



## MODULE IV: HEALTH & WELLNESS

*Disclosure: Most of the information presented in this section is based on publications from the Institute of Medicine (IOM), the U.S. Preventive Task Force (USPTF), the Department of Navy Virtual Medicine website, the National Heart Lung and Blood Institute (NHLBI) website, and information from the American Cancer Society (ACS), the American College of OB/GYN, and the American College of Preventive Medicine (ACPM). The information has been adapted to aid refugee populations as they adjust to a new life in the United States. When recommendations from the different associations conflicted, all the views were presented in order to allow each individual to make up his/her own mind about the issue. (Akintoye Adelakun, MD. March 24, 1999).*

### Overview

This module consists of a number of sections covering a variety of health and wellness topics/issues.

- Section 1:** Nutrition
- Section 2:** Preventative Healthcare
- Section 3:** Substance Abuse (*Cigarettes, Alcohol & Drugs*)
- Section 4:** Counseling to Promote Physical Activity
- Section 5:** Counseling to Prevent Low Back Pain
- Section 6:** Hypertension (*High Blood Pressure*)
- Section 7:** Diabetes
- Section 8:** Gynecological Care
- Section 9:** Medications

While each section's curriculum is fairly complete, trainers must adapt the curriculum to reflect the following:

1. The cultural norms, values, beliefs, and experiences of the ethnic group(s) represented by the participants.
2. The specific needs of the participants and their families.
3. The particular community environment.

Towards that end, it is recommended that the following steps be taken to maximize effectiveness in the use of this curriculum:

1. Only individuals who have background and experience in health should deliver this curriculum. While every attempt has been made to design a complete and thorough curriculum, the trainer(s) should have some experience in this subject matter prior to offering the training.

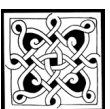




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2. The assessment at the beginning of each section is critical to the further development of the section. The series of questions posed are not designed to be just an ice breaker activity, but rather to help the trainer(s) understand the health problems and practices of the participants and the particular issues they may be facing. Trainers should consider this section as an opportunity for the participants to educate the trainer(s). Trainers should expect to make modifications in the curriculum based on the outcomes of this first section, as well as knowledge of community issues, prior to commencing the program.
3. Modifications should be made in the curriculum to reflect the specific cultural norms, values, beliefs, and experiences of trainees. While there are some references made to cultural norms, values, beliefs, and experiences of individuals from different countries, these are offered for illustrative purposes only; these references are, by necessity, generalizations and therefore should be used cautiously. Nuances related to the specific cultures of participants should be incorporated where appropriate. Answers to the assessment questions should provide some insight to such cultural norms, values, beliefs, and experiences as they relate to health. Community leaders and literature should also be consulted as well.
4. The curriculum is written in a style of English suitable for trainers (specifically those with health experience), but which will need to be simplified for clients for whom English is not their first language. Finding simple ways to communicate some of these concepts is important to gaining participants' understanding.

While it is beyond the scope of this manual to address serving the needs of individual families, trainers should be aware that delivery of this program to groups of families could help to identify specific families who could benefit from more individualized services.





## **Section 1: Nutrition**

### **Objectives**

*Participants will—*

1. Discuss the importance of nutritional need counseling and healthcare prior to conception.
2. Learn how to improve their family's overall nutritional status, before conception, during conception, and after conception, by introducing healthful dietary practices.
3. Learn about behavioral changes before conception that will contribute to a successful pregnancy.

### **Materials**

1. Cultural Nutrition Assessment Questionnaires (for adults, children, and the elderly)
2. Cultural Nutrition Evaluation Questionnaire
3. Pictures of foods from all food groups
4. Large sheets of unlined paper
5. Flipchart
6. Scotch tape
7. Markers

### **Introduction**

Nutrition plays a major role in promoting maternal and infant health. The goal of this section is to help women's health trainers to understand the rationale for nutrition services and to incorporate appropriate nutrition education into their class sessions. This manual promotes an individualized approach to nutrition services for refugee women's health.

Refugees have complicated nutrition requirements because of their previous socioeconomic circumstances. Many refugees have had to do with just getting enough to eat, rather than getting a balanced diet. Depending on their country of origin, and their prior circumstances (War vs. Politics), the nutritional picture can be very diverse. For example, infant nutrition within former Soviet Union countries has been compromised because mothers have not been encouraged to breastfeed and imported formulas are in short





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supply; as a result, iron deficiency anemia is rampant (>25 percent) and goiters are common. Among Somali refugees, there are iron and vitamin deficiencies (such as scurvy); meanwhile, Ethiopians have significant protein malnutrition. The nutritional picture can be further complicated by parasitic infections that make correction of the refugee's nutritional deficiencies more difficult. Among Cubans, poor economic conditions have resulted in micronutrient deficiencies, which in turn have been responsible for epidemics of vision problems (optic neuropathy), hearing deficits, and problems of the nervous system (neuropathies).

*Note to Facilitators:*

*The intention of the information presented in this section is to provide a knowledge base for effective counseling on this topic.*

### **Differences to Consider**

1. Participants who are single or without children.
2. Participants with religious dietary restrictions.
3. The physical state/life stage of the woman, i.e. adolescence, pregnancy, old age, or breastfeeding.

### **Assessment**

The following questionnaire can be completed individually or as a group. It is designed to be an icebreaker to allow for cultural exchange about nutrition and to be an introduction to cultural biases regarding nutrition.

Use the participants' answers to guide you as you use the curriculum. The material may be adapted or added to as the participants' needs indicate.

*Note to Facilitators:*

*Remember that children with special nutritional needs are to be referred; therefore, only appropriate nutrition behavior and strict compliance with physician's recommendations need to be stressed.*

*Special children's conditions include diabetes, cystic fibrosis, phenylketonuria (PKU), oral facial abnormalities, Down's syndrome, or children with gastrointestinal diseases requiring specialized feedings and formula.*

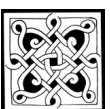






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9. What do you know about diabetes, beriberi, and anemia?
  
10. What are your worries or concerns about food in United States?
  
11. Are you on a special diet at home based on cultural or religious reasons?
  
12. Do you have any food-related allergies and/or medical problems?
  
13. Do you know where (stores) to find the kinds of foods that you like to eat?
  
14. What kind of support do you need in feeding yourself and your children?
  
15. What is your cultural attitude about breastfeeding?
  
16. Are you familiar with the kinds of food that are good for your children?
  
17. What kinds of dietary traditions would you like to continue in the United States?

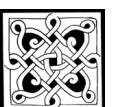




18. How do you prepare your food at home?

19. Do you let your plates air-dry after washing?

20. Who eats first in your family and why?





## **Cultural Nutritional Assessment for Children Questionnaire**

1. How is your child tolerating American food?
  
2. Are you feeding your child traditional foods from your country?
  
3. If this is not your first child, how does his/her growth compare to your previous child (or children) at the same age?
  
4. How does your child's growth compare to your neighbor's children?
  
5. Do you have any concerns about your child eating American foods?
  
6. Do you know where to find baby food?
  
7. How often do you measure your child's height or take his/her weight?
  
8. Does your child have any medical problems?
  
9. Does your child have any food-related allergies and/or medical problems?





10. When was the last time your child saw a physician?

11. Are all his/her immunization shots up to date?

12. Do you feed your child specialized formulas?

13. Do you know how to make homemade children's food? If not, would you like to know?





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**Cultural Nutrition Assessment for the Elderly**

1. How are your elderly dependents eating?
  
2. Does he/she need a special diet?
  
3. Do you have concerns about the way they are eating?
  
4. Do they have any other medical problems, such as dental problems, etc.?
  
5. Do they have any food-related allergies and/or medical problems?





## **Outline/Lesson Plan**

### **General Nutritional Recommendations**

#### **Women's Nutritional Needs**

*- Special Considerations for Pregnant Women*

#### **Infants & Children**

#### **Food Safety**

#### **Fast Facts**

#### **Intervention Strategies**

#### **Activities**

- The Food Pyramid Game*
- TIC-TAC-TOE*
- Creating Nutrition Plans*
- "How-To" Seminars*

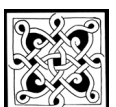
#### **Field Trips**

#### **Speakers**

#### **Evaluation**

## **General Nutritional Recommendations**

1. Adults and children over age two should limit their total fat intake to <30 percent of total calories and dietary cholesterol <300 mg/day. Saturated fat consumption should be reduced to less than 10 percent of total calories. To achieve these goals, patients should be encouraged to eat fish, poultry prepared without skin, lean meats, and low-fat dairy products. They should be encouraged to eat a variety of foods, especially whole grain products and cereals, legumes (beans, peas), vegetables, and fruits.
2. The U.S. Department of Health and Human Services (DHHS) currently recommends at least five servings of fruits and vegetables and at least six servings of breads, cereals, or legumes each day.
3. Increase dietary intake of iron, beta-carotene, or other antioxidants.
4. People with high blood pressure (hypertension) should reduce their sodium intake.
5. Emphasize that intake of refined sugars and sticky starches may affect dental health.
6. Explain that diseases associated with dietary excess and imbalance rank among the leading causes of illness and death in the United States.





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### **Women's Nutritional Needs**

1. Women should consume the recommended quantities of calcium for their condition (pregnant, nursing) or age: adolescents and young adults (1,200-1,500 mg/day); adults aged 25-50 (1,000 mg/day); postmenopausal women (1,000-1,500 mg/day); and pregnant and nursing women (1,200-1,500 mg/day).
2. Provide pregnant women with specific nutritional guidelines to enhance fetal and maternal health.
3. Explain the role of iron during pregnancy and in the diets of newborns and young children.
4. Explain the use of folic acid by women of childbearing age to prevent neural defects.

### *Special Considerations for Pregnant Women:*

The following table lists conditions that put a woman at higher nutritional risk. These women need more specialized attention, and require one-to-one counseling sessions and interventions. Subsequently, it may be necessary to separate these women from the rest of the group so as not to confuse the situation.

*Note to Facilitators:*

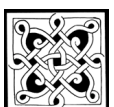
*The following table can be converted into a handout if necessary.*

<b>Special Condition</b>	<b>Medical Problem</b>	<b>Counseling Needed/Intervention</b>
<b>Diabetes (Mother has Type 1 or Type 2)</b>	Is caused by too much sugar in the blood, either because the pancreas is not producing adequate amount of insulin, or the insulin that the body produces is not doing the job of controlling sugar. Diabetes, if not controlled properly, can lead to blindness, amputations, pregnancy problems, and organ failures.	<ul style="list-style-type: none"> <li>❖ Complications are preventable.</li> <li>❖ Regular exercise, adherence to medications, diet, and good vigilance should be emphasized.</li> <li>❖ Pregnant women need special care from a physician.</li> </ul>
<b>Gestational diabetes</b>	Diabetes that occurs only during pregnancy. It usually goes away after the baby is born.	<ul style="list-style-type: none"> <li>❖ Observe a specialized diet during pregnancy.</li> </ul>





<b>Special Condition</b>	<b>Medical Problem</b>	<b>Counseling Needed/Intervention</b>
<b>Phenylketonuria (PKU)</b>	Inherited condition consisting of an inability to metabolize the amino acid (phenylalanine). A person with this problem may develop mental retardation either from eating foods high in phenylalanine as a young adult or if their mother ate foods high in phenylalanine while pregnant.	❖ Mother (and children until they reach adolescence) should observe a phenylalanine-restricted (avoiding meat, dairy, and other foods high in protein) diet before and during pregnancy.
<b>Obesity</b>	Has been associated with many pregnancy complications.	❖ Special care when pregnant.  ❖ Counsel to reduce weight, then stabilize before getting pregnant.
<b>Hypertension (either before or during pregnancy)</b>	Can cause pregnancy complications requiring a special diet.  Can cause organ damage, including brain stroke and seizures/convulsions.	❖ Reinforce physician's warnings, and assist person to understand their disease, follow their programs, and take their medications.
<b>History of caesarian or operative birth</b>	Increased risk for many problems, including another caesarian section. Adhesions from previous surgery can cause abdominal problems and affect eating habits.	❖ Refer to a nutritionist and a doctor.
<b>Pregnant, but not gaining weight</b>	The baby may not be growing properly, or the mother is not eating well, or both.	❖ Discuss possible causes and address any identified nutrition problems. Refer to a physician.
<b>History of premature birth</b>	Possibly low nutrient intake, but could have many other causes.	❖ Provide guidance, support, counsel, and emphasize physician warnings and recommendations.  ❖ Discuss possible causes and address any identified nutrition problems. Refer to a physician.
<b>Renal (kidney) disease</b>	Can be caused by other diseases. Can lead to organ damage and need for transplant.	❖ Discuss possible causes and address any identified nutrition problems. Refer to a physician.
<b>History of hemorrhage (bleeding) after birth</b>	Has many causes.	❖ Discuss possible causes and address any identified nutrition problems. Refer to a physician.





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Special Condition	Medical Problem	Counseling Needed/Intervention
<b>Multiple pregnancy</b>	Mother's resources are shared by more than one baby; therefore, there are problems relating to how to sustain the pregnancy. There is increased risk of low birth weight.	❖ May need a vitamin supplement along with balanced daily diet.
<b>History of poor pregnancy outcomes</b>	Has many causes.	❖ Discuss possible causes and address any identified nutrition problems. Refer to a physician.
<b><i>Use of Drugs/Medications</i></b>		
<b>Cigarettes &amp; other tobacco Products</b>	Cigarette smoking causes many problems, from hypertension to organ failure.	❖ Encourage them to stop smoking completely.
<b>Alcohol</b>	Can cause fetal-alcohol syndrome (FAS) in babies.	❖ Refer to Alcoholics Anonymous, and encourage CAGE screening.
<b>Retinol (is sold in some pharmacies as a supplement)</b>	Is often prescribed for skin diseases. Too much of it during pregnancy can cause problems for the baby.	❖ Avoid retinoin products during pregnancy.
<b>Isoretinoin</b>	It is a vitamin A analogue; as such, it is toxic in high amounts.	❖ Avoid during pregnancy.
<b>Dihydrophenylhyd antoin (Dilantin) for seizures</b>	Interferes with folic acid metabolic pathway.	❖ People who have to take this drug need special care during pregnancy.

## Infants & Children

1. Infants require breast milk or appropriate alternatives (e.g., infant formulas) to provide adequate nutrition. Parents should be encouraged to breastfeed.
2. Current studies suggest that infant consumption of breast milk for at least 6 months may reduce the child's risk of ear infection, lower respiratory tract illness, meningitis, allergies, diarrhea, and abnormal mental development.
3. Infants may also benefit from iron-fortified formula and foods to replace depleted iron stores, as iron deficiency anemia during infancy may be associated with impaired mental and nervous system development.





4. Proper nutrition throughout childhood is important to facilitate normal growth and development.

## **Food Safety**

The following are methods to prevent food poisoning.

1. Keep food in refrigerator at 40°F or 4°C.
2. Refrigerate all cooked food within two hours of being cooked.
3. Sanitize kitchen dishcloths with one tablespoon of bleach in one quart of water.
4. Wash hands carefully after handling raw meat.
5. Wash meat boards periodically with bleach.
6. Date all leftovers, and eat within two days.
7. Cook ground beef, meat products, and poultry until they are no longer red in the middle (160°F or 72°C).
8. Do not eat raw or lightly cooked eggs.
9. Defrost meat, poultry, and fish products in refrigerator, microwave, or cold water (this must be changed every 30 minutes).
- 10 Allow dishes and utensils to air dry to prevent recontamination, and wash dishes within two hours of use.

## **Fast Facts**

1. Because foods high in complex carbohydrates and fiber and low in fat content are also lower in calories, they are ideal for helping maintain a healthy body weight.
2. The replacement of foods high in simple carbohydrates (e.g., table sugar, honey, corn sweeteners) with those containing starch and fiber improves caloric balance and may lower the risk of developing cavities.
3. Increased intake of dietary fiber improves bowel function.
4. The consumption of foods containing large amounts of soluble fiber (e.g., dried beans, oat products) appears to lower levels of LDL cholesterol (whether or not they have replaced foods high in saturated fat and cholesterol).
5. Observational studies suggest an association between eating vegetables and fruits and a lower risk of cancer.



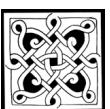


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6. Cross-cultural studies have shown a correlation between the sodium intake of different populations and the incidence of hypertension (high blood pressure).
7. The following are the recommended amounts of dietary calcium for individuals: men (1,000 mg/day); adolescents and young adults (1,200-1,500 mg/day); women 25-50 years old (1,000 mg/day); postmenopausal women (1,000-1,500 mg/day); pregnant and nursing women (1,200-1,500 mg/day).
8. Adequate dietary iron intake is important for menstruating and pregnant women and for young children to maintain iron stores and prevent iron deficiency anemia.
9. Women of childbearing age who take folic acid supplements may be less likely to give birth to children with neural tube defects.
10. While women who give birth prematurely have breast milk high in protein, the protein is still not enough to sustain the baby (thus the baby would need protein supplements).
11. Nutritional status is especially important during pregnancy.
12. Studies have shown that low birth weight and neonatal (newborn to one month) mortality are more common in pregnant women with very poor nutritional status and in those who fail to gain adequate weight during pregnancy.
13. Pregnancy brings increased requirements for energy and specific nutrients, such as protein, calcium, folic acid, and iron.
14. The elderly can also have special nutritional requirements. Depending on the patient's nutritional status, underlying medical disorders, functional status, teeth, and therapeutic drug regimens, it is be important to modify recommended daily intake levels of calories, sodium, calcium, water, dietary fat, fiber, protein, and other nutrients to reduce the risk of complications.

## **Intervention Strategies**

1. Develop strategies for increasing participants' healthy nutrition behavior and knowledge about nutrition.
2. Develop lesson plans on different foods and different categories of foods.
3. Continuously monitor participants' progress and adjust the lesson plan.
4. Become familiar with the community where the participants reside and facilitate their use of the community's resources.





5. Educate participants about the benefits of breastfeeding unless there is a potential problem, e.g. the mother is on medications or the baby has a medical condition.
6. Identify barriers to breastfeeding.
7. Encourage the use of a food diary and monthly health diary (weight, height, and baby's weight, height, and growth pattern).
8. Develop a more intensive intervention program, consisting of the following, for participants in need:
  - ❖ Home visits.
  - ❖ Periodic telephone calls.
  - ❖ Permission to talk to patient's physician regarding your concerns, and interventions thus far.
9. Incorporate new knowledge and be culturally sensitive.

## **Activities**

Depending on the needs of the participants and available resources, one or more of the following activities can be used for this section.

### ***The Food Pyramid Game:***

**Time:** 20 minutes

#### **Objective:**

Given a set of pictures representing different food groups, participants will be able to create a food pyramid.

#### **Procedure:**

1. Divide participants into groups of not more than four members.
2. Give each group a pile of pictures of foods and ask them to create a food pyramid.
3. Invite each group in turn to present their pyramid to the class, explaining why they decided to place the pictures as they did.

*Note to Facilitators:*

*In the absence of pictures, the trainer can ask participants to draw different foods in the pyramid. Also, the activity can be conducted as a competition—the fastest group gets a prize (a healthy snack) and other groups get consolation prizes or they are*





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asked to prepare a healthy meal for the class. Another possible variation is to have the class choose a panel of "judges" who will pick the "best" food pyramid and award a prize.

### ***TIC-TAC-TOE:***

The Nutrition Evaluation Questionnaire can also be used as questions in a TIC-TAC-TOE game.

#### **Procedure:**

1. Divide the class into two groups.
2. Assign one group to be the "X" group.
3. Assign the other to be the "O" group.
4. On the flipchart, draw a TIC-TAC-TOE Board.
5. Place one question card (face down) in each square on the image. There should be a total of nine question cards in the image.
6. One group begins by choosing a square. The facilitator turns over the card in the chosen square and reads the question to whichever group chose the square. If the group can answer the question correctly, either an "X" or "O" is then drawn in the square (depending on whether the group answering the question is the "X" or the "O" group). If they answer the question incorrectly, the card is placed face down again and they are not awarded an "X" or an "O." The other team then chooses a square and attempts to answer the question. The game ends when one group is able to answer enough questions so that there is a vertical diagonal or horizontal row of "X"s or "O"s.
7. Encourage groups to choose the squares strategically so that they can maximize their opportunity to win while minimizing their opponent's opportunity to do so.

#### ***Creating Nutrition Plans:***

1. Nutrition diary: breakfast, lunch, and dinner.
2. Baby's nutritional diary: breakfast, lunch, and dinner.
3. Health diary: weight, height, significant health events, etc.
4. Baby's health diary: weight, height, growth pattern, doctor's visits, immunization shots, etc.





**"How-To" Seminars:**

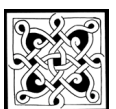
1. How to make homemade baby food.
2. How to breastfeed.
3. How to lose weight.
4. How to reduce stress at home.
5. Ways to prevent food poisoning.

**Field Trips**

1. Trips to the neighborhood supermarket, international market, and/or Food Cooperatives.
  - ❖ Exercise on picking the right vegetables.
2. Trips to farms or farmer's markets, including organically grown vegetable farms.
3. Trips to Sam's Cluts or Costco for information on bulk purchasing.

**Speakers**

1. Dieticians with the same cultural background as the participants.
2. Guest lectures on cooking for people with diabetes, high blood pressure, etc.
3. Presenter from local Women, Infants and Children program (WIC) office to present on healthy nutrition for mothers and babies and how the WIC program can benefit the participants.





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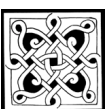
### **Evaluation**

*Part 1:* To determine whether the objectives have been met and how much information the participants have retained, have the class complete the following questionnaire (either individually as a handout or orally as a group).

*Part 2:* This is an opportunity for students to ask the trainer questions. Encourage students to ask questions about the different topics covered (Presenter should feel free to use own initiative/experience and if necessary use the "fast fact" section for elaboration).

*Part 3:* Feedback about lectures and presentations. Review with participants what worked, what didn't, and give participants the opportunity to make suggestions for improvement.

*Part 4:* Reflections from the presenter's perspective—Have I learned anything? What would I do differently?





## **Cultural Nutrition Evaluation Questionnaire**

1. What are the different states/stages of womanhood and the nutritional requirements that they impose?
2. How many servings of fruits and vegetables are recommended per day?
3. How many servings of breads, cereals, or legumes are recommended per day?
4. How much calcium per day does a pregnant woman need?
5. What three elements are very important in pregnancy?
6. What are the possible consequences of eating too much?
7. How should meat be defrosted?
8. Name two uses of bleach in the kitchen.





## **Section 2: Preventive Healthcare**

### **Objectives**

*Participants will—*

1. Become familiar with preventive health resources in the United States and the importance of utilizing preventive services.
2. Discuss their approach to preventive health care as gained from their culture(s).
3. Identify potential obstacles that may prevent women from getting necessary care.
4. Learn about particular health risks so that they can change unhealthy lifestyle behaviors.

### **Materials**

1. Preventative Healthcare Assessment Questionnaire (for adults, children, and the elderly)
2. Preventative Healthcare Evaluation Questionnaire
3. Flipchart
4. Markers

### **Introduction**

This section aims to alert women to the important role prevention and preventive clinical services play in reducing women's risk for illness, injury, chronic disease, disability, and early death. Personal behaviors such as smoking, exercise, dietary habits, use of alcohol, and safe sexual practices impact health and reduce or enhance a woman's risk of illness and disability. For example, tobacco use is estimated to have caused 400,000 deaths in 1990; poor diet and lack of regular physical activity, another 300,000 deaths; and alcohol use, an additional 100,000 deaths. Education and outreach programs are important avenues for identifying and changing health-damaging behaviors that enable women to lead healthier lives.

Effective interventions and educational programs that encourage women to adopt healthful behaviors and avoid harmful ones must address personal and environmental factors that influence women's behaviors. In addition to social norms that encourage particular behaviors as a form of group solidarity or identification, knowledge and attitudes about the effects of health damaging





behaviors and social support from family and friends are also important factors.

A comprehensive approach to preventive health education must include information about the effects of health-related behaviors and strategies to change these behaviors, as well as information about the importance of preventive clinical services. These clinical services include clinical breast exams, blood pressure screening and bone density tests that reduce the risk of serious illness and premature death through early detection of problems within treatable stages of illness and disease. Some factors that impact women's ability to utilize clinical services include lack of transportation and time constraints, in addition to health care arrangements that fail to include coverage for preventive services. For instance, there is considerable variation among plans in the coverage of preventive services, and poor women and minority women in particular continue to face financial barriers to receiving preventive services.

*Note to Facilitators:*

*The intention of the information presented in this section is to provide a knowledge base for effective counseling on this topic.*

## **Differences to Consider**

Participants may have different perceptions, expectations, and cultural understandings regarding prevention, including the techniques and methods used. They may lack access to health care services (i.e., time constraints, transportation, etc.), or be restricted due to a lack of coverage for preventative screening. Additional differences that affect the type of and need for preventative health care are:

1. People who are single or without children vs. families with children.
2. Religious and/or cultural dietary concerns.
3. The age/state of the woman—whether adolescent, menopausal, pregnant, or breastfeeding.

## **Assessment**

The following questionnaire can be completed individually or as a group. It is designed to be an icebreaker to allow for cultural exchange about and be an introduction to cultural biases regarding preventative healthcare.

Use the participants' answers to guide you as you use the curriculum. The material may be adapted or added to as the participants' needs indicate.





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### **Preventative Healthcare Assessment Questionnaire**

1. What kinds of health services are available in your country?
  
2. When do people go to see a doctor in your country?
  
3. When people are sick, whom do they go to see in your country?
  
4. Are women required to see doctors even when they are not sick?
  
5. In your country, what are the recommendations about doctor's visits for women, men, children, and the elderly?
  
6. Do you know how often you are supposed to see your healthcare provider or a doctor here in United States and why?
  
7. Do you know how often men, the elderly, and children are supposed to visit doctors in United States and why?
  
8. What does risk or risk factors mean to you? Give examples of risks.
  
9. What do you know about cancer and its causes? Who gets what?





10. How is cancer prevented in your country of origin?
  
11. How is cancer prevented in the United States?
  
12. What is high blood pressure?
  
13. In your country, what do you do for people with high blood pressure?
  
14. If high blood pressure is not treated, what do you think happens?
  
15. What do you know about diabetes?
  
16. How do you treat or prevent diabetes in your country?
  
17. If diabetes is not controlled properly, what do you think happens?
  
18. What do people do for dental problems in your country?
  
19. How often do you think you should see a dentist here in United States?





## **Preventive Healthcare for Children & the Elderly Assessment Questionnaire**

1. How often should your child see a doctor?
  
2. What are immunization schedules?
  
3. What are the advantages of immunization?
  
4. Do you know where to go for immunization in your area?
  
5. Do you know that many of your child's immunizations are free?
  
6. When was the last time your child saw a physician?
  
7. Does your child have any health conditions?
  
8. How often do the elderly members of your family see a doctor? When was the last time they did?
  
9. Do you know what medication your family's elderly members should be taking to prevent disease?





10. Do you know which vaccinations your family's elderly members should be getting and how often?

11. Do your family's elderly members have any medical problems?





## Outline/Lesson Plan

### General Preventative Healthcare

- *General*
- *Female Specific*
- *Male Specific*

### The Basics of Dental & Oral Health

### Intervention Strategies

### Evaluation

## General Preventative Healthcare

General physical exams should occur every 5 years, until age 50, after which they should occur each year. The routine physical exam should be tailored to a patient's individual risk factors, and they should receive counseling on health behaviors and referral for appropriate preventive services.

Controversy and contradiction among major authorities (regarding recommendations for screening services) continue. The following tables, however, list the recently released recommendations from the U.S. Preventive Services Task Force (USPSTF).

### *General:*

<b>Skin cancer</b>	A skin examination should be performed annually for individuals with a family or personal history of skin cancer, increased occupational or recreational exposure to sunlight, or evidence of precursor lesions. Starting at age 40, all individuals should also be examined every year.
<b>Thyroid cancer</b>	Adults whose upper body has been exposed to radiation should be checked regularly for thyroid nodules.
<b>Hypertension screening</b>	In general, individuals should have their blood pressure taken regularly. Individuals with the following risk factors, however, should have yearly blood pressure measurements: <ul style="list-style-type: none"> <li>❖ An initial diastolic pressure of 85-89.</li> <li>❖ African-American males.</li> <li>❖ Family history of hypertension in a first degree relative.</li> <li>❖ Obesity.</li> <li>❖ Diabetes.</li> </ul>





<b>Vision screening</b>	Comprehensive eye examinations should be performed every 3 to 5 years in African Americans aged 20-39 years, and regardless of race, every 2 to 4 years for individuals aged 40-64 years.
<b>Cholesterol screening</b>	Beginning at age 18, blood cholesterol should be tested at least every 5 years. The USPSTF states that routine cholesterol screening should be performed on all men aged 35-65 and all women aged 45-65.
<b>HIV</b>	Counseling concerning high-risk behaviors and the use of condoms is extremely important.
<b>Counseling service</b>	Participants may require counseling on the following: dietary assessment and nutrition; physical activity and exercise; cancer surveillance; safe sex practices; tobacco, alcohol, and substance abuse; accident and injury prevention; dental health; domestic violence; stress; bereavement; and suicide.
<b>Tuberculosis</b>	Because refugees are considered high-risk individuals, tuberculin skin testing should be included as part of a health screening within the first 30 days after a refugee arrives in the United States.
<b>Immunization</b>	<ul style="list-style-type: none"> <li>❖ <b>Tetanus/Diphtheria:</b> Primary series followed by a booster every 10 years or single booster at age 50.</li> <li>❖ <b>Hepatitis B:</b> People with high-risk behaviors (IV drug use, multiple partners) should be immunized.</li> <li>❖ <b>Influenza:</b> This vaccination should occur annually for the elderly and those with chronic illness. May be of benefit for healthy adults as well.</li> </ul>

*Female Specific:*

<b>Breast cancer</b>	For women 40 and older, an annual clinical exam should be performed. In women older than 40, physicians may elect to perform a clinical breast examination for those who are at high risk. Most authorities recommend a baseline mammogram at age 40, then every 2 years for the ages of 40-50, and annually for age 50 and over. For high-risk women, mammograms may start at age 35 years, then annually. USPSTF advises routine mammography to be performed alone or with a clinical breast exam (CBE) every 1 to 2 years in women aged 50-69 years. They further state that there is insufficient evidence to recommend for or against routine mammography or CBE for women aged 40-49 or aged 70 or older. (See Section 8: Gynecological Care.)
<b>Cervical Cancer</b>	Pelvic examination with a Pap smear should be performed annually on women 18 years and over, until 3 consecutive satisfactory examinations. Frequency may then be less often at the physician's discretion, but should be at least every 3 years. (See Section 8: Gynecological Care.)
<b>Osteoporosis</b>	All women should be counseled on proper intake of calcium and regular exercise, especially in young adulthood.





## *Journey of Hope*

<b>Pregnancy</b>	It is important to counsel young women on contraception.
<b>Abuse</b>	Women are at high risk for both physical and mental abuse. It is estimated that up to 1 in 4 emergency room visits by females may be the result of abuse. All female participants must be asked about abuse!

### *Male Specific:*

<b>Testicular Cancer</b>	A testicular exam should be performed annually for males age 13-39 years, especially those with a previous history of testicular problems.
<b>Prostate Cancer</b>	A rectal examination should be part of the periodic health examination of males 40 years and older, and annually for men 50 years and older. Is often combined with a colorectal examination.
<b>Colorectal Cancer</b>	A rectal examination should be included in the periodic health examination of individuals 40 years of age and over. For those over 50 years of age, their stool should be tested annually for the presence of blood, with a sigmoidoscopy performed every 3-5 years. The USPSTF states that there is insufficient evidence to recommend for or against routine screening by barium enema or colonoscopy.

## **The Basics of Dental & Oral Health**

The American College of Obstetricians and Gynecologists (ACOG) recommends that dental hygiene should be included in counseling as part of periodic evaluation visits, which should occur yearly or as appropriate. The American Dental Association (ADA) recommends that adults should be seen annually for routine dental care and preventive services, including oral cancer screening and oral hygiene counseling. This recommendation applies to patients with full dentures as well as patients "with teeth."

1. Encourage all participants (including older adults and the toothless) to see a dentist regularly for preventive care.
2. Encourage all participants to brush their teeth with fluoride-containing toothpaste and to use dental floss daily.
3. Encourage individuals who have a history of frequent cavities to reduce their intake of foods containing refined sugars and to avoid sugary/starchy between-meal snacks. A fluoride-containing mouthwash might also be beneficial.
4. Counsel participants not to use tobacco in any form, and to limit alcohol consumption.





5. Encourage individuals who are out in the sun to protect their lips and skin from the harmful effects of ultraviolet rays by using sunscreens and lip balms of SPF 15 or more, to wear protective clothing such as hats, and to avoid direct sun exposure between the hours of 10:00 a.m. and 3:00 p.m.
6. Encourage individuals who engage in sports that have the potential for oral and dental trauma (such as football, hockey, boxing, etc.) to use appropriate protective equipment, including headgear and mouth guards. Urge participants to wear safety belts while in motor vehicles and helmets while riding bicycles and motorcycles.
7. Encourage individuals, especially those who use tobacco or alcohol, to see a dentist or physician if they have any mouth problems (such as color changes, cracks, ulcers, bleeding; or swelling or thickening in the lips, cheeks, gums, tongue, or roof of the mouth) that last longer than 2 weeks.
8. Encourage participants to obtain counseling about the effects and complications of any medications they are taking.

### **Intervention Strategies**

1. Develop strategies for emphasizing the importance of primary prevention and healthy behavior to the participants.
2. Develop lesson plans around different health problems (cancer) and preventive recommendations.
3. Continuously monitor progress and adjust the lesson plan.
4. Facilitate participants' use of their community's primary prevention resources (free breast exams, free blood pressure (BP) check, etc).
5. Encourage activities that increase knowledge about prevention (prevention games).
6. Identify barriers that may be preventing the participants from seeking preventive medical services and educate them about the barriers.
7. Encourage the use of a monthly health diary (weight, height, BP, doctor's visit, and medications).
8. Develop a more intensive intervention program for at-risk participants which includes:
  - ❖ Home visits
  - ❖ Periodic telephone calls
  - ❖ Family education (women, husbands, and children)
  - ❖ Permission to talk to person's physician regarding concerns and interventions thus far.





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9. Incorporate new knowledge, communicate it to the participants, and be culturally sensitive.

### **Evaluation:**

*Part 1:* To determine whether the objectives have been met and how much information the participants have retained, have the class complete the following questionnaire (either individually as a handout or orally as a group).

*Part 2:* This is an opportunity for students to ask the trainer questions. Encourage students to ask questions about the different topics covered (Trainer should feel free to use own initiative and experience, and if necessary use the "fast fact" section for elaboration).

*Part 3:* Feedback about lectures, and presentations. Review of what works, what didn't, what needs work, and suggestions.

*Part 4:* Reflections from the presenter's perspective—Have I learned anything? What would I do differently?





## **Preventative Healthcare Evaluation Questionnaire**

1. How often should a person have a general physical exam? After age 50, how often?
  
2. What are the advantages of immunization? What are immunization schedules?
  
3. What does "risk factor" mean?
  
4. What is high blood pressure and what does it put you at risk for?
  
5. What is a baseline mammogram and when is it recommended that you have one?
  
6. What is the purpose of preventative healthcare?
  
7. What are vaccinations?





## **Section 3: Substance Abuse**

### ***(Cigarettes, Alcohol, & Drugs)***

#### **Objectives**

*Participants will—*

1. Learn about the nature and problems of substance abuse.
2. Discuss the special circumstances and the methods of addressing substance abuse in the refugee population.

#### **Materials**

1. General & Cultural Substance Abuse Assessment Questionnaire
2. Substance Abuse Evaluation Questionnaire
3. Flipchart
4. Markers

#### **Introduction**

During resettlement in host countries, refugee women often face problems that are worse than those faced by voluntary migrants. While these problems are often related to previous traumatic experiences, there are many refugee women who may not have personally experienced torture or trauma, but who, nonetheless, perceive themselves as being marginalized from mainstream society. These feelings of marginalization can lead to isolation and depression, risk factors that may result in the abuse of alcohol, cigarettes, and other drugs. Besides the usual street drugs like heroin, cannabis, cocaine, etc., refugees may have other addictions—such as amphetamines and khat (Also known as Qat or Miraa. Consists of the fresh young leaves of the *Catha edulis* plant, which contain a psychoactive substance, and has been associated with many health problems).

Before resettlement, all refugees are screened for drug abuse and those who fail are considered excludable to the U.S. resettlement program until rehabilitation has occurred and the refugee has completed a clean drug test. However, not all drugs are tested for or excludable, and once resettled, some refugees may once again begin using drugs because of old habits or as a way to deal with the increased socioeconomic pressures following resettlement. The most commonly abused substance is tobacco (in the form of cigarettes), followed by alcohol, cannabis, amphetamines, and khat.





*Note to Facilitators:*

*The intention of the information presented in this section is to provide a knowledge base for effective counseling on this topic.*

## **Differences to Consider**

1. Cultural attitudes towards drugs—some may find it offensive/accusatory.
2. Views on khat as a drug.
3. Views on cigarettes and alcohol as drugs.

## **Assessment**

The following questionnaire can be completed individually or as a group. It is designed to be an icebreaker to allow for cultural exchange about drugs and to be an introduction to cultural biases regarding drugs and drug abuse.

Use the participants' answers to guide you as you use the curriculum. The material may be adapted or added to as the participants' needs indicate.

*Note to Facilitators:*

*For specific substance abuse assessments, which are used when substance abuse is suspected, see Appendix A: Health & Wellness—Section 3: Substance Abuse for the standard questionnaires.*







*Journey of Hope*

10. Are you familiar with available programs regarding drug abuse prevention?

11. Does your work place have an Employee Assistant Program (EAP)?

12. What is an EAP?

13. Does your work place have a drug policy?





## **Outline/Lesson Plan**

**Tobacco**

**Alcohol**

**Drugs**

**Special Circumstances: Pregnancy, Adolescents, & Children**

- *Pregnancy*

- *Adolescents & Young Adults*

**Fast Facts**

**Intervention Strategies**

**Activities**

- *List Game*

- *Diaries*

- *How-To Seminars*

**Field Trips**

**Speakers**

**Evaluation**

## **Tobacco**

Many refugees are not aware (due to the lack of public health education in their home country) that tobacco is a drug or of the debates regarding cigarettes in the United States. In the United States, most tobacco users have at least a vague idea that the habit is harmful, but may be unaware of the specifics or the magnitude of the risk.

To put it in perspective, smoking kills more Americans every 6 weeks than died in the entire Vietnam War and also kills more Americans every 2 months than died of AIDS during the 1980's. The figures for the leading causes of preventable death in the United States are: 434,000 yearly from smoking (data for chewing tobacco is unavailable), 100,000 from alcohol abuse (including accidents), 53,000 from passive smoking (that is, 1 death from environmental tobacco smoke for every 8 from active smoking), followed by only 6,000 per year from drug abuse. Knowing the health burden of cigarette smoking in United States, one can only imagine the health effects of cigarettes among the refugee population. Furthermore, the health effects of smoking have not been properly personalized; for example, a young adult nonsmoker has a 15 percent chance of dying before 65, but a smoker has a 40 percent chance—triple the nonsmoker's risk of early and premature death.





The notion that it is too late to stop or that "the damage is already done" is also unfounded; a 50-year-old lifelong smoker who quits doubles his/her chance of living to 65. Forty million Americans are now successful ex-smokers.

Unfortunately younger smokers, especially adolescents, are less amenable to persuasion not to start smoking or to quit because of future harm to their health; as a result, the following points also need to be emphasized with them.

- ❖ Smoking is very expensive. A two-pack-a-day smoker would have \$180,000 at the end of 30 years if he/she simply invested the cigarette money at standard interest rates.
- ❖ Smoking damages physical fitness.

## **Alcohol**

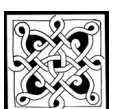
The American Psychiatric Association's diagnosis guidelines (DSM-IV) recognizes two distinct primary disorders of alcohol use: Alcohol Abuse and Alcohol Dependence. Together, their lifetime prevalence in the general population is 13.6 percent. Alcohol use disorders are many times more common in males than in females (4:1 in the United States), and their onset is usually between the ages 16 and 30; both genetic and environmental factors contribute to this. It is crucial to be able to distinguish recreational alcohol use from Alcohol Abuse and Alcohol Dependence.

*Alcohol Abuse:* Is a maladaptive pattern of alcohol use leading to clinically significant impairment or distress (evident in recurrent failures to fulfill obligations at work, school, or home, or in recurrent health or legal problems due to alcohol use). Typically, individuals with alcohol abuse continue to use alcohol despite these adverse consequences.

*Alcohol Dependence:* Is alcohol abuse with the additional feature of physiological and psychosocial evidence of addiction. The symptoms of Alcohol Dependence include:

- ❖ Tolerance (needing increasing amounts to obtain desired effect.)
- ❖ Withdrawal (irritability, insomnia, malaise, increased heart rate, tremors, nausea, vomiting, and/or tactile hallucinations beginning 24-48 hours after the last drink.)
- ❖ Unsuccessful attempts to cut down or stop.
- ❖ Devoting more time (obsession) to activities necessary for obtaining alcohol and giving up other activities because of alcohol.

The social consequences of problem drinking are often as damaging as the direct medical consequences. Nearly 20 percent of drinkers report problems





## *Journey of Hope*

with friends, family, work, or police due to drinking. People who abuse alcohol have a higher risk of divorce, depression, suicide, domestic violence, unemployment, and poverty. Intoxication may lead to unsafe sexual behavior—increasing the risk of STDs, including HIV. Finally, an estimated 27 million American children are at risk for abnormal psychosocial development due to the their parent's abuse of alcohol.

Moderate alcohol consumption, however, has favorable effects on the risk of coronary heart disease (CHD). CHD incidence and mortality rates are 20-40 percent lower in men and women who drink 1-2 drinks/day than in nondrinkers. The exact mechanism for the protective effect of alcohol is not known.

## **Drugs**

The abuse of both illicit and legal drugs remains an important medical problem in the United States. Although casual (i.e., occasional) use of illicit drugs declined steadily from 1979 to 1992 in the general population, drug use has apparently been increasing since then, especially among teenagers and young adults. Occasional use of marijuana accounts for a large proportion of reported drug use, but many drug users use other illicit drugs (cocaine, heroin, phencyclidine, methaqualone, hallucinogens, etc.), legal drugs not prescribed by a physician (e.g., amphetamines, benzodiazepines, barbiturates, and anabolic steroids), or inhalants (amyl and butyl nitrite, gasoline, nitrous oxide, glue, and other solvents). An estimated 5 million Americans smoke marijuana regularly (at least once a week), almost 500,000 use cocaine weekly, and over 500,000 used heroin or other injectable drugs in the past year.

Drug use is more common among men, the unemployed, adults who have not completed high school, and urban residents. The overall prevalence of drug use does not differ greatly among Caucasian, African American, and Hispanic populations, but patterns of drug use may. Drug use statistics, however, may be different for refugees; for example, many refugees from the Horn of Africa are addicted to khat—the leaves of which contain many different psychoactive compounds. Adverse effects of khat include reproductive toxicity (infertility due, in men, to decreased testosterone and decreased sperm count and motility), central nervous system stimulatory effects, insomnia, restlessness, and anxiety (from pseudoephedrine effect), a strong association with oral cancer (independent of smoking), and drug interaction with some antibiotics. It is also secreted in breast milk and can, therefore, cause problems in breastfed infants. Published information regarding khat and refugees in London and Liverpool, England highlighted a significant problem that must be addressed.

The adverse effects of other drugs include acute cardiovascular complications (e.g., arrhythmias, myocardial infarction, cerebral hemorrhage, and seizures); nasal and sinus disease and respiratory problems (when





smoked); and diminished motivation, irregular sleep patterns and other symptoms of depression. "Crack," a popular and cheap smokeable form of cocaine, is also highly addictive.

Drugs that are injected intravenously result in a high death rate due to overdose, suicide, violence, and medical complications from injecting contaminated materials (e.g., HIV infection, hepatitis, bacterial endocarditis [bacteria infection of the lining of the heart], kidney infections and blood clots in the lungs); in some cities, up to 40 percent of intravenous drug users (IDUs) are infected with HIV.

Although the extent of adverse effects of marijuana use is controversial, chronic use may be associated with respiratory complications or lack of motivation. There are other indirect medical and social consequences of drug use that are equally important: criminal activities related to illegal drugs take a tremendous toll in many communities, intravenous drug use and crack are major factors in the spread of HIV infection, and drugs play a role in many homicides, suicides, and motor vehicle injuries. Nearly half of all users of cocaine or marijuana reported having driven a car shortly after using drugs.

## **Special Circumstances: Pregnancy, Adolescents, & Children**

### *Pregnancy:*

*Alcohol Use:* The proportion of pregnant women who report drinking has declined steadily in the United States. Recent surveys indicate 12-14 percent of pregnant women continue to consume some alcohol, with most reporting only occasional, light drinking (median: 4 drinks per month). Binge drinking or daily risk drinking (usually defined as 2 drinks per day or greater) is reported by 1-2 percent of pregnant women, but higher rates (4-6 percent) have been reported in some screening studies.

Pregnant women should be advised to limit or cease drinking during pregnancy. Excessive use of alcohol during pregnancy can cause Fetal Alcohol Syndrome (FAS), a mixture of growth retardation, facial deformities, and central nervous system dysfunction (microcephaly, mental retardation, or behavioral abnormalities). Even infants who do not have full FAS, often display growth retardation or neurologic problems. FAS, has been estimated to affect approximately 1 in 3,000 births in the United States (1,200 children annually), making it a leading treatable cause of birth defects and mental retardation.

The level of alcohol consumption that poses a risk during pregnancy remains controversial. FAS has only been described in infants born to alcoholic mothers, but the variable incidence of FAS among alcoholic women (from 3-40 percent) suggests that other factors (e.g., genetic, nutritional, metabolic, or temporal) may influence the expression of FAS.





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The timing of exposure and pattern of drinking may be important, with greater effects proposed for exposure early in pregnancy and for frequent binge drinking.

*Drug Use:* While associated with a variety of adverse outcomes, the problems associated with drug use (e.g., use of alcohol or cigarettes, poverty, poor nutrition, and inadequate prenatal care) may be more important than the direct effects of the drugs. Regular use of cocaine and opiates is associated with poor weight gain among pregnant women, impaired fetal growth, and increased risk of premature birth; cocaine appears to increase the risk of premature detachment of the placenta. The effects of the social use of cocaine in the first trimester are uncertain. Cocaine has been blamed for some congenital (present at birth) defects, but their full extent have not been definitively established. Infants exposed to drugs in the uterus may exhibit withdrawal symptoms, due to opiates, or increased tremors, hyperexcitability, and hypertonicity (excessive tone of the skeletal muscles resulting in inflexibility) due to cocaine.

### *Adolescents & Young Adults:*

The leading causes of adolescent and young adult death in the United States are motor vehicle accidents and other unintentional injuries, homicides, and suicides; of these, about half of the cases are associated with alcohol or other drug intoxication. Driving under the influence of alcohol is more than twice as common in adolescents than in adults. Binge drinking is especially prevalent among college students: half of all men and roughly one third of all women report heavy drinking within the previous two weeks. Most frequent binge drinkers report numerous alcohol-related problems, including problems with schoolwork, unplanned or unsafe sex, and trouble with police.

Drug use and abuse remain important problems among adolescents. The use of illicit drugs may interfere with school, increase the risk of injuries, contribute to unsafe sex, and progress to more harmful drug use. Abuse of anabolic steroids in adolescent boys and young men can cause psychiatric symptoms and has been associated with liver, hormonal, and cardiovascular problems.

Alcohol interventions in adolescents have focused on primary prevention of alcohol use. Recent reviews of school-based programs found that most effects were inconsistent, small, and short-lived; programs that sought to develop social skills to resist drug use seem to be more effective than programs that emphasize factual knowledge.

### **Fast Facts**

1. The symptoms and signs of Alcoholism include the presence of an alcohol odor on the breath, ataxia (lack of coordination), red nose or palms, jaundice, poor dental care, abdominal tenderness, signs of portal





hypertension (increased blood flow/pressure in the veins of the liver), or loss of peripheral sensation or motor power. Heavy drinkers may underestimate the amount they drink because of denial, forgetfulness, or fear of the consequences of being diagnosed with a drinking problem. One result is that doctors are frequently unaware of problem drinking by their patients.

2. Persons who are dangerously intoxicated, with a history of serious withdrawal symptoms in the past, with unstable medical complications, or who are suicidal need immediate medical assistance.
3. Levels of intervention range from brief educational classes (Level 1) to home rehabilitation (Level 3). Abstinence from alcohol use and attendance at Alcoholics Anonymous (AA) meetings is recommended. Alcohol use disorders are chronic and recovery is a long and difficult road. Refusal to participate in treatment for an alcohol use disorder is grounds for separation.

## **Intervention Strategies**

1. Adopt the National Cancer Institute "Fours A's" in smoking cessation, and adapt it for alcohol, drugs, and cigarettes.
  - ❖ **Ask** about smoking, drugs, and alcohol regularly.
  - ❖ **Advise** all smokers, drug users, and alcohol users to quit; personalize the message and risk as discussed in the subsection on tobacco.
  - ❖ **Assist** the participant in stopping by setting a quitting date, providing self-help materials, etc.
  - ❖ **Arrange** appropriate follow-up counseling (it takes time, effort, and usually several attempts to be successful).
2. Develop an effective screening tool to detect problem drinking, smoking, and drug use for adults and adolescents.
3. Develop a standard method of interviewing refugees about substance abuse that is clear, concise, and culturally sensitive. It should include
  - ❖ Careful history of substance abuse.
  - ❖ Use of standardized screening questionnaires.
  - ❖ Participants should be asked to describe quantity, frequency, and tolerance effects. One drink is defined as 12 ounces of beer, a 5-ounce glass of wine, or 1.5 fluid ounces (one jigger) of distilled spirits.





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- ❖ Responses suggestive of problems with substance abuse usage should be confirmed with more extensive discussions with the participant (and family members where indicated) about patterns of use and problems related to use.
- 4. Discussions with adolescents should be approached with discretion in order to establish a trusting relationship and to respect the participant's concerns about the confidentiality of disclosed information.
- 5. Discuss U.S. employment and drug policy.
- 6. All pregnant women should be screened for evidence of substance abuse.
- 7. Personalize discussions about substance abuse and pregnancy as previously described in this section. Women who smoke should be advised that the risk of low birth weight is greatest for mothers who both smoke and drink.
- 8. If necessary, assist the participant to obtain advice and counseling. Counseling should involve feedback of the evidence of a substance abuse use, direct advice to reduce abuse, and plans for regular follow-up.
- 9. People with physical symptoms, behavioral or mood problems, or difficulties at work and home should be monitored to determine whether further interventions are needed.
- 10. Develop plans for accessing the community mental health resources.
- 11. Develop plans for lost cause and difficult cases.

## **Activities**

### *List Game:*

1. List five substances that can be abused.
2. List five adverse effects of substance abuse of your choice.
3. List five social and medical problems associated with alcohol.
4. List five problems associated with khat.

### *Diaries:*

1. Smoking "holidays" and quitting schedule.
2. Diet diary.





### ***How-To Seminars:***

1. Videotaped educational materials.
2. How to quit smoking seminars.
3. How to stop drugs coming into your home.

### **Field Trips**

Trips to substance abuse intervention centers in the neighborhood.

- ❖ Exercise on drug prevention, emphasizing the four A's.

### **Speakers**

1. Substance abuse professionals (SAPs), ideally with the same cultural background as the women.
2. Guest lectures on drug abuse prevention.
3. Guest lectures on the use of the Employee Assistant Program (EAP) at work.

### **Evaluation**

*Part 1:* Use the following questionnaire to determine whether this section's objectives have been met and how much information the participants have retained.

*Part 2:* This is an opportunity for participants to ask the trainer questions to (trainer should feel free to rely on own initiative and/or experience in dealing with this section. Fast facts, however, are available for reference). Encourage students to ask questions about the different topics covered.

*Part 3:* Feedback about lectures and presentations—what works, what doesn't, what needs work, and suggestions.

*Part 4:* The presenter's own reflections—Have I learned anything? What would I do differently?





*Journey of Hope*

**Substance Abuse Evaluation Questionnaire**

1. What are the different drugs discussed?
  
  
  
  
  
  
  
  
  
  
2. What are the side effects of drugs—social, medical, and psychological?
  
  
  
  
  
  
  
  
  
  
3. What are the prevention recommendations regarding pregnancy and adolescents?
  
  
  
  
  
  
  
  
  
  
4. Where are the substance abuse intervention centers in the community?
  
  
  
  
  
  
  
  
  
  
5. How might you and your family deal with drug abuse?





## **Section 4: Counseling**

### **To Promote Physical Activity**

#### **Objectives**

*Participants will—*

1. Learn how to improve the health of their families through healthy living and regular physical exercise.
2. Discuss the available exercise resources and programs in the United States.

#### **Materials**

1. Physical Activity Assessment Questionnaire
2. Physical Activity Evaluation Questionnaire
3. Flipchart
4. Markers

#### **Introduction**

Regular physical activity is recommended to prevent coronary heart disease (CHD), hypertension, obesity, and diabetes.

In 1985, national survey data revealed that 56 percent of men and 61 percent of women in the United States either never engaged in physical activity or did so on an irregular basis. The 1991 surveillance data suggests that the prevalence of a sedentary lifestyle (58 percent overall) has not changed. For example, CHD, the predominant risk associated with a sedentary lifestyle, is the leading cause of death in the United States. It is estimated that the incidence of CHD could be reduced by 35 percent if people became more physically active. Furthermore, there is evidence that physical activity and fitness reduce the incidence of at least five other chronic conditions: hypertension, obesity, diabetes, osteoporosis, and mental health disorders. Moderate physical activity comprises activities that can be comfortably sustained for at least 60 minutes (e.g., walking, slow biking, etc.). Vigorous activity describes those of an intensity sufficient to result in fatigue within 20 minutes.

It is important to mention that there are presently no good studies on exercise and the refugee population; however, given the situation in the United States





## *Journey of Hope*

regarding sedentary living, the topic of exercise with emphasis on its health benefits needs to be addressed.

*Note to Facilitators:*

*The intention of the information presented in this section is to provide a knowledge base for effective counseling on this topic.*

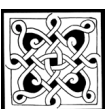
### **Differences to Consider**

1. Cultural and religious attitudes towards exercise.
2. Emphasize exercise programs that are family focused.
3. Emphasize caution when pregnant and exercising.

### **Assessment**

The following questionnaire can be completed individually or as a group. It is designed to be an icebreaker to allow for cultural exchange and be an introduction to cultural biases regarding physical exercise.

Use the participants' answers to guide you as you use the curriculum. The material may be adapted or added to as the participants' needs indicate.









## Outline/Lesson Plan

### **Fast Facts**

### **Intervention Strategies**

### **Activities**

- *List Game*
- *Diaries*
- *How-To Seminars*

### **Field Trips**

### **Speakers**

### **Evaluation**

## Fast Facts

1. Studies suggest that physically inactive people have a 35-52 percent greater risk of developing hypertension than those who exercise. Studies have shown that increased physical activity leads to lowered blood pressure.
2. Among men, moderately vigorous sports activity has been associated with a 41 percent lower risk of death from CHD (the risk reduction from stopping smoking was 44 percent).
3. The age-adjusted risk of Non-Insulin Dependent Diabetes Mellitus (NIDDM) is significantly reduced with consistent exercise. The protective effect of physical activity is more pronounced in persons at highest risk for NIDDM (i.e., those with positive family history, obesity, or hypertension.) These preventive effects are most probably due to decreased insulin resistance. (See *Section 7: Diabetes.*)
4. Physical activity assists with weight maintenance and increases the chances of success for initial and long-term weight loss. This results from increased total energy output, the preservation and creation of lean body mass (muscle versus fat), and an increased metabolic rate. It also helps provide positive mental reinforcement.
5. Postmenopausal women can slow down bone loss through physical activity. For example, studies examining exercise history and fitness level reveal greater bone mass in the more active and fit. Physical activity can also reduce the rate of bone loss in premenopausal women.
6. Direct evidence that physical activity reduces the incidence of hip fractures includes a recent large case-control study. This study found a reduction in the risk of hip fracture in women who were active in the past, as well as in those with recent moderate exercise history.



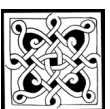


## *Journey of Hope*

7. Most exercise-induced injuries are preventable. They often occur as a result of excessive levels of physical activity, sudden dramatic increases in activity level (especially in persons with poor baseline fitness), and improper exercise techniques or equipment. Intense exercise training can also result in the interruption of menstrual function, bone loss (partly reversible), and an increased fracture risk.

### **Intervention Strategies**

1. Counseling to promote regular physical activity is recommended for all children and adults.
2. Develop a method of presenting an exercise-counseling program that is culturally sensitive.
3. In counseling about exercise, emphasize the proven efficacy of regular physical activity in reducing the risk for CHD, hypertension, obesity, and diabetes.
4. In preparing for the counseling, ascertain the individual's activity level and any barriers, and provide information on the role of physical activity in disease prevention.
5. Emphasize the family approach when appropriate (families that exercise together, live well together).
6. Assist in selecting appropriate types of physical activity. Factor in medical limitations, disabilities, and activity characteristics that both improve health (e.g., increased caloric expenditure, enhanced cardiovascular fitness, and low potential adverse effects) and enhance compliance (e.g., low perceived exertion, minimal cost, and convenience).
7. Emphasize regular, moderate-intensity physical activity rather than vigorous exercise. This emphasis encourages a variety of self-directed, moderate-level physical activities (e.g., walking or cycling to work, taking the stairs, raking leaves, cycling for pleasure, swimming, racket sports, etc.) that can be more easily incorporated into an individual's daily routine.
8. Develop appropriate short-term and long-term goals. Over a period of several months, progression to a level of activity that achieves cardiovascular fitness (e.g., 30 minutes of brisk walking most days of the week) would be ideal. Development and maintenance of muscular strength and joint flexibility is also desirable. Sporadic exercise, especially if extremely vigorous in an otherwise sedentary individual, should be discouraged in favor of moderate-level activities performed consistently.
9. Develop an agreed-upon method of evaluation based on the individual's goals.





10. Yoga, Tai Chi, and Step Aerobic exercises can be performed and taught on-site. Progress would then be measured over an agreed upon time period. Experience in IRSA's refugee women's training program has shown that most women were receptive to a variety of group exercise activities if the activities were conducted exclusively with women in a secluded area, if the program moved gradually from easier activities to more strenuous, if women could wear culturally appropriate attire, and if the trainer used humor and camaraderie to encourage participation.
11. Know when to quit and move on!

## **Activities**

### *List Game:*

1. List five benefits of regular physical activity.
2. List five types of regular exercise activities mentioned.
3. List five medical problems that exercise can improve.

### *Diaries:*

1. Individual exercise plans, goals, and progress evaluation method.
2. Diary review of weight gain and exercise duration times.
3. Graded exercise protocol plan review.

### *How-To Seminars:*

1. Videotape on different exercise and physical activities.
2. How to start an exercise program.
3. How to start physical activity programs for the family.
4. How to find a good weight-loss program.
5. How to avoid the pitfalls and abuse of some physical activity/lose weight fast programs.

## **Field Trips**

1. Trips to gyms in the neighborhood.
2. Trips to different fields, tennis courts, basketball courts, or swimming pools—free versus paying centers.





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### **Speakers**

1. Different exercise instructors, gurus, specialists in the martial arts of Tai Chi, Tae Kwan Do, etc.
2. Aerobic specialists.
3. Yoga instructors and relaxation specialists.

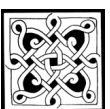
### **Evaluation**

*Part I:* Use the following questionnaire to determine whether this section's objectives have been met and how much information the participants have retained.

*Part II:* Students' opportunity to question the presenter (Presenter should feel free to use own initiative and experience. "Fast Fact" section is available as a resource.) Encourage students to ask questions about the different topics covered.

*Part III:* Feedback about lectures and presentations—what works, what doesn't, what need work, and suggestions

*Part IV:* The trainer's own reflections. Have I learned anything? Would I do anything differently?





## **Physical Activity Evaluation Questionnaire**

1. What are the reasons for having a physical activity program?
2. What are the possible problems with starting an exercise program?
3. List three features of a good exercise program?
4. What are the special recommendations regarding pregnancy and adolescents?
5. Where are the gymnasiums and physical activity centers in the community?
6. What kinds of activities might you start with your family?





## **Section 5: Counseling to Prevent Low Back Pain**

### **Objectives**

*Participants will—*

1. Learn how to improve the health of their families through low back injury prevention.
2. Discuss available low back pain prevention resources and programs in the United States.

### **Materials**

1. Back Pain Assessment Questionnaire
2. Low Back Pain Evaluation Questionnaire
3. Flipchart
4. Markers

### **Introduction**

Low back pain affects 60-80 percent of U.S. adults at some time during their lives, and up to 50 percent have back pain within a given year. Back symptoms are among the 10 leading reasons for patient visits to emergency rooms, hospital outpatient departments, and physicians' offices. Although symptoms are usually acute and self-limited, low back pain often recurs, and in 5-10 percent of patients low back pain becomes chronic. Back pain is the most common cause of disability for persons under age 45. In addition, treatment (and disability costs) are expensive.

Many back injuries are occupational in nature. Occupational back injury is clearly related to lifting and repeated activities. Persons in occupations that require repetitive lifting, such as nursing and heavy industry, are especially at risk. Based on national data, occupational groups with the highest estimated prevalence of low back pain (10.1-10.5 percent) include mechanics and repairers of vehicles, engines, and heavy equipment; operators of extractive, mining, and material-moving equipment; and people in construction trades and other construction occupations. There is no specific information regarding the prevalence of back injury among the refugee population.





*Note to Facilitators:*

*The intention of the information presented in this section is to provide a knowledge base for effective counseling on this topic.*

## **Differences to Consider**

1. Cultural attitudes towards exercise—some may find it offensive/accusatory, some may not understand the necessity for back injury prevention.
2. Emphasize precautions to take if pregnant and exercising.

## **Assessment**

The following questionnaire can be completed individually or as a group. It is designed to be an icebreaker to allow for cultural exchange about low back pain and be an introduction to cultural biases about low back pain.

Use the participants' answers to guide you as you use the curriculum. The material may be adapted or added to as the participants' needs indicate.





*Journey of Hope*

**Back Pain Assessment Questionnaire**

1. Do people suffer from back pain in your country?
  
2. Do you know anybody suffering from back pain?
  
3. Do you suffer from back pain?
  
4. Do you want to know how to prevent back trouble?
  
5. What kinds of jobs are likely to give you back trouble?





## Outline/Lesson Plan

### **Fast Facts**

### **Intervention Strategies**

### **Activities**

- *List Game*
- *Diaries*
- *How-to Seminars*

### **Field Trips**

### **Speakers**

### **Evaluation**

## Fast Facts

1. Among the most commonly proposed strategies to prevent low back pain and injury are:
  - ❖ Back stretching and general fitness exercises.
  - ❖ Improved back mechanic and ergonomic techniques (i.e., maximizing the efficient use of human energy in performing work).
  - ❖ Mechanical back supports (back belts or corsets).
  - ❖ Risk factor modification (such as reducing obesity and smoking).
2. Clinical strategies for preventing low back pain are aimed at subjects both with and without a history of back pain.
3. Exercise is typically aimed at strengthening back extensor or flexor muscles and increasing back flexibility to reduce injury risk, improving cardiovascular fitness to minimize injury and enhance recovery should injury occur, and improving mood and pain perception to reduce the impact of injury.
4. Studies support an association between greater fitness or higher levels of physical activity and reduced prevalence of low back pain or injury, but results are less consistent regarding the effect of greater strength or flexibility.
5. There is inadequate evidence to show a benefit from back belts; indeed, they may even cause harm. In addition, poor compliance in these and other studies raises the question of whether subjects will routinely use corsets for prevention of back pain.



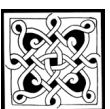


## *Journey of Hope*

6. Evidence suggests that several modifiable risk factors, including smoking, obesity, and certain psychological profiles, predispose certain individuals to develop low back pain. Risk factors are presumed to exert their influence either by increasing an individual's risk of hurting themselves or by increasing the chance that if they do hurt themselves, the experience will be painful or disabling.
7. Education through "back school" training, including information on back biomechanics, preferred lifting strategies, optimal posture, exercises to prevent back pain, and stress and pain management, has been effective in reducing employment-related injuries and relieving chronic low back pain.

### **Intervention Strategies**

1. Counseling to promote knowledge about back injury is recommended for all children and adults.
2. Develop a method of presenting a back injury prevention program that is culturally sensitive to the participants.
3. In counseling about back injury prevention, emphasize the proven efficacy of regular physical activity in reducing the risk for coronary heart disease, hypertension, obesity, and diabetes.
4. Ascertain each individual's knowledge about back injury, their physical activity levels, and any bias and barriers they may have. Also provide information on the role of disease prevention.
5. Emphasize regular moderate-intensity physical activity rather than vigorous exercise. This emphasis encourages a variety of self-directed, moderate-level physical activities (e.g., walking or cycling to work, taking the stairs, raking leaves, mowing the lawn with a power mower, cycling for pleasure, swimming, racket sports) that can be more easily incorporated into an individual's daily routine.
6. Develop an agreed-upon method of evaluation based on the individual's initial goals.
7. Yoga, Tai Chi, and Step Aerobic exercises can be performed and taught on-site. Then progress is measured over an agreed upon time period.





## **Activities**

### ***List Game:***

1. List five benefits of regular physical activity and back stretching exercises.
2. List five types of regular exercise activities mentioned previously.
3. List five habits that increase back injury.

### ***Diaries:***

1. Individual exercise plans, goals, and method of evaluation of progress.
2. Diary review of weight gain, smoking cessation, and exercise duration times.
3. Graded exercise protocol plan review.

### ***How-To Seminars:***

1. Videotapes on different exercise and physical activities.
2. Videotape on how to prevent back injury.
3. How to find a good weight-loss program.
4. How to avoid the pitfalls and abuse of some physical activity/lose weight fast programs.

## **Field Trips**

1. Trips to gyms in the neighborhood.
2. Trips to different fields, tennis courts, basketball courts, or swimming pools—free versus paying centers.

## **Speakers**

1. Different exercise instructors, gurus, specialists in the martial arts of Tai Chi, Tae Kwan Do, etc.
2. Aerobic specialists.





## *Journey of Hope*

### **Evaluation**

*Part 1:* Use the following questionnaire to determine whether the objectives have been met and how much information the participants have retained.

*Part II:* Students ask questions of the presenter. Trainer should feel free to use own initiative and experience when answering student's questions. (The "fast fact" section is available if help is needed). Encourage students to ask questions about the different topics covered.

*Part III:* Feedback about lectures and presentations. What works, what doesn't, what needs help, and suggestions.

*Part IV:* The trainer's own reflections. Have I learned anything? Would I do anything differently?





## **Low Back Pain Evaluation Questionnaire**

1. What are the different benefits of back prevention programs?
2. What is known and unknown about back injury and exercises?
3. What are the special recommendations regarding pregnancy and adolescents?
4. Where are the gymnasiums and physical activity centers in the community?
5. What kinds of activities might you start with your family?





## **Section 6: Hypertension (*High Blood Pressure*)**

### **Objectives**

*Participants will—*

1. Become familiar with the risk factors, symptoms, and complications of high blood pressure.
2. Learn how to prevent and manage high blood pressure in their families.

### **Materials**

1. Hypertension Assessment Questionnaire
2. Hypertension Evaluation Questionnaire
3. Flipchart
4. Markers

### **Introduction**

For blood to be carried from the heart to the body, pressure is needed to pump the blood against the arteries. In fact, each time the heart beats (about 60-70 times a minute at rest), it pumps out blood into the arteries. The blood pressure is at its greatest when the heart contracts and pumps the blood—this is called systolic pressure. When the heart is at rest, in between beats, the blood pressure falls—this is called diastolic pressure.

Blood pressure, therefore, is reported as two numbers—systolic and diastolic pressures. Both are important. Usually they are written one above or before the other, such as 120/80 mm Hg (millimeters of mercury—the standard unit of measurement for blood pressure), with the top number the systolic and the bottom the diastolic. When performing certain actions, the blood pressure rises; for example, if one is running, the body needs more blood, therefore, the blood pressure goes up. When one sleeps at night, however, the body is at rest and does not need a lot of energy and blood pressure goes down. These changes in blood pressure are normal. Problems with blood pressure occur when the blood pressure stays elevated for all or most of the time. In this instance, the blood pushes against the walls of the arteries with higher-than-normal force. If untreated, this can lead to serious medical problems.

*Note to Facilitators:*

*The intention of the information presented in this section is to provide a knowledge base for effective counseling on this topic.*





## **Differences to Consider**

1. Cultural attitudes towards hypertension, exercise—some may find it offensive/accusatory, some may not understand the necessity for prevention.
2. Emphasize taking precautions during pregnancy with regards to hypertension, diabetes, and exercise.

## **Assessment**

The following questionnaire can be completed individually or as a group. It is designed to be an icebreaker to allow for cultural exchange about hypertension and to be an introduction to cultural biases regarding this disease.

Use the participants' answers to guide you as you use the curriculum. The material may be adapted or added to as the participants' needs indicate.







## **Outline/Lesson Plan**

### **Risk Factors for High Blood Pressure**

### **Medical Problems Associated with Hypertension**

### **Controlling High Blood Pressure**

- *Blood Pressure Categories for Adults*
- *Recommended Steps for Controlling High Blood Pressure*

### **The Main Types of High Blood Pressure Drugs**

### **Fast Facts**

### **Activities**

- *List Game*
- *Diaries*
- *How-To Seminars*

### **Field Trips**

### **Speakers**

### **Evaluation**

## **Risk Factors for High Blood Pressure**

While anyone can develop high blood pressure (nearly 50 million Americans have it), some groups of people are more likely to develop it than others. For example, high blood pressure is more common in African-Americans than in Caucasians (it develops earlier and is more severe). In the early and middle adult years, men have high blood pressure more often than women (probably due to the protective effect of estrogen in women), but as men and women age, the reverse is true. After menopause more women have high blood pressure than men of the same age (probably a result of the lowered estrogen in women undergoing menopause), but in the older age groups, the number of both men and women with high blood pressure increases. More than half of all Americans over age 65 have high blood pressure. There are also geographical variations; for example, older African-American women who live in the Southeast are more likely to have high blood pressure than those in other regions of the United States.

Heredity can make some families more likely than others to get high blood pressure. If one's parents or grandparents had high blood pressure, then one's risk may be increased. While it is mainly a disease of adults, high blood pressure can occur in children as well.

There is insufficient information regarding the incidence of hypertension among refugees.





## Medical Problems Associated with Hypertension

<b>Arteriosclerosis ("hardening of the arteries")</b>	High blood pressure harms the arteries by making them thick and stiff. This speeds up the accumulation of cholesterol and fats in the blood vessels like rust in a pipe, which prevents the blood from flowing through the body and, in time, can lead to a heart attack or stroke.
<b>Heart Attack</b>	Heart attacks occur when the blood carried to the body is not sufficiently enriched with oxygen or when the arterial blood supply to the heart muscle becomes blocked—preventing the heart from getting enough oxygen. Reduced blood flow can also cause chest pain (angina)—which is also a precursor to heart attack.
<b>Stroke</b>	<p>High blood pressure is the key risk factor for stroke (other risk factors include cigarette smoking and being overweight). High blood pressure can harm the arteries, causing them to narrow faster, resulting in less blood getting to the brain. If a blood clot blocks one of the narrowed arteries, a stroke (thrombotic stroke) may occur. A stroke can also occur when very high pressure causes a break in a weakened blood vessel in the brain (hemorrhagic stroke).</p> <p>Eleven states—Alabama, Arkansas, Georgia, Indiana, Kentucky, Louisiana, Mississippi, North Carolina, South Carolina, Tennessee, and Virginia—have such high rates of stroke among persons of all races and in both sexes that they are called the "Stroke Belt States."</p>
<b>Enlarged Heart (Cardiomyopathy)</b>	Often the heart enlarges to be able to generate the force needed to pump against the arteries or in order to accommodate large amounts of blood. High blood pressure, therefore, causes the heart to work harder. Over time, this causes the heart to thicken and stretch. Eventually the heart fails to function normally, causing fluids to back up into the lungs. Controlling high blood pressure can prevent this from happening.
<b>Other Problems</b>	High blood pressure can also damage other vital body organs. In the case of the kidneys, which normally act as a filter to rid the body of wastes, high blood pressure can, over a number of years, narrow and thicken their blood vessels. As a result, the kidneys filter less fluid and waste builds up in the blood. The kidneys may fail altogether. When this happens, dialysis (the mechanical filtering of the blood via machine) or a kidney transplant may be needed.

## Controlling High Blood Pressure

An inflatable cuff around an arm is used to measure blood pressure. If the pressure is high, the test will be repeated on several days to get an accurate reading. Blood pressure is high if the systolic pressure is 140 or above, if the diastolic pressure is 90 or above, or both are high.

Those with high blood pressure often do not feel sick. In fact, high blood pressure is often called "the silent killer," because it may cause no symptoms for a long time. Women who have both diabetes and high blood pressure are





at an even higher risk of stroke, heart, and kidney problems than those who have only high blood pressure.

***Blood Pressure Categories for Adults:***

<b>Category</b>	<b>Systolic**</b>	<b>Diastolic**</b>	
<b>Normal</b>	<130	<85	
<b>High Normal</b>	130-139	85-89	
<b>High Blood Pressure</b>			
	<b>Stage 1</b>	140-159	90-99
	<b>Stage 2</b>	160-179	100-109
	<b>Stage 3</b>	180-209	110-119
	<b>Stage 4</b>	≥210	≥120
<b>Key</b>	" <b>&lt;</b> " means less than " <b>≥</b> " means equal to or more than		
* <i>These categories for those 18 and older are from the National High Blood Pressure Education Program. The categories are for those not on a high blood pressure drug and with no short-term serious illness.</i>			
** <i>If the systolic and diastolic pressures fall into different categories, your overall status is the higher category.</i>			

***Recommended Steps for Controlling Blood Pressure:***

1. Lose weight if overweight.
2. Become physically active.
3. Control other medical problems, such as diabetes (*see Section 7: Diabetes*), which may worsen the body's reaction to blood pressure (and result in organ damage).
4. Limit alcohol intake.
5. If prescribed, take high blood pressure pills.
6. Limit nicotine intake (i.e.: stop smoking!).
7. Choose foods low in salt and sodium.





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### *Tips to Cut Back Salt & Sodium:*

1. Add less salt at the table and in cooking. Try reducing the amount a little at a time until you use none.
2. Season with black or green pepper, garlic, ginger, minced onion, or lemon juice.
3. Use fewer prepared sauces, mixes, and "instant" products, such as flavored rice, pasta, and cereals. These usually have salt added.
4. Store-bought snacks tend to be particularly high in sodium. To help cut back on sodium, snack on:
  - ❖ Bagels, raisin toast, or English muffins.
  - ❖ Air-popped popcorn with no salt or butter.
  - ❖ Unsalted pretzels and crackers.
  - ❖ Low-fat cookies (animal crackers, fig bars, ginger snaps).
  - ❖ Fruit juices and drinks.
  - ❖ Nonfat frozen yogurt, sherbet, and popsicles.
  - ❖ Hard candy or jelly beans.
5. Use vegetables that are fresh, or those that have been frozen or canned without added salt.
6. Check nutrition labels for a product's amount of sodium. Cans, boxes, bottles, and bags have these labels. Look for products that say "sodium free," "low sodium," "reduced sodium," "less sodium," "light in sodium," or "unsalted."
7. Ask a doctor before trying salt substitutes. These contain potassium chloride and can be harmful for women with certain medical conditions.



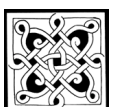


## The Main Types of High Blood Pressure Drugs

<b>Diuretics</b>	These are sometimes called "water pills" because they work on the kidney and flush excess water and sodium from the body through urine, thus reducing the amount of fluid in the blood. Since sodium is flushed out of blood vessel walls, the vessels open wider and pressure goes down. There are different types of diuretics. They are often used with other high blood pressure drugs.
<b>Beta blockers</b>	These reduce nerve impulses to the heart and blood vessels. This makes the heart beat less often and with less force. Blood pressure drops and the heart works less hard.
<b>Angiotensin antagonists</b>	These are a new type of high blood pressure drug. They shield blood vessels from a hormone called angiotensin II, which normally causes vessels to narrow. As a result, the vessels are wider and pressure lowers.
<b>Angiotensin converting enzyme (ACE) inhibitors</b>	These prevent angiotensin II from being formed. They relax blood vessels and pressure goes down.
<b>Calcium channel blockers (CCBs)</b>	These keep calcium from entering the muscle cells of the heart and blood vessels. Blood vessels relax and pressure goes down. <i>(Note: One short-acting type of CCB has been found to increase the chance of a repeat heart attack. Short-acting CCBs are taken several times a day.)</i>
<b>Alpha blockers</b>	These work on the nervous system to relax blood vessels, allowing blood to pass more easily.
<b>Alpha-beta blockers</b>	These work the same way as alpha blockers, but they also slow the heartbeat like beta-blockers do. As a result, less blood is pumped through the vessels.
<b>Nervous system inhibitors</b>	These relax blood vessels by controlling nerve impulses.
<b>Vasodilators</b>	These open blood vessels by relaxing the muscle in the vessel walls.

### Fast Facts

1. When blood pressure is lowered, the heart does not have to work as hard. As a result, women who have had a heart attack are less likely to have another if they reduce their blood pressure.
2. Drinking too much alcohol can raise blood pressure. Most women with high blood pressure, however, can have an occasional drink. Also, those trying to prevent high blood pressure can drink if they do so in moderation.





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3. Research shows that eating lots of fruits and vegetables and low fat dairy products can lower blood pressure—as much as some medicines. Such foods supply plenty of potassium and calcium. Potassium is especially important for blood pressure and eating foods rich in potassium seems to help prevent high blood pressure. Most women get enough potassium in everyday foods. Good sources of potassium are many fruits and vegetables, some dairy foods, and fish.
4. Some populations with low intakes of calcium have a higher incidence of high blood pressure—it is not yet clear if the higher rates are from a lack of calcium or an as-yet-unknown cause. Women also need calcium to prevent osteoporosis, a severe thinning of bones (it tends to develop after menopause) that can lead to fractures. For women, 1,000-1,500 milligrams of calcium daily is mandatory. Good sources are dairy foods, such as milk, yogurt, and cheese—but be sure to choose low or nonfat types. They have as much or more calcium, but with less fat and fewer calories. If milk causes digestive discomfort, try yogurt or some lactose-free dairy products.
5. Scientists think a diet low in magnesium may cause an increase in blood pressure; however, they are not sure whether the increase is from the lack of magnesium or some unknown factor. A healthy diet provides sufficient amounts of magnesium. Good sources are whole grains, green leafy vegetables, nuts, and dry peas and beans.

## **Activities**

### *List Game:*

1. List the three causes of hypertension.
2. List five ways to prevent hypertension.
3. List five complications of hypertension.
4. List five risk factors for getting hypertension.

### *Diaries:*

1. Individual exercise plans, goals, and method of evaluation of progress.
2. Diary review of weight gain, smoking cessation, and exercise duration times.
3. Graded exercise plan review.

### *How-To Seminars:*

1. Videotape on hypertension.





2. How to prevent hypertension.
3. How to monitor blood pressure at home.
4. How to avoid the pitfalls and abuse of some physical activity/lose weight fast programs.

### **Field Trips**

1. Trips to gyms in the neighborhood.
2. Trips to different fields, tennis courts, basketball courts, and swimming pools—free versus paying centers.
3. Trips to community clinics.

### **Speakers**

1. Nutritionists, internists.
2. Different exercise instructors, gurus, and specialists in the martial arts of Tai Chi, Tai Kwon Do, etc.
3. Aerobic specialists.
4. Weight-loss experts.

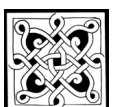
### **Evaluation**

*Part I:* Use the following questionnaire to determine whether the section's objectives have been met and how much information the participants have retained.

*Part II:* Students' opportunity to ask the trainer questions. (Trainer should feel free to rely on own initiative and experience when answering questions. The "fast fact" section is a resource.) Encourage students to ask questions about the different topics covered.

*Part III:* Feedback about lectures and presentations. What works what doesn't, what needs work, and suggestions.

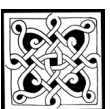
*Part IV:* The trainer's own reflections. Have I learned anything? Would I do anything differently?





## **Hypertension Evaluation Questionnaire**

1. What are the different benefits between taking medication for and the prevention of hypertension?
  
2. What are the risk factors?
  
3. What are the roles of diet and exercise in hypertension prevention?
  
4. What are the roles of diet and exercises on managing hypertension?
  
5. What are the special recommendations regarding pregnancy and adolescents?
  
6. Where are the gymnasiums and physical activity centers in the community?
  
7. What activities might you start with your family?





## **Section 7: Diabetes**

### **Objectives**

*Participants will—*

1. Learn about diabetes and methods to prevent it.
2. Discuss the complications of the disease.

### **Materials**

1. Diabetes Assessment Questionnaire
2. Diabetes Evaluation Questionnaire
3. Flipchart
4. Markers

### **Introduction**

Diabetes is a very old disease—written records of it date back to 1550 BC; however, it was relatively rare until the 20th century. An estimated 16 million Americans currently suffer from diabetes mellitus (DM), and approximately half of these cases are undiagnosed. DM is the seventh leading cause of death in the United States.

Diabetes has two forms—Type 1 and Type 2. Nine out of ten people with diabetes have Type 2 diabetes. Type 1 diabetes is, at least initially, much more serious than Type 2. Type 1 diabetes is sometimes referred to as insulin-dependent diabetes. It used to be known as juvenile diabetes because most people develop it when they are children or teenagers. Type 2 diabetes is known as non-insulin-dependent diabetes. In the past it was often referred to as adult-onset diabetes because it usually occurs after age 40. Unlike Type 2 diabetes, there is no known way to prevent Type 1 diabetes.

Diabetes is a metabolic disorder—as a result, the body's normal metabolic processes, by which food is broken down into energy, do not function properly. Food eaten is usually broken down by digestive juices into chemicals, including a simple sugar called glucose. Glucose is the body's main source of energy. After digestion, glucose passes into the bloodstream, where it is available for cells to take up and utilize immediately or store for later use. The hormone that allows cells to take up glucose is insulin. Insulin acts as a "key" that unlocks "doors" on cell surfaces to allow glucose to enter the cells.





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Insulin is produced by special cells (called islet cells) in the pancreas, an organ that is about six inches long and lies behind your stomach. In healthy people, the pancreas automatically produces the right amounts of insulin to enable glucose to enter cells. In people who have diabetes, cells do not respond to the effects of the insulin that the pancreas produces. If glucose cannot enter cells, it builds up in the bloodstream. The buildup of glucose in the blood—sometimes referred to as high blood sugar or hyperglycemia (which literally means "too much glucose in the blood")—is the hallmark of diabetes.

When the glucose level in the blood goes above a certain level, the excess glucose flows out from the kidneys (the two organs that filter wastes from the bloodstream) into the urine. The glucose takes water with it, which then results in increased or frequent urination and the person affected becomes extremely thirsty. These two conditions—frequent urination and unusual thirst—are usually the first noticeable signs of diabetes. Another symptom is weight loss, which results from the loss of calories and water in the urine.

In Type 1 diabetes, the pancreas cannot make enough insulin to help glucose get inside the cells. This usually occurs when the cells in the pancreas (that make insulin) are attacked by body's own immune system, which mistakes these insulin-producing cells for germs and tries to destroy them. Physicians do not know what the exact trigger is that causes this to happen; some think a virus may be the cause. People with Type 1 diabetes cannot survive for long without insulin, and must give themselves shots of insulin every day.

Considering its anthropological history, Diabetes is an important topic with regards to the refugee population. Over thousands of years, the human body has become very good at converting digested food into fat and storing the fat in cells to use later for energy. This ability to store food as fat was helpful for our ancestors, who often went long periods without food. When food was scarce, their bodies could rely on the stored fat for their energy needs. When there is too much food around, however, the ability to store fat can be a serious problem. When we gain weight, the extra weight causes our cells to become resistant to the effects of insulin. The pancreas responds by producing more and more insulin, which eventually begins to build up in the blood.

High levels of insulin in the blood lead to a condition called insulin resistance, which may cause problems such as high blood pressure and harmful changes in the levels of different fats (cholesterol) in the blood. Insulin resistance is the first step on the path to type 2 diabetes.

The second step to Type 2 diabetes is a condition called impaired glucose tolerance. Impaired glucose tolerance occurs when the pancreas becomes exhausted and can no longer produce enough insulin in response to blood glucose levels. Glucose then begins to build up in the blood. If this problem is





not diagnosed and treated in time, this gradual rise in glucose often leads to Type 2 diabetes, high blood pressure, and heart disease.

The reason that Type 2 diabetes is now widespread in every industrialized country in the world (more than 14 million Americans have Type 2 diabetes) is because increasing numbers of people are eating more, exercising less, and becoming overweight (obese). Also, as the population ages, more and more people are developing Type 2 diabetes, which usually occurs after age 40.

Type 2 diabetes is considered to be a "silent disease" because it works its destruction over many years without causing any noticeable symptoms. As a result, half of the people with Type 2 diabetes are not aware of it.

*Note to Facilitators:*

*The intention of the information presented in this section is to provide a knowledge base for effective counseling on this topic.*

## **Differences to Consider**

1. Cultural attitudes towards diabetes and exercise—some may find it offensive/accusatory, some may not understand the necessity for prevention.
2. Special requirements and precautions are necessary for pregnant women.

## **Assessment**

The following questionnaire can be completed individually or as a group. It is designed to be an icebreaker to allow for cultural exchange about diabetes and to be an introduction to cultural biases regarding this disease.

Use the participants' answers to guide you as you use the curriculum. The material may be adapted or added to as participants' needs indicate.

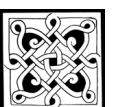






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10. Do you have or have had the following: high blood pressure, an abnormal glucose tolerance or cholesterol test, or given birth to a larger than nine-pound baby?





## **Outline/Lesson Plan**

### **Symptoms of Diabetes**

### **Risk Factors for Diabetes**

### **Tests for Diabetes**

### **Complications from Diabetes**

- *Damage to Blood Vessels*
- *Heart Disease & Stroke*
- *Nerve Damage (Neuropathy)*
- *Peripheral Vascular Disease*
- *Eye Damage*
- *Kidney Disease*

### **Methods to Prevent Diabetes-Related Complications**

### **Preventing & Managing Diabetes**

- *Examples of Good Eating Habits*
- *Eating a Healthy Diet & Getting the Essential Nutrients*
- *Exercise*
- *Medications*

### **Diabetes during Pregnancy**

### **Intervention Strategies**

- *List Game*
- *Diaries*
- *How-To Seminars*

### **Activities**

### **Field Trips**

### **Speakers**

### **Evaluation**

## **Symptoms of Diabetes**

- ❖ Frequent urination.
- ❖ Unusual thirst.
- ❖ Extreme hunger.
- ❖ Unexplained weight loss.
- ❖ Extreme fatigue.





- ❖ Blurred vision.
- ❖ Irritability.
- ❖ Tingling or numbness in the legs, feet, or hands.
- ❖ Frequent infections of the skin, gums, vagina, or bladder.
- ❖ Itchy skin.
- ❖ Slow healing of cuts and bruises.

### **Risk Factors for Diabetes**

- ❖ Age 45 years or older (If the results are normal, testing should be repeated at 3-year intervals.).
- ❖ Obesity.
- ❖ First-degree relative with diabetes.
- ❖ High-risk ethnic group (eg, African-American, Hispanic, Native American).
- ❖ Have given birth to a baby weighing more than nine pounds or have been diagnosed with gestational diabetes.
- ❖ Hypertension.
- ❖ A high-density lipoprotein cholesterol level of less than 35 mg/dL or a triglyceride level of 250 mg/dL or above.
- ❖ Impaired glucose tolerance or impaired fasting at a previous testing.

### **Tests for Diabetes**

The following are tests that physicians perform to determine whether or not a person has diabetes.

- ❖ Fasting glucose test
- ❖ A fasting plasma glucose test is a blood test that measures blood glucose level after 10 to 16 hours of fasting, usually overnight.
- ❖ Oral glucose tolerance test. For this test, the individual is asked to eat a diet rich in carbohydrates (foods such as whole grains, dried beans, and vegetables) for 2 or 3 days and then to fast overnight (or for 10 to 16 hours) before the test. Then the person is given

1. A fasting glucose test.





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2. Then they are asked to drink a sweet-tasting glucose liquid.
3. Next, samples of the blood will be taken at every 30 minutes for a period of 3 hours. (Person may be asked to lie or sit quietly during the time because any amount of exercise can lower his/her glucose level, which would change the results of the test.)

## **Complications from Diabetes**

Diabetes can have serious long-term complications. Over time, if the blood glucose level is not carefully controlled, diabetes can cause the following:

### *Damage to Blood Vessels:*

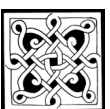
The best way to avoid these serious complications is to maintain your blood glucose level in a healthy range.

### *Heart Disease & Stroke:*

There is an increased risk of developing heart disease as a result of changes in the body's chemistry. One of the effects of these changes is the buildup of fatty deposits inside the arteries, the blood vessels that carry blood to the heart. These deposits are made up mostly of cholesterol, and can narrow the arteries and reduce the flow of blood to the heart or brain. If a fatty deposit gets too large, it can totally block blood flow through the blood vessel, causing a heart attack (damage to the heart muscle from lack of oxygen) or stroke (damage to the brain from lack of oxygen).

Symptoms of heart disease include:

- ❖ Mild tightness or heaviness in chest.
- ❖ Severe pain or pressure in chest.
- ❖ Chest pain or shortness of breath during physical activity, such as climbing stairs.
- ❖ Relief of chest pain brought on by physical activity shortly after the activity is stopped.
- ❖ Nausea, sweating, or dizziness.
- ❖ Difficulty breathing.
- ❖ Nerve damage.





***Nerve Damage (Neuropathy):***

This affects half of all people with diabetes. An uncontrolled high glucose level reduces the ability of nerves to carry messages (such as the sense of feeling) to various parts of the body, including the feet and legs, bladder, digestive tract, and reproductive system.

When feeling in the feet is reduced, they become easy to injure and not even know it. Reduced blood flow can slow the healing of even small cuts, which can become infected—which if it does not heal well can cause the tissue to die (gangrene). In severe cases, the toes may have to be amputated in order to save the rest of the foot and leg.

Depending on the nerves that are affected, a person may experience one or more of the following symptoms:

- ❖ Loss of feeling.
- ❖ Muscle weakness.
- ❖ Tingling, burning, or jabbing feelings.
- ❖ Fainting.
- ❖ Vomiting.
- ❖ Frequent bladder infections.
- ❖ Diarrhea.
- ❖ Sexual problems, such as impotence in men or an inability to achieve orgasm in either sex.
- ❖ Peripheral vascular disease.

***Peripheral Vascular Disease:***

This is a narrowing of the blood vessels that deliver blood to the extremities—hands, feet, and legs. The term "peripheral" means "outer"; "vascular" means "relating to blood vessels." Without a regular supply of nourishing oxygen-rich blood, the tissues that are farthest away from the heart can die. In severe cases, part or all of a foot or leg may need to be amputated.

Peripheral vascular disease can cause the following symptoms: pain in your thigh, calf, or buttocks during physical activity that is relieved upon cessation of the activity, infections that heal poorly, itchy skin, shininess of the skin on the legs, and loss of leg hair.





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### *Eye Damage:*

Diabetes can damage the small blood vessels that supply the back of the eye, causing them to leak blood or other fluid into the eye. This condition, called diabetic retinopathy, is a major cause of blindness in people between 25 and 74. Having diabetes also increases risk of other vision-robbing eye disorders such as cataracts (clouding of the lens of the eye) and glaucoma (buildup of pressure from fluid inside the eye). These eye problems are sudden and may go unnoticed until they have progressed quite far. Diabetics should have their vision examined every year. Detecting retinopathy early can help prevent blindness.

People with the following symptoms should see their physician immediately:

- ❖ Blurred vision.
- ❖ Seeing double.
- ❖ Seeing spots.
- ❖ Pain in one or both eyes.
- ❖ Feeling of pressure in one or both eyes.
- ❖ Inability to see to one side.
- ❖ Difficulty reading.

### *Kidney Disease:*

Diabetes can cause narrowing of the blood vessels that carry blood to the kidneys, reducing the kidney's ability to filter out and eliminate wastes. Diabetes can also damage the kidneys by causing frequent infections of the urinary tract. In order to prevent damage to the kidneys, it is important to keep glucose levels under control.

## **Methods to Prevent Diabetes-Related Complications**

1. Inspect feet every day for scratches, cuts, blisters, ingrown toenails, or warts on the soles of your feet (called plantar warts)—refer to physician.
2. Immediately report signs of infection, burning, tingling, or numbness in your feet to a doctor.
3. Do not cut or treat corns or calluses. Have a doctor remove them.
4. Make sure your doctor examines your feet at each visit.
5. Wash your feet every day and dry them well, especially between the toes.





6. Check inside shoes for pebbles, gravel, or other objects that could cause a cut or blister.
7. Break in new shoes slowly.
8. Wear comfortable, well-cushioned shoes that do not pinch at the toes or scrape at the heel. Try wearing shoes that are a half size larger than you normally wear. Do not wear high heels.
9. Change socks every day. Cotton socks, which absorb moisture, are best. Smooth socks or panty hose over feet carefully, leaving no lumps that could cause chafing or blisters.
10. Never walk barefoot—even in own home.
11. Absolutely no smoking. Smoking reduces blood flow to feet.
12. To prevent ingrown toenails and infections, be extra careful with trimming toenails. Cut nails straight across from side to side (ask your doctor to show you how). If there is numbness in your feet, have someone else trim your nails.
13. Do not test the bath-water temperature with feet.

## **Preventing & Managing Diabetes**

The best way to prevent diabetes is to follow a healthy lifestyle, which is recommended for everyone. Eating a well-balanced diet that is low in fat and rich in high-fiber foods such as whole grains, vegetables, and legumes (beans and peas) can help ensure that the body has all the nutrients it needs to stay healthy. Along with eating a healthy diet, it is essential to keep weight down and exercise regularly (*see Section 1: Nutrition*).

Even a small amount of weight loss can be helpful. If a person is 40 pounds overweight, losing just 10 to 15 pounds may be sufficient to bring glucose down to a healthy level. In fact, some may be able to avoid diabetes altogether by maintaining a lower weight. Weight loss can also improve cholesterol levels and blood pressure, which are worsened by diabetes.

Weight lost gradually—one to two pounds a week—is more likely to stay off over the long term. A habit of nutritious eating, in addition to resulting in weight loss, will help improve overall wellness.

### ***Examples of Good Eating Habits:***

1. Stop eating when full.
2. Watch appetite when eating with other people. People tend to eat more when dining with friends or family than when dining alone.





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3. Eating several small meals and nutritious snacks throughout the day; this is healthier than eating one large meal.
4. Don't skip meals. If a person eats too little, their body will respond by burning fewer calories.
5. Eating breakfast sparks the body's calorie-burning furnace and helps it burn more calories throughout the day.
6. Avoid alcohol or limit to one drink a day if a woman, two drinks a day if a man.
7. Get most calories from starchy foods, such as whole-grain breads and cereals, pasta, and potatoes. These foods are less likely to be stored as fat.
8. Lose weight by limiting fat—reducing the amount of fat eaten can help with weight loss because when fat is cut out extra calories usually are eliminated too. It's also a good habit to continue over the long term because a low-fat diet can help keep cholesterol under control. An easy way to limit the amount of fat eaten is to read the nutrition facts on the labels of all packaged foods when shopping for groceries. The label details how many grams of fat are in each serving of the food. A good rule of thumb is to buy only those foods that have less than 3 grams of fat for every 100 calories in a serving.

### *Additional Tips for Limiting Fat:*

- ❖ Eat more vegetables, fruits, and whole grains, which are usually low in fat as well as calories and provide a feeling of fullness.
- ❖ Eat meat in small portions—no larger than a deck of cards (about three or four ounces).
- ❖ Cook foods by baking, steaming, grilling, stir-frying, or microwaving, using little or no oil. Use nonstick pans or vegetable oil sprays.
- ❖ Avoid commercially prepared baked goods such as muffins, cookies, and croissants.
- ❖ Use nonfat salad dressing. The creamy nonfat salad dressings contain more starch than others so limit a serving of these to less than two tablespoons.
- ❖ Use egg substitutes (which are egg whites with food coloring) or substitute two egg whites for each whole egg a recipe calls for. (Egg whites contain no cholesterol and are lower in fat than yolks.)





The following lists the amount of fat recommended, relative to daily caloric intake.

<b>Calories/day</b>	<b>Grams of Fat/day</b>
1,200	40
1,400	46
1,600	53
1,800	60
2,000	66
2,200	73
2,400	80

***Eating a Healthy Diet & Getting the Essential Nutrients:***

Diets should include a variety of foods that provide all the essential nutrients the body needs—carbohydrates, protein, fat, vitamins, minerals, fiber, and water. The American Diabetes Association (ADA) provides nutrition recommendations for the appropriate proportions of each of these nutrients that should be eaten each day. Doctors and/or dieticians can help people incorporate these recommendations into an eating plan they can live with.

*Carbohydrates:* Starches and sugars found in fruits, vegetables, and grains. These are the body's main source of energy. There are two kinds of carbohydrates—simple and complex. Complex carbohydrates are found in starchy foods such as pasta, bread, dried beans, rice, and potatoes. Simple carbohydrates, which are also called simple sugars, are found in fruits, vegetables, and milk as well as in table sugar, desserts, and other sweets.

The largest portion of a person's diet should consist of complex carbohydrates, as they are better for the body than simple ones. Complex carbohydrates provide fiber and a variety of vitamins and minerals and are usually low in fat. They also take longer to digest, which helps keep glucose under control.





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*Tips for choosing healthy carbohydrates:*

- ❖ Eat whole-grain foods such as whole-grain bread and crackers, bran cereal, or brown rice. They provide lots of nutrients and are high in fiber.
- ❖ Eat legumes (dried beans, peas, or lentils); they're an excellent source of fiber and a good substitute for meat (which provides no fiber).
- ❖ Eat starches made with little fat. Low-fat breads include bagels, tortillas, English muffins, and pita bread.
- ❖ Use whole-wheat or other whole-grain flours in cooking and baking.
- ❖ Choose pretzels, low-fat (baked) potato chips, or low-fat crackers.

*Fat:* Fat is a source of stored energy. When a person eats fat, it travels in the bloodstream. Insulin enables the body's cells to take in fat and store it for when it is needed. Fats have more calories than any other food—nine calories/gram, which is more than twice as many as carbohydrates and proteins have. Fat is found in foods such as meat, oils, nuts, milk and other dairy products, fish and poultry, snacks, and desserts.

Limit fat because it is usually a source of extra calories. Limit fat to no more than 25 to 30 percent of the total daily calories. Monounsaturated fats are the healthiest. These fats are found in olive oil and canola oil. Monounsaturated fats can have a beneficial effect on the cholesterol (fat) in the blood.

*Polyunsaturated fats:* Like monounsaturated fats, polyunsaturated fats, in moderation, can be beneficial for cholesterol levels. Polyunsaturated fats are found in vegetable oils such as safflower oil, corn oil, and soybean oil.

When vegetable oils are turned into solid stick margarine in a process called hydrogenation, they become harmful and can worsen cholesterol.

*Saturated fat:* Saturated fat is found in meats, dairy products, and tropical vegetable oils (such as palm oil and coconut oil). It is the least healthy type and the one that should be avoided. Saturated fat raises blood cholesterol more than any other kind of fat, so it should be limited to no more than 10 percent of the total daily calories. Foods highest in saturated fat include red meats, poultry skin, butter, whole milk products, ice cream, cheese, and some baked goods.





**Cholesterol:** This type of fat is found only in animal products, such as meat, fish, dairy products, poultry, and eggs. While essential for many bodily functions, the body makes most of the cholesterol it needs.

***Exercise:***

Exercise is just as important as diet in helping to prevent Type 2 diabetes (see *Section 4: Counseling to Promote Physical Activity*).

***Medications:***

There are medications, available in pill form, that lower blood glucose levels. Taking an overdose of glucose-lowering medicines, however, can lead to a condition called hypoglycemia (low blood sugar) and can be serious. It can make a person feel tired, confused, shaky, hungry, or sweaty.

Other possible side effects include loss of appetite, upset stomach, diarrhea, rashes, or itching.

## **Diabetes during Pregnancy**

Some women develop a form of diabetes when they are pregnant that goes away after the baby is born. This is a form of Type 2 diabetes called gestational diabetes ("gestation" means "pregnancy"). Doctors believe that this form of diabetes occurs when a pregnant woman's pancreas cannot produce enough insulin to counteract the effects of a pregnancy hormone her body produces that causes insulin resistance. Risk factors for gestational diabetes are:

- ❖ Older than 30.
- ❖ Weigh more than 20 percent over ideal weight.
- ❖ Have a relative (parent or sibling) who has diabetes.
- ❖ Had a still-born child.
- ❖ A previous pregnancy with an unusually large baby (over nine pounds).

Most women are given a blood test for gestational diabetes during the 24th and 28th weeks of pregnancy. This is usually when gestational diabetes develops. (Women who are younger than 25 years, of normal body weight, have no family history of diabetes, and are not members of ethnic groups that have a high prevalence of diabetes need not be screened.)





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### **Intervention Strategies**

1. Counseling to promote knowledge about diabetes is recommended for all children and adults.
2. Develop a method of presenting a diabetes prevention program that is culturally sensitive to the participants.
3. In counseling about diabetes prevention, emphasize the proven efficacy of nutrition and regular physical activity in reducing the risk for diabetes complications as well as coronary heart disease, hypertension, and obesity.
4. During counseling preparation, first determine what the person knows about diabetes and their physical activity levels, biases and barriers, then provide them with information on disease prevention.
5. Assist the participants in selecting appropriate types of nutrition programs. Factor in medical limitations, present disabilities, history of diabetes complication, and activity characteristics that both improve health (e.g., increased caloric expenditure, enhanced cardiovascular fitness, low potential adverse effects) and enhance compliance (e.g., low perceived exertion, minimal cost, and convenience).
6. Develop an agreed-upon method of evaluation based on the individual's goals at the beginning of therapy.
7. Measure progress over an agreed upon time period.

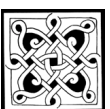
### **Activities**

#### *List Game:*

1. List the three types of diabetes.
2. List five things about preventing diabetes.
3. List five complications of diabetes.
4. List five risk factors for getting diabetes.

#### *Diaries:*

1. Individual exercise plans, goals, and method for evaluation of progress.
2. Review of diary of weight gain, smoking cessation, and exercise duration times.
3. Graded exercise plan review.





***How-To Seminars:***

1. Videotape on diabetes and caring for a diabetic.
2. How to prevent diabetes.
3. How to monitor blood glucose levels at home.
4. How to avoid the pitfalls and abuse of some physical activity/lose weight fast programs.

**Field Trips**

1. Trips to gyms in the neighborhood.
2. Trips to different fields, tennis courts, basketball courts, or swimming pools—free versus paying centers.
3. Trips to diabetic clinics.

**Speakers**

1. Diabetologists, Internists and/or other doctors.
2. Different exercise instructors, gurus, specialists in the martial arts of Tai Chi, Tae Kwan Do, etc.
3. Aerobic specialists.
4. Weight loss experts.

**Evaluation**

*Part 1:* Use the following questionnaire to determine whether the section's objectives have been met and how much information the participants have retained.

*Part II:* Students' opportunity to ask trainer questions. (Trainer should feel free to rely on own initiative and experience when answering questions. The "fast fact" section is available as a resource.) Encourage students to ask questions about the different topics covered.

*Part III:* Feedback about lectures and presentations; what works what doesn't, what needs work, and suggestions.

*Part IV:* The trainer's own reflections. Have I learned anything? Would I do anything differently?





## **Diabetes Evaluation Questionnaire**

1. What are the different benefits of diabetes prevention programs?
  
2. What are the risk factors of diabetes?
  
3. What are the roles of diet and exercise in diabetes prevention?
  
4. What are the roles of diet and exercise on managing diabetes?
  
5. What are the special recommendations regarding pregnancy?
  
6. Where are the gymnasiums and physical activity centers in the community?
  
7. What activities might you start with your family?





## **Section 8: Gynecological Care**

### **Objectives**

*Participants will—*

1. Discuss women's health issues, including healthy habits about pregnancy, pap smears, etc.
2. Learn how to improve their families' overall wellness.
3. Learn about contraceptives and sexually transmitted diseases (STDs) and their prevention.
4. Become generally familiar with the American health care system.

### **Materials**

1. Gynecological Assessment Questionnaire
2. Gynecological Evaluation Questionnaire
3. Flipchart
4. Markers

### **Introduction**

Of the two sexes, women have by far the most complex biological system—a system designed to undergo pregnancy, birth, and menopause. As a result of this complexity, women have special physical requirements that need to be taken into account and that are often overlooked or ignored when dealing with refugee populations.

*Note to Facilitators:*

*The intention of the information presented in this section is to provide a knowledge base for effective counseling on this topic.*

### **Differences to Consider**

1. Cultural bias against contraception, fertility medication, etc.
2. Some women are very timid about touching themselves—be culturally sensitive.
3. Some women may have been victims of sexual abuse—this topic may strike a nerve.





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4. Female circumcision/Female genital mutilation is still a sensitive issue.
5. Some women may not be used to discussing personal issues openly, so great care needs to be taken.
6. Some issues may be religiously and culturally charged.

## **Assessment**

The Gynecological Assessment Questionnaire can be completed individually or as a group. It is designed to be an icebreaker to allow for cultural exchange about women's health and to be an introduction to cultural biases regarding gynecological care and other related issues.

Use the participants' answers to guide you as you use the curriculum. The material may be adapted or added to as the participants' needs indicate.





## **Gynecological Assessment Questionnaire**

1. What kinds of care do women receive when they are well in your country?  
Are women encouraged to see doctors when they are well?
  
2. Are there times when women, though well, should see doctors? Are you familiar with the recommendations about seeing doctors in America? If not, do you want to know what those recommendations are?
  
3. What is a Pap smear?
  
4. What is breast cancer?
  
5. Do you know what the common sexually transmitted diseases are? How to prevent them?
  
6. Are you aware of female circumcision/female genital mutilation (FC/FGM)?  
The laws regarding FC/FGM in America?
  
7. What is a "normal" pregnancy?
  
8. What types of contraception are you familiar with?





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9. Are you familiar with the morning-after-pill?

10. Do you have any topics, besides those mentioned, that you wish to address today? If so, what are they?





## **Outline/Lesson Plan**

### **Reproductive Health**

- *Routine Gynecological Care*
- *Necessary Gynecological Care*

### **Pregnancy**

- *Prenatal Care*
- *Exercise during Pregnancy*
- *Nausea & Vomiting*
- *Medications & X-rays during Pregnancy*

### **Family Planning & Contraception**

- *Combination Oral Contraceptives*
- *Injectable Progestins*
- *Barrier Methods*
- *Intrauterine Devices*
- *Coitus Interruptus & Periodic Abstinence*
- *Sterilization*
- *Breastfeeding*
- *Family Planning & Islam*

### **Intervention Strategies**

- *Breast Cancer*
- *Cervical Cancer*
- *Contraception*

### **Activities**

- *List Game*
- *Diaries*
- *Exercises*
- *How-To Seminars*

### **Field Trips**

### **Speakers**

### **Evaluation**

## **Reproductive Health**

The lack of appropriate care can lead to or exacerbate many reproductive problems such as unwanted pregnancies; complications during pregnancy;





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cancer of the cervix, uterus, breasts, and ovaries; STDs; abnormal bleedings, and infertility. In order to address these problems properly, this section is divided into two parts: routine gynecological care and necessary gynecological care.

### ***Routine Gynecological Care:***

Proper routine care includes the following:

- ❖ A yearly physical
- ❖ A Pap smear (as necessary)
- ❖ Regular self breast exams
- ❖ Mammography (as necessary)
- ❖ Prenatal care and check-ups (as necessary)
- ❖ Contraception (as necessary)

### **The Pap Smear & Cervical Cancer:**

About 14,500 cases of invasive cervical cancer (with approximately 4,500 deaths) are diagnosed yearly in the United States. The major risk factor for cervical cancer is a sexually transmitted infection caused by the human papillomavirus (HPV). Other risk factors include:

- ❖ Intercourse at an early age
- ❖ Multiple sexual partners
- ❖ The long-term use (>5 years) of oral contraceptives
- ❖ Low socioeconomic status
- ❖ Cigarette smoking

In both African-American and Caucasian women, the incidence of pre-cancerous cervical cell abnormalities reaches its peak between the ages of 20 and 30. After the age of 25, the incidence of invasive cancer in African-American women increases dramatically with advancing age; in Caucasian women, however, the incidence rises more slowly. Over 25 percent of invasive cervical cancers occur in women older than 65, and 40 to 50 percent of all women who die of cervical cancer are older than 65.

A Pap smear is a very simple process that involves obtaining a sample of cells from a woman's cervix. These cells are then examined in a lab for any abnormalities that would indicate the presence of a disease or





cancer. The full description of the Pap smear procedure is available in Appendix A: Health & Wellness—Section 5: Gynecological Care.

A Pap smear can easily detect cervical abnormalities before they become cancerous. Since the widespread adoption of the Pap smear, the result of early treatment has been an impressive 70 percent decrease in the number of incidents of and deaths from cervical cancer. Nonetheless, a large proportion of women, particularly elderly African-American women, refugees, and middle-aged women of lower socio-economic status, do not have regular Pap smears. In some geographic areas of the US, as many as 75 percent of women older than 65 have not had a Pap smear within the past 5 years.

While there is little specific information available with regards to refugees and Pap smears, economic conditions and other environmental variables of higher priority like safety and food make it difficult, if not impossible, for refugees to have regular health screenings. As a result, some women have quite probably not seen a doctor or any health professional in years, and their first contact with a physician is the mandatory physical exam required before resettlement. Furthermore, it is possible for refugees to acquire diseases and other health problems after passing their physical but prior to being resettled.

The time period between initial infection with HPV virus and the development of cervical cancer is 8 to 9 years. This long lead-time provides adequate opportunity to detect, via Pap smear, the presence of pre-cancerous or early-stage lesions and malignancies before the actual development of cancer. Despite this, it remains a severe problem for refugees, and is even the leading cause of death among Vietnamese refugee women.

For the U.S. Preventive Services Task Force's (USPSTF's) current recommendations regarding the use of the Pap smear see Appendix A: Health & Wellness—Section 5: Gynecological Care.

### **Breast Cancer & Mammography:**

Breast cancer is the most common type of cancer in American women, and is the second leading cause of cancer death after lung cancer. As there is a little information regarding the incidence of breast cancer among refugee women, it can only be assumed that it is similar to that of women in the United States. According to the American Cancer Society (ACS), about 180,000 new cases of breast cancer are diagnosed each year in the United States with about 43,000 related deaths. While an American woman's average lifetime risk for developing breast cancer is approximately one in eight, death due to breast cancer increases consistently with age. Risk factors in addition to age include:

- ❖ A family history of breast cancer in a first-degree relative (sister or mother).





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- ❖ Childlessness (only a very modest increase in risk for this factor).
- ❖ First pregnancy after 30 years of age.
- ❖ Menstruation before 12 years of age.
- ❖ Menopause after 50 years of age.
- ❖ Postmenopausal obesity.
- ❖ Some types of benign (non-cancerous) breast disease.
- ❖ High socioeconomic status.
- ❖ A personal history of ovarian or endometrial cancer.

Since women who do not see their doctors regularly have an increased chance of dying from breast cancer, early detection is key. This is particularly important for refugee women, so the increased likelihood of early detection by breast self-exam and yearly physical check-ups should be emphasized.

The most effective approach to early detection of breast cancer is mammography. A mammogram is an x-ray of the breast. While there has been concern about radiation exposure, well-maintained, modern mammography equipment is very safe and uses only extremely low radiation levels.

Although it can detect small tumors in younger women, controversy exists regarding whether mammography screening is really useful in detecting tumors in women younger than 50. Screening does, however, carry the added risk of other problems attributable to unnecessary biopsies that are often performed following false-positive mammography results. As a result, recommendations for mammography are still controversial.

Some organizations believe that routine mammography screening (every 1 to 2 years) should begin at age 40, while most agree that it is necessary for women aged 50 and older. Many also recommend that screening continue until 70 years of age. For women 70 years of age or older, however, the American Association of Family Practitioners and the USPSTF state that there is insufficient evidence to recommend either for or against routine screening.

### ***Mammography recommendations from other societies:***

The American College of Preventive Medicine (ACPM) advises that women aged 70 or older should continue undergoing mammography screening provided their health status permits breast cancer treatment. However, the American College of Physicians discourages the use of mammography in women >75 years of age. Meanwhile, the American Geriatrics Society recommends that women >65 years of age receive mammograms at least every two or three years until at least age 85.





As a result of such conflicting information, women aged 70 and older should receive counseling about the differing mammography recommendations in order that they may make informed decisions regarding their health. Many healthcare organizations also recommend counseling about the potential risks and benefits of mammography and clinical breast exams for women under 50.

The decision about whether to screen or not to screen, therefore, should be left to the individual patient following counseling about potential risks and benefits.

### *Necessary Gynecological Care:*

Necessary care addresses health problems such as:

- ❖ STDs
- ❖ Painful urination
- ❖ Abnormal bleeding
- ❖ Postmenopausal complaints
- ❖ Infertility

### **STDs:**

Almost 12 million cases of STDs occur annually in the United States. Of these cases, 86 percent occur during the ages of 15 to 29. The list of STDs includes syphilis, gonorrhea, human immunodeficiency virus (HIV), chlamydia, genital herpes, HPV infection (*see previous subsection on Pap smears*), chancroid, hepatitis B, vaginitis, and ectoparasitic diseases (e.g. pubic lice, etc.)

Chlamydia is currently the most common STD in the United States, causing an estimated 4 million acute cases annually. The incidence of gonorrhea and syphilis decreased in the early 1990s, but they remain a persistent public health problem.

Acquired Immunodeficiency Syndrome (AIDS), which is caused by HIV, is the eighth leading cause of death in the United States. It is the leading cause of death among men aged 25 to 44, and the third leading cause of death among women of the same age group. No cure for AIDS currently exists, although treatment can delay onset of symptoms.

The consequences of STDs are particularly troublesome for women and children. Apart from AIDS, the most serious complications of STDs for women are pelvic inflammatory disease (PID) and an increased risk of cervical cancer, ectopic pregnancy, congenital infection and malformations, delivery of premature and low-birth-weight infants, and





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fetal death. Persons who are poor or lack medical care and racial and ethnic minorities contract a disproportionate number of STDs and the disabilities associated with them.

While the true incidence of STDs among refugee populations is not known, studies have shown that 12 percent of Vietnamese refugees test positive for syphilis; 42 out of every 100,000 Russian refugees are estimated to be infected with HIV; among Horn of Africa refugees, syphilis, gonorrhea, and Hepatitis B are common; and 5 percent test positive for syphilis and 7 percent test positive for HIV among Haitian refugees.

Individuals who are at increased risk for STDs (and HIV infection) include:

- ❖ Those who are or were recently sexually active, especially persons with multiple sexual partners.
- ❖ Those who use alcohol or illicit drugs.
- ❖ Gay or bisexual men who have sex with other men.
- ❖ Persons with a previous history of STD/HIV infection.
- ❖ Prostitutes and persons who are sexually active with infected prostitutes.
- ❖ Persons living in areas where the prevalence of HIV infection and STDs is high.

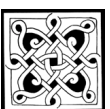
### **Other Gynecological Complaints:**

#### ***Menopause:***

Menopause is the natural ending of a woman's reproductive stage of life, which began with the onset of menstruation (usually at age 13 or 14); it occurs when a woman's ovaries stop producing estrogen. A number of symptoms are associated with menopause, the most common being hot flashes. Due to the profound reduction in estrogen availability, however, the full biological consequences of menopause are subtle. As estrogen levels decrease, the advantages of estrogen—such as its protective effect against heart disease and osteoporosis—are lost. As a result, during menopause estrogen supplements are often recommended and can be given in form of Estrogen Replacement Therapy (ERT).

Estrogen therapy after menopause helps to relieve vasomotor and urogenital symptoms (such as vaginal dryness and painful intercourse). It also reduces the incidence of health problems and death from coronary disease (a form of heart disease) and osteoporosis.

Recommendations about hormone therapy are best made on an individual basis, weighing probable benefits against the costs,





inconvenience, and possible adverse effects of estrogen and progestin (another reproductive hormone that is given as part of ERT). There is some evidence indicating that long-term use of hormones may increase the risk of breast cancer in older women; however, any increase in the incidence of death (if any exists) from breast cancer resulting from ERT is likely to be minimal. Regular mammography further reduces any risk, but participants will have to make their own decisions regarding the possible risks vs. the potential benefits of ERT. In fact, those women most likely to benefit from ERT include those with early or surgical menopause, those with other cardiac risk factors (especially an adverse cholesterol profile), and women at high risk of osteoporosis or fracture (women who are thin, smoke, or have a family history of fracture). Finally, since the risk of dying from heart disease is far higher than the risk of dying from breast cancer, doctors usually find it prudent to recommend ERT on an individual basis.

The participants should also understand that current estimates and recommendations are based on available knowledge, which is often incomplete, and may change with new information.

***Painful urination:***

Along with frequency, urgency, and sometimes blood in the urine (hematuria), painful urination is a classic symptom of bladder infection in women; however, menopause could also be the cause. If the painful urination is the result of an infection, this would be confirmed by a tender bladder (normally the bladder is not tender at all) upon examination by a doctor. Women should pay attention to pain during urination, as non-symptomatic (without symptoms) infection of the bladder is common and, if not detected, can lead to significant health problems such as kidney infections.

***Loss of urine—Incontinence:***

There are four main forms of urinary incontinence:

1. Loss of urine when coughing, sneezing, or straining (stress urinary incontinence).
2. Sudden, involuntary loss of urine accompanied by urgency (unstable bladder, irritable bladder, or a lack of appropriate coordination of bladder muscles [detrussor dysynergia]).
3. Involuntary loss of urine when getting up or standing.
4. Loss of urine at unpredictable times, which is not associated with urgency, frequency, or other activities.

*Stress incontinence:* Loss of urine when straining affects nearly all women at sometime in their life. If a woman's bladder is full enough and she strains hard enough, some urine will escape, due to the shortness of her urethra, the fragility of the normal





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continence mechanism, and its vulnerability to trauma during intercourse and childbirth. Genuine stress incontinence, which occurs more or less daily and requires the patient to wear a pad to avoid soiling her clothing, requires the attention of a gynecologist or urologist. Surgery is usually necessary to repair it.

Exercises to prevent/treat incontinence:

- ❖ Kegel exercises (periodic tightening of the muscles of the pelvic floor 10-15 times a day for 4 weeks).
- ❖ Frequent emptying of the bladder and "double voiding" (re-emptying the bladder 10-15 minutes after the initial void) to keep the bladder as empty as possible.
- ❖ Elimination of caffeine, alcohol, and tobacco (common bladder irritants) which may aggravate the incontinence.
- ❖ A course of oral antibiotics to eliminate any bladder infection that might be aggravating the incontinence.

*Irritable bladder:* Women with an "irritable bladder" will complain that when they have the urge to urinate, they must find a bathroom within one to two minutes or else they will involuntarily lose urine.

Because specialized instruments are needed to examine the urethra properly, women experiencing irritable bladder problems need to be examined by a gynecologist.

### ***Abnormal bleeding:***

Women experiencing abnormal vaginal bleeding need to be examined by a gynecologist.

### ***Female Circumcision/Female Genital Mutilation (FC/FGM):***

In many parts of the world, a type of circumcision (*for a more complete discussion, see Appendix D: Female Circumcision/Female Genital Mutilation*) is performed which involves the removal of clitoris, labia minora, and most of the labia majora (the Pharaonic type of infibulation). Circumcised women are at increased risk for infection and physical problems such as painful urination, intercourse, and labor. They also often suffer from profound psychological problems. Because circumcisions are often performed by traditional faith healers or midwives, women can also develop a hole between the vagina and bladder (Vesico-vaginal fistula) that causes them to leak urine. There is no health benefit to justify female circumcision and it is illegal to perform the procedure in the United States.





## **Pregnancy**

Among refugees, the likelihood of complications during pregnancy is high, due to basic reasons, such as lack of prenatal care and access to care, malnutrition, stress, and infections. As a result, the need for prenatal care should be emphasized.

### *Prenatal Care:*

While prenatal care is normally provided in a hospital or clinic setting, an awareness of the normal routine management of pregnant women may be helpful. The following prenatal care guidelines are recommended by ACOG.

- ❖ Routine visits: every 4 weeks until 28 weeks' gestation, every 2-3 weeks until 36 weeks' gestation, and every week from 36 weeks to delivery.
- ❖ Routine lab tests as early in pregnancy as feasible.
- ❖ Pap smear, Amniocentesis, or Chorio Vilionic Sampling (CVS) for women 35 or older at 10-17 weeks.
- ❖ A blood test of alpha-fetoprotein (AFP) levels to screen for fetal defects/abnormalities at 16-18 weeks. Both raised or depressed levels of AFP in the mother's blood can identify a problem pregnancy.
- ❖ A blood test of hemoglobin/hematocrit levels to screen for anemia (low levels of hemoglobin/hematocrit) at 26–28 weeks.
- ❖ A blood sugar test (glucose levels in the mother's blood) at 26–28 weeks to screen for gestational diabetes.
- ❖ Blood group and Rh testing of mother, followed by the administration of RhoGam (Rh immunoglobulin) if necessary (i.e.: the father is Rh positive) to Rh negative women to prevent the formulation of Rh antibodies that would endanger an Rh positive fetus.
- ❖ Estimating Gestational Age: A physician can use one of three methods:
  1. By menstrual period: The estimated delivery date is calculated by adding 280 days to the first day of the last menstrual period (LMP). An alternative method of determining the due date is to add seven days to the LMP, subtract three months, and add one year.
  2. By examination using a tape measure to determine the distance from the pubic bone up over the top of the uterus to the very top. That distance in centimeters is approximately equal to the weeks of gestation, from about mid-pregnancy until nearly the end of pregnancy.
  3. By the use of a sonogram very early in pregnancy.





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*What to expect when visiting physicians office:*

At each routine visit, the patient's weight, blood pressure, and fetal heart rate is recorded. The urine is tested for the presence of glucose and protein. By 17-18 weeks, the mother should start to feel the baby's movement (Quicking) and this should be recorded.

### *Exercise during Pregnancy:*

In general, as long as the pregnancy is normal, moderate amounts of exercise, using the following guidelines, are acceptable.

1. Women should not start a new sport or exercise while pregnant, but may continue previous activities.
2. Activities which require a fine sense of balance to preserve the woman's personal safety are inadvisable (horseback riding, downhill skiing, etc.) because pregnant women are inherently and unavoidably unstable in their balance. Also, due to pregnancy-induced changes, the joints are unstable; it is, therefore, better to avoid activities which place great stress on any joints.

### *Nausea & Vomiting:*

While common during pregnancy, it can be aggravated by strong smells (food, garbage, machine oil, etc.) and motion. Symptoms appear quite early and are usually mild, requiring no treatment; they generally disappear by the 16th week or sooner.

### *Medications & X-rays during Pregnancy:*

No medication should be taken without physician's consent.

X-rays, however, are perfectly acceptable during pregnancy if there is a medical need for them (chronic cough, possible fracture, etc.). During the x-ray, the woman should shield the baby with a lead apron to minimize fetal exposure.

## **Family Planning & Contraception**

While modern contraceptives have enabled women to increase control over their reproductive lives, in the United States 60 percent of all pregnancies are unplanned. Unplanned pregnancies affect women of all ages and circumstances, but their number is higher in certain population groups, such as teenagers (82 percent) and never-married women (88 percent). The consequences of these pregnancies in the United States include approximately 1.5 million abortions annually, children who are at increased





risk of health and behavior problems both in childhood and later in life, and pregnancies that have not benefited from risk identification and management.

Modern contraceptives marketed in the United States are safe and effective. Although most are relatively inexpensive, their costs vary.

### *Combination Oral Contraceptives (OCs):*

The most popular method of reversible contraception, OCs are used by an estimated 10 million American women. The pill is generally taken daily for 21 days, followed by a sugar pill (used to mark time) or no pills for 7 days. The failure rate is about 3 percent per year with typical use and as low as 0.1 percent per year when used correctly and consistently.

The side effects, which include breakthrough bleeding, nausea, and breast tenderness, decline over time and in recent years have been minimized by lowering the dose of hormones. While there is an association between the early use of OCs and cardiovascular disease (myocardial infarction, stroke, and thromboembolic disorders), particularly in heavy smokers and older women, this is attributed to the blood-clotting effects of the higher hormone dose of the early OC formulations.

Any risks associated with current OCs seem to be minimal. Patient satisfaction is generally higher for OCs (94 percent) than most other methods. The lifetime risk of breast cancer is similar in OC users and nonusers, but some studies suggest a modest increase in early breast cancer among long-term users or those beginning OC use at a young age. The absolute increase in risk is small, may be due to factors other than OCs (e.g., delayed childbearing), and may not apply to current formulations. A modest increase in cervical cancer has also been reported, but the significance of this association is also controversial. Additional non-contraceptive benefits of OCs include a lower incidence of menstrual disorders, benign breast disease, uterine fibroids, and PID.

Postcoital administration of estrogen and progestin (Morning-after pill) can reduce subsequent pregnancy if initiated within 72 hours after unprotected intercourse. The best-evaluated regimen consists of two doses of 100 mg ethinyl estradiol and 1 mg levonorgestrel (i.e., two 50 mg combination OC pills), given 12 hours apart. Based on reported failure rates (0.2-7.4 percent), it is estimated to reduce the risk of pregnancy by 75 percent. Prominent side effects include irregular bleeding, nausea (up to 50 percent), and vomiting. Alternate regimens using danocrine (Danazol) have fewer side effects but have been less well studied. In two recent trials in Great Britain, mifepristone (RU 486) was as effective as, and better tolerated than, estrogen/progestin regimens for postcoital contraception. RU486 is not currently available in the United States.





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### ***Injectable Progestins:***

Depot-medroxyprogesterone acetate (DMPA—i.e., Depo-Provera) and subdermal (under the skin) progestin implants (i.e., Norplant) provide long-term contraception without the need for a daily regimen. DMPA is administered 4 times a year as intramuscular (into the muscle) injections and has a failure rate of only 0.3 percent. Subdermal implants can be inserted and removed as an office procedure and provide effective contraception for up to 5 years. Satisfaction with subdermal implants seems high among selected groups, but it is not as high as with OCs. Common side effects with progestin-only contraceptives include irregular bleeding (up to 50-70 percent), headache, and weight gain. Cases of stroke and false tumors have been reported among Norplant users, but no causal association has been established.

### ***Barrier Contraceptive Methods:***

These include the male and female condom and female barriers (such as the diaphragm, cervical cap, vaginal sponge, and vaginal film) used with spermicide. Barrier methods have fewer side effects than hormonal contraception, but average effectiveness is more variable due to inconsistent or incorrect use.

*Latex condoms:* When used reliably, condoms have a 3 percent failure rate, compared to 12-16 percent among average users. The female condom has failure rates comparable to other female barriers: 5 percent under perfect use and 20 percent under typical use. Cost (\$2.50) and unfamiliar appearance may be obstacles to regular use. Latex condoms (and presumably female condoms) also provide protection against HIV and other STDs. While condoms occasionally slip or rupture, most failure is due to inconsistent or improper use.

*Diaphragms, cervical caps, & vaginal sponges:* These have a failure rate of about 6 percent when used consistently, and 18-22 percent under average conditions. Among reliable users, failure rates appear higher (10 percent vs. 3 percent) in women who have frequent intercourse (>3 times per week). The cervical cap and contraceptive vaginal sponge are as effective as the diaphragm in women who have never given birth, but less effective in women who have (failure rates 20-36 percent). Both can be left in for longer periods than the diaphragm (24 hours); however, the only American manufacturer of sponges discontinued production in 1995.

*Spermicides (foams, creams, and jellies):* When used alone, they are estimated to have failure rates of 6 percent when used consistently and 21-25 percent under typical usage conditions. Both barrier methods and spermicides can reduce the risk of infection with gonorrhea and chlamydia, but effects on HIV transmission are uncertain.





***Intrauterine Devices (IUDs):***

These can provide very effective contraception (0.1-0.6 percent failure rate) for extended periods. Two IUDs are currently available in the United States: a copper IUD (Paragard), approved for continued use for up to 8 years, and a progesterone-releasing IUD (Progestasert), which should be replaced annually. The approval of a levonorgestrel IUD, which can be left in place for 5 years, is pending in the United States.

***Coitus Interruptus (Withdrawal) & Periodic Abstinence:***

These may be more acceptable alternatives for persons with religious objections to artificial contraception and others who are unwilling or unable to use other methods. It is often difficult to perform these methods correctly.

Abstinence during fertile periods can be based on the date of the LMP (calendar or "rhythm" method) or changes in temperature or cervical mucus (ovulation method). The ovulation method is more effective than the calendar method (1-3 percent vs. 9 percent failure rate under perfect use), but requires abstinence for approximately 17 days of each menstrual cycle. Coitus interruptus can fail if it is not timed properly or if pre-ejaculatory fluid contains sperm.

Due to these difficulties, the failure rates of withdrawal and periodic abstinence are 18-20 percent in actual practice. Combining these methods with other contraception during the woman's fertile period may improve effectiveness.

***Sterilization:***

This is the most common method of contraception in the United States and has no proven long-term risks. It differs from other methods in that it is intended to provide permanent contraception. The average failure rate is 0.1 to 0.2 percent for male sterilization (vasectomy) and 0.4 percent for female sterilization (tubal ligation). Between one and two percent of vasectomies are accompanied by side effects (hematoma, infection, or epididymitis) that soon stop. The complication rate from tubal ligation depends on the type of procedure (e.g., mini-laparotomy, laparoscopy, colpotomy), but is generally less than one percent. Within two years of the procedure, up to three percent of American women report regret over sterilization. Fertility can be restored in up to 50 percent of men after reversal of vasectomy, and up to 70 percent of women after reversal of tubal ligation. Sterilization does not protect against STDs, but tubal ligation is associated with lower risk of PID and ovarian cancer.





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### ***Breastfeeding:***

Breastfeeding is effective as a contraceptive method only if a woman is breastfeeding exclusively on her infant's demand (with no other food being given to the baby), if she is not menstruating, and if her infant is less than six months old. If any one of these three criteria are not met, then an additional method of contraception is advised.

*Note: The above information on breastfeeding was taken directly from Reproductive Health in Refugee Situations: An Interagency Field Manual, 1999 UNHCR.*

### ***Family Planning & Islam:***

Islam permits contraception as long as it does not separate marriage from its reproductive function. IUDs can be used as long as they do not cause abortion—use of the copper IUD or the Progestert is acceptable. Abortion is only permitted if the continuation of pregnancy poses a threat for the mother. Sterilization is frowned upon, and is only permitted when the woman has a reasonable number of children.

Islam allows the pursuit of pregnancy as long as Shari'a (Islamic law) is not broken. Artificial insemination and invitrofertilization are only permissible if the sperm used is that of the father/husband. Surrogate motherhood is not permitted.

## **Intervention Strategies**

### ***Breast Cancer:***

1. Develop a method for explaining the need for breast self-exams and mammography (*see how to perform a breast self-exam in Appendix A: Health & Wellness—Section 5: Gynecological Care*).
2. Using video and other materials, discuss the devastating effects of breast cancer.

### ***Cervical Cancer:***

1. Develop teaching materials on cervical cancer.

### ***Contraception:***

1. Discuss the pros and cons of different contraceptive methods:
  - a. Starting with natural family planning, discuss
    - ❖ withdrawal,
    - ❖ the rhythm or calendar method,





- ❖ cervical mucus and the ovulation method, and
- ❖ breastfeeding.
- b. Emphasize the contraceptive advantages of condoms and other barrier methods.
  - ❖ Bring condoms to class and pass them around.
  - ❖ Bring a plastic penis to class and demonstrate the proper use a condom.
  - ❖ Bring a diaphragm, sponge, and cervical cap to class and demonstrate their use.
- c) Discuss the use of IUDs.
  - ❖ Bring a plastic model of an IUD for demonstration.
- d) Discuss the use of oral contraceptives
  - ❖ Bring an example of OC pills to class and explain how they work and how to take them.
- 2. Use this opportunity to discuss female hygiene, the use of tampons, and stable families.
- 3. Personalize your discussion, and get a firm commitment from each individual counseled.

## **Activities**

### ***List Game:***

1. List five methods of contraception and family planning.
2. Identify three methods of contraception, then list three advantages and three disadvantages.
3. List five STDs.
4. List five signs and symptoms of STDs.
5. List three things about Pap smears.
6. List five reasons to do a breast self-exam and what to look for when performing one.
7. List five things that should be done when pregnant.





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### *Diaries:*

1. Encourage women to keep a health diary of doctors visits, weights, medications, menstrual periods, contraception method used, etc.
2. Review the diary individually.
3. Have drills about how to develop a diary for pregnancy.

### *Exercises:*

1. Bring a speculum and allow women to handle it.
2. Bring a silicon- or water-filled breast, and demonstrate a breast self-exam.
3. Bring different types of contraception and, using a plastic pelvis, demonstrate how to insert female condom, cervical cap, diaphragm, etc.
4. Bring condoms and demonstrate how to properly fit it on a plastic penis.

### *How-To Seminars:*

1. Videotapes on contraception, STD's, breast exams, Pap smears, and pregnancy.
2. Videotape on abortion as woman's right, however, use it to emphasize family planning.

## **Field Trips**

1. Community clinics, radiology centers, etc. to demystify issues discussed.
2. Health departments.

## **Speakers**

1. Gynecologists
2. Obstetricians
3. Nurse practitioners





## **Evaluation**

*Part 1:* Use the following questionnaire to determine whether this section's objectives have been met and how much information people remember or retain.

*Part 2:* Opportunity for students to pose questions to trainer (Trainer should feel free to elaborate and use own initiative and experience).

*Part 3:* Feedback about lectures, what works, what doesn't, what needs work, and suggestions.

*Part 4:* The trainer's reflections: Have I learnt anything? What would I do differently?





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**Gynecological Evaluation Questionnaire**

1. What do you remember about STDs?
  
2. What are the STD prevention methods discussed?
  
3. What are the different contraception methods and how do you use them?
  
4. What should you expect when visiting a physician?
  
6. How do you do a breast self-exam?
  
7. What is the importance of the Pap smear and breast self-exam?
  
8. Were the class discussions helpful?





## **Section 9: Medications**

