

## **Audience Questions and Answers Making CLAS Happen webinar**

During the *Making CLAS Happen* webinar, participants had the opportunity to submit questions to the presenters. Due to time constraints, not all questions were answered during the webinar. Questions and responses are provided here for those questions that were not covered during the webinar. The webinar can be viewed on the Refugee Health Technical Assistance Center (RHTAC) website [www.refugeehealthta.org](http://www.refugeehealthta.org). For further questions or comments, please contact RHTAC by email at [refugeehealthTA@jsi.com](mailto:refugeehealthTA@jsi.com).

**How does one deal with cultural differences (e.g.; a parent who beats his/her child that has left a bruise on the child's hand for misbehaving at home) when the child arrives for a medical problem such as stomachache?**

The question is very broad and warrants a discussion about cultural norms for child-rearing and a culturally competent understanding of what constitutes abuse in any domestic situation. All clinicians in the state of Massachusetts are mandated reporters for child and elder abuse, which means that we are required to file a report when we have any reason to suspect it. Even among US-born, English-speaking Americans, this can be very tricky as families who are doing their best may experience these investigations as accusations and value judgments, perhaps even as racially biased since reporting is more likely when minority families are involved. This may threaten the future of clinical relationships and reduce effectiveness. Understanding the situation and proceeding with these actions across the unknowns of cultural and language barriers can be extremely challenging and should be carefully individualized. To be sure, this type of situation, along with other cases of suspected domestic violence, precludes the sole use of family members as interpreters; a qualified, professional interpreter is of critical value here both as an interpreter and as a cultural mediator.

**Dr. Chilume, could you talk more about the stigma you are addressing around HIV? Are you speaking more to decreasing stigma around treatment? There may be a very real anti-HIV sentiment in the communities people are coming from, so it seems like this may be a difficult stigma to address. Would you include community education in addressing that stigma?**

The stigma I was referring to is the stigma surrounding the diagnosis of HIV itself. The stigma in developing countries can be so strong that some people do not even want to lose weight for fear of being labeled as having "the disease." It has been well documented that stigma can prevent people from getting tested or seeking care after being diagnosed. We also know that HIV is spread to a large extent by people who don't even know they have it.

So taking this into consideration it goes without saying that we have to address stigma with all our patients to understand better the negative messages they might be getting in their own communities regarding this disease. These negative messages can influence greatly their likelihood to keep coming back for appointments and to keep taking their treatment. If you recall RJ from the case study I presented resisted advice to start medications for 4 years due to the stigma that he feels exists in his community. Many people have not been as lucky as RJ and have died while refusing care due to the fear of having that label.

Hopefully in the future HIV will be regarded just like any other chronic disease we have, but until then we need to acknowledge that the stigma is still present, and help our patients deal with this illness while maintaining some sense of pride and self worth.