the majority of screening recommendations are targeted towards infectious diseases and nutritional deficiencies specific to immigrant and refugee populations, many refugees also have chronic diseases. In the past, it was thought that migrant populations were generally healthier than host populations, termed the “healthy migrant effect” (Norredam *et al.*, 2014). However, recent research has shown that refugee populations carry a significant burden of chronic diseases. Rates of hypertension, diabetes, and obesity, have been shown to be as high as 30%, 14%, and 64.8% respectively (Bhatta, Shakya, Assad & Zullo 2015; Kumar *et al.* 2014; Redditt, Graziano, Janakiram & Rashid 2015). There are many factors contributing to this occurrence, including acculturation, food insecurity, poverty, and varying health beliefs. Food insecurity, for example, is more prevalent among refugees than other immigrant populations and is associated with worsening of chronic health conditions, such as diabetes and heart disease (Dharod, Croom & Sady, 2013).

For primary care providers, these phenomena complicate the screening of refugee patients. In addition to focusing on refugee-specific medicine, physicians must also screen for chronic disease and understand the impact of local circumstances on their health.

Women’s Health

Now that we have reviewed general guidelines for refugee care, we will present gender-specific considerations pertaining to refugee women. A template for a women’s health-focused visit for a newly arrived female refugee patient is included in **Figure 1**.

Sexual Health and Contraception

Women’s reproductive rights and access to family planning are improving globally, but there remain large disparities among migrant and refugee populations (Pottie *et al.*, 2011). Up to 40% of refugee and immigrant women have an unmet contraceptive need (United Nations, Department of Economic and Social Affairs, Population Division). This disparity is associated with poor health outcomes for already vulnerable migrant populations, including high rates of unintended pregnancy, increased rates of abortion, and higher rates of maternal mortality (Ahmed, Li, Liu & Robinson, 2012). For domestic providers, it is important to know that migrant populations have high pregnancy rates, especially in the first three months of resettlement (Gagnon, Merry & Robinson, 2002). While women are encouraged to make their own choices about family planning, providers should counsel women early and often about family planning.

There are many barriers to effectively providing family planning resources to refugee populations. Lack of knowledge about modern contraception is often cited as an important factor

(Pottie *et al.*, 2011; Salisbury *et al.*, 2016). Religious and cultural beliefs are also considerations, although most religions do allow contraception use for proper birth spacing (Davidson, Fabyi, Demissie, Getachew & Gilliam 2016). In some cultures, a woman’s partner and family have the greatest influence on her family planning decisions; worldwide, it is estimated that 12% of married women do not use contraception because of the influence of one or more outside parties (Sedgh, Hussain, Bankole *et al.*, 2007). These other individuals can be brought into family planning conversations when appropriate.

In addition to one-on-one contraceptive counseling, group education may be helpful in educating refugees about family planning options. Since women most often get their contraceptive information from their peers, community education can be effective (Pottie *et al.*, 2011).

Female Genital Mutilation/Cutting

Female genital mutilation or cutting (FGM/C) includes any procedure that intentionally removes part or all of the external female genitalia without medical benefit (WHO, 2008). FGM is practiced worldwide, but is most commonly practiced in areas of Sub-Saharan Africa, the Middle East, and Asia. UNICEF estimates that almost 200 million women and girls have been subject to the procedure. Given the high prevalence of this practice and increasing global migration, it is increasingly important for physicians in the United States to be aware of the complications, health implications and practice of FGM/C (UN Children’s Fund UNICEF, 2004).

FGM/C is a human rights violation and can have serious medical consequences. Immediate complications from FGM/C include hemorrhage, infection, urinary problems, and fractures from forceful restraint. Long term consequences include chronic pain, recurrent UTIs, scarring, infertility, and complications during pregnancy (WHO, 2008; Nour, 2004).

When caring for a patient who has a known history of FGM or comes from a country with high rates of FGM, providers should be aware of the types of FGM (**Table 2**, UN Children’s Fund UNICEF, 2004) and the language used to discuss cutting. Before the pelvic exam, providers should explain the examination process to the patient. When female patients with FGM/C are considering having children, providers should counsel patients on deinfibulation, a reversal procedure, and refer to obstetrics and gynecology for appropriate prenatal or obstetric care (Nour, 2004). Beyond medical complications, FGM may also cause psychological trauma and embarrassment for women (Connor *et al.* 2016). Providers should be prepared to provide reassurance and support for patients with FGM.

Cervical Cancer Screening

Refugee women should undergo cervical cancer screening between ages 21 and 65 as per USPSTF guidelines for the general population. For women over the age of 65 who have never had a Pap test before, a one-time Pap test is recommended (U.S. Preventative Services Task Force; ACOG Cervical Cancer Screening).

Figure 1 Women's Refugee Clinic Note Template

<p>Name: ***</p> <p>Active Gynecologic Complaints: ***</p> <p>Past Obstetric History: P *** G *** A *** Complicated Pregnancies? ***</p> <p>Past Gynecologic History: Menstruating? *** Date of last period: *** Age at Menarche? *** Abnormal uterine bleeding (menorrhagia, metorrhagia, dysmenorrhea)? *** Hysterectomy or other gyn surgeries? *** Do you know what a pap smear is? *** Have you ever had a pap smear? *** Prior Birth control use? *** History of FGM or trauma to your genitals? ***</p> <p>Past Breast History: Have you ever had a mammogram (if indicated)? *** Have you noticed any changes in your breasts in the last year (lumps, discharge, pain)? ***</p> <p>Past Bone History: Calcium/Vitamin d intake: *** History of fractures: *** H/o steroids: *** Last DEXA results (if indicated): ***</p> <p>Relevant PMH/PSH: ***</p> <p>Relevant Family History: (Breast cancer, ovarian cancer, STIs, fractures, osteoporosis, bleeding disorders, non-contributory, etc.) ***</p> <p>Allergy List: ***</p> <p>Social History: Tobacco Use: *** Alcohol Use: *** Drug Use: *** Safe at home and at work? *** Highest Level of Education? *** Literacy level? ***</p> <p>Mental Health Screen: Flashbacks/nightmares: *** Need for referral for trauma counseling: ***</p>	<p>Sexual History:</p> <p>Number of Partners: *** Gender of Partners: *** How do you identify with regard to sexual orientation? ***</p> <p>What kind of sexual practices (anal, vaginal, oral)? *** Past history of STIs: *** Have you been exposed to anyone you knew had a STI? ***</p> <p>Current Birth control method: *** Are you currently trying to conceive? *** Currently interested in birth control? ***</p> <p>Sexual Assault History: Did anyone ever hurt you or threaten you to have sex or to commit sexual acts? *** Did you ever feel that something bad would happen to you if you did not have sex with someone? ***</p> <p>ROS (OB/GYN): ***</p> <p>Physical Exam: ***</p> <p>Assessment:</p> <p>Plan: Routine refugee women's health screening -- GC/Chlamydia (if not previously ordered) -- Urine Pregnancy -- HIV and RPR (if not previously ordered) -- Pap smear</p> <p>Preventive refugee women's health screening -- Mammogram -- DEXA -- Immunizations given: ***</p> <p>Contraception and family planning --Patient (is/is not) pregnant today --Counseled regarding pregnancy test results --Counseled about Contraception and family planning (contraindications to contraception) --Contraception provided to patient: *** --Pre-natal vitamins ordered if patient refuses contraception or is trying to conceive: ***</p> <p>Mental Health screen: ***</p> <p>Referrals: ***</p>
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Table 2 Types of Female Genital Mutilation or Cutting, WHO

Type I	Total or partial removal of the clitoris, often referred to as a clitoridectomy
Type II	Partial or total removal of the clitoris with total or partial excision of the labia minora
Type III	Infibulation; narrowing of the vaginal opening with or without removal of the clitoris
Type IV	All other harmful procedures to the female genitalia for non-medical purposes, including pricking, piercing, incising, scraping, or burning

Most refugee women come from countries where the rate of cervical cancer screening is low and, consequently, the incidence of cervical cancer is high (Ferlay *et al.*, 2012). Screening services are often unavailable or inaccessible in refugees' home countries due to cost, travel, and limited medical resources. Even after resettlement, refugee patients continue to have lower screening rates than the general population and other immigrant populations (Anaman, Correa-Velez & King, 2016). A study of Bhutanese refugee women reported that only 22.2% had heard of a pap smear and only 13.9% had reported ever having one (Haworth, Margalit, Ross, Nepal & Soliman, 2014). This disparity is due to lack of understanding, language barriers, cultural beliefs, embarrassment, and negative past experiences (Abdullah, Copping, Kessel, Luck & Bonel, 2009; Fang & Baker, 2013). Because of these barriers, refugee women are at risk for delayed diagnosis of cervical cancer and higher morbidity and mortality (Anaman, Correa-Velez & King, 2016).

There are several actions that providers can take in order to make cervical cancer screening more accessible and acceptable to refugee women. Education in the patient's native language about the purpose of screening and a step-by-step description of the procedure helps provide knowledge and reassurance (Anaman, Correa-Velez & King, 2016; Abdullahi, Copping, Kessel, Luck & Bonell, 2013; Zhang *et al.*, 2016). In addition, having female-only providers and interpreters and deferring the Pap smear until the second clinic visit can also make the procedure more acceptable to the patient.

In our clinic, we try to apply these methods to increase patient comfort and compliance. We use culturally sensitive teaching about pap smears and ensure proper education through visual aids and teach-back methodology. We also conduct all cervical cancer screening during a designated women's-only clinic day, subsequent to the initial clinic visit. This model allows us to ensure that patients have met the clinic staff before and are only seeing female providers and interpreters for their women's health exams.

Breast Cancer Screening

Similar to cervical cancer screening, breast cancer screening rates are also lower in refugee populations and associated with later diagnoses and elevated morbidity. A study in Ontario, Canada demonstrated screening rates as low as 48.5% among certain refugee populations (Vahabi, Lofters, Kumar & Glazier, 2016). Many similar barriers have been shown to affect breast cancer screening, such as knowledge, language barriers, cultural practices, embarrassment, and fear (Saadi, Bond & Percac-Lima, 2012; 2015). Culturally sensitive and language-concordant educational programs are effective in increasing breast cancer screening rates. Patient navigation services have also been shown to increase screening rates, though these services are unavailable in most healthcare settings. In addition, encouraging preventative health visits and increased contact with the healthcare system has been correlated with increased cancer screenings (Gondek *et al.*, 2015; Brown, Consedine & Magai 2006; Percac-Lima, Ashburner, Bond, Oo & Atlas, 2013).

Mental Health

Refugee patients are at high risk for mental health disease

including post-traumatic stress disorder (PTSD) and depression (Taylor *et al.*, 2014; Berthold *et al.*, 2014). It is estimated that refugees experience PTSD at 2-10 times higher rates than the general Western population (Mollica *et al.*, 2004; Fazel, Wheeler & Danesh, 2005). The consequences extend beyond mental health; PTSD is associated with increased cardiovascular disease, poor health behaviors, and higher morbidity and mortality, further increasing health disparities in an already disadvantaged population (Zen, Whooley, Zhao & Cohen, 2012). Compounding this problem, refugees have much lower rates of engagement in care for mental health disorders (Johnson-Agbakwu, Allen, Nizigiyimana, Ramirez & Hollifield, 2014). Some barriers, such as language, transportation, and health insurance, are similar to those barriers preventing refugees from accessing general health services (Berthold *et al.*, 2014). However, there are more significant burdens in relation to mental health due to religious and cultural beliefs, stigmatization, and low mental health literacy among refugee population (Colucci, Minas, Szware, Guerra & Paxton, 2015; Piwowarczyk, Bishop, Yusuf, Mudymba & Raj, 2014). These factors often lead to a lack of understanding of the role of mental health professionals and resistance to engagement in therapy.

Mental Health Screening

Because refugees have limited contact with the healthcare system, efficient and effective screening measures are required to identify refugees who have or are at risk of developing mental health conditions. Mental health screening should take place at the initial refugee health visit and all subsequent visits (Shannon, 2014; CDC, 2014a). Due to stigma and trauma, it may take several visits before refugees are able or willing to disclose any mental health problems. For example, although only 1% of Congolese refugees were identified to have mental health disorders in their pre-departure health screening from 2010 to 2012, a population-based study performed around the same time found rates as high as 41% and 50% of depression and PTSD, respectively (U.S. HHS, CDC Congolese Refugee Health Profile, 2016). Thus, it is important to screen at each encounter, even if the initial screen is negative.

Several screening tools exist for providers. In our clinic, we use Refugee Health Screener-15 (RHS-15), which consists of 15 questions and takes between 4 and 12 minutes to administer (Hollifield *et al.*, 2013). Unlike other screening tools, the RHS-15 screens for a variety of psychological disorders and is available in 12 languages (Hollifield *et al.*, 2016). When doing mental health screenings, physicians must plan for patient safety if any acute suicidal or homicidal ideation is expressed, and they should be aware of mental health services for refugees in their area and be able to make referrals if needed (CDC, 2014a). Professional interpreters should also be utilized in all mental health discussions (Shannon, 2014; Crosby, 2013).

PTSD, Gender-based Violence, and Somatization

PTSD and depression are exacerbated by recurrent exposure to trauma, social stressors, poverty, malnutrition, illness, and loss of social networks (Terasaki, Ahrenholz & Haider, 2015; Fazel, Reed, Panter-Brick & Stein, 2012). The PTSD experienced by refugees is often compared to that of war veterans or sexual

assault survivors, however there are several crucial differences. Traumatized refugees often experience repeat severe traumas, such as torture, sexual assault, imprisonment, witnessed killing or abuse, and life endangerment (Buhmann, 2014). The severity and repetitiveness of trauma make refugees a unique population in discussing PTSD.

For female refugees, the impact of trauma may be amplified through gender-specific violence. Sexual and domestic violence increase during periods of instability and displacement (Asgary, Emery & Wong, 2013). The consequences of gender-based violence are broad, leading not only to psychological distress, but also physical, medical, and social problems for female refugees.

In addition to higher rates of PTSD and depression, refugees also experience more somatization than the general population, with one study demonstrating the prevalence to be as high as 63% (Rohlof, Knipscheer & Kleber, 2014). There are several well-defined culturally-specific somatization syndromes, such as “sore-neck syndrome” among Khmer refugees or gastrointestinal focused panic attacks among Cambodian refugees (Hinton, Um & Ba, 2001; Hinton, Chhean, Fama, Pollack & McNally, 2007). Torture survivors may complain of pain in an area they were traumatized, even without physical evidence of existing pathology (Rohlof, Knipscheer & Kleber, 2014). Providers should recognize the commonality of somatic complaints and realize that it can be difficult to differentiate somatic complaints from true medical conditions. Somatic complaints should not be addressed with opioids or other medical therapies, but with referral to appropriate mental health services.

Since the trauma experienced by refugees is unique, the treatment for the resulting mental health disorders must be appropriately adjusted. In general, a combination of medication and trauma-focused cognitive behavioral therapy are recommended for PTSD (Crumlish & O'Rourke, 2010). However, this treatment model may be unfitting for refugee populations due to resource scarcity, cultural differences, long history of trauma, and stigma. Refugee patients in need of psychiatric care should be referred to providers who are knowledgeable about refugee patients and may use different therapies, such as narrative exposure therapy (NET), that have been proven effective in treating traumatized refugee patients (Hijazi *et al.*, 2014).

Conclusion

Caring for refugee patients is both extremely challenging and rewarding. Newly resettled refugees face many barriers to medical care, including language, transportation, knowledge, and cultural and religious beliefs. Like many other vulnerable patient groups in our country, they also struggle with food insecurity, chronic illness, and poverty in numbers previously unrecognized. Despite these hardships, this is a population that is characterized by resiliency and that has much to gain from our medical institution. Physicians should be aware of the ever-changing guidelines and evolving needs of this population. This review summarizes the existing clinical guidelines and recommendations for culturally competent and empathic care for female refugee individuals. We hope that this review will help providers feel more prepared to provide effective care for this unique population.

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