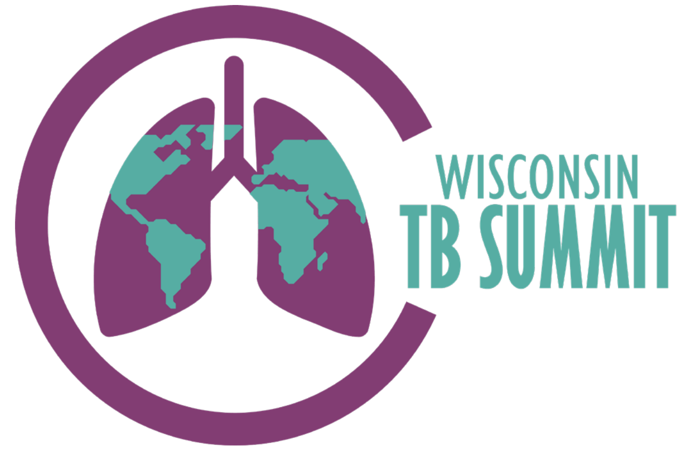

BRIDGING CULTURE & TB CARE

TOWARD CULTURALLY RESPONSIVE & TRAUMA-INFORMED HEALTHCARE

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LEARNING OBJECTIVES

- By the end of this presentation, participants should be able to:
- **Recognize** the impact of trauma, displacement, and systemic barriers on TB prevention, diagnosis, and treatment outcomes among refugee and immigrant populations.
- **Identify** common fears, cultural beliefs, and stigma related to TB that influence patient engagement and adherence to care.
- **Analyze** how systemic racism and structural inequities shape healthcare experiences and contribute to disparities in TB care.
- **Apply** trauma-informed and culturally responsive principles to improve communication, build trust, and support patient-centered TB care.
- **Implement** practical strategies to reduce barriers, enhance patient engagement, and promote equitable TB treatment outcomes within their professional roles.

FOR THE PURPOSE OF THIS PRESENTATION….

- All facts and data were obtained from
  - The World Health Organization
  - The US Centers for Disease Control
  - Any books or websites used for information will be cited on the slide

INTRODUCTION & INTENTION

- TB care is not just medical, it is deeply human, and for many of the community members we serve.
- TB care is not linear. It is layered with fear, stigma, and survival.
- This is about bridging gaps, not just treating disease
- We are here to examine both patient experience and system responsibility
- How do we as practitioners, caregivers, and healers (especially wounded healers) use a trauma-informed approach when working with community members with TB?

“INTERESTING” FACTS ABOUT TB

- On March 24, 1882, Dr. Robert Koch announced the discovery of *Mycobacterium tuberculosis*, the germ that causes tuberculosis (TB). A century later, in 1982, the global health community recognized March 24 as World TB Day. (CDC.gov)
- WWI can be indirectly attributed to TB as can cowboy hats
- James Watt, father of modern power, lost two children to TB and became consumed with finding a cure
- According to the Guinness Book of World Records, TB is the oldest disease in the world
  - TB has been found in Egyptian mummies dating back at least 5,400 years. In the 1800s, it caused roughly 1/3 of all deaths in the US and Europe, where it was nicknamed the "White Plague“
- TB used to be called consumption due to its wasting of the body from within
- Since the 1950’s, when a cure for TB was found, 150,000,000 people have died of TB. TB is preventable and curable.

Everything is Tuberculosis, John Green

THE WHO - 2024

- Migrants and refugees are at heightened risk for tuberculosis (TB) due to a convergence of complex and compounding factors.
  - The migration journey itself, often marked by instability and trauma, combined with overcrowded and substandard living conditions, unsafe or exploitative work environments, and pervasive stigma, significantly increases vulnerability.
- At the same time, social, cultural, and financial barriers limit access to healthcare and essential support services.
  - Gaps in policy, particularly around cross-border protections, further leave many without adequate safeguards. As a result, individuals often experience delayed, interrupted, or insufficient care, leading to serious health, social, and economic consequences that further widen existing health disparities.

STATISTICS ACCORDING TO THE WHO

- A total of 1.23 million people died from tuberculosis (TB) in 2024 (including 150 000 among people with HIV). Globally, TB is the world's leading cause of death from a single infectious agent and among the top 10 causes of death.
- TB was also both the leading killer of people with HIV in 2024 and a major cause of deaths related to antimicrobial resistance.
- In 2024, an estimated 10.7 million people fell ill with TB worldwide, including 5.8 million men, 3.7 million women and 1.2 million children. TB is present in all countries and age groups.
- Multidrug-resistant TB (MDR-TB) remains a public health crisis and a health security threat. Only about 2 in 5 people with drug-resistant TB accessed treatment in 2024.
- Global efforts to combat TB have saved an estimated 83 million lives since the year 2000.

WHERE ARE WE AS OF 2025

- **Total Foreign-Born Population**: As of January 2025, the foreign-born population was 53.3 million, with roughly 15.4 million categorized as illegal immigrants.
- **Net International Migration (NIM):** The U.S. Census Bureau estimated that net international migration fell from a peak of 2.7 million in 2024 to 1.3 million in 2025.
- **Refugee Arrivals:** According to Statista, 38,102 refugees were admitted in fiscal year 2025, representing a decrease from 100,034 in 2024.
- **Border Encounters**: Pew Research Center reported that migrant encounters at the Southwest border fell significantly, with just over 237,000 total encounters for the 2025 fiscal year, marking a sharp decline from 2024.
- **Asylum Claims**: Over 872,000 defensive asylum applications were filed in FY 2025, with USCIS projecting a rise in affirmative applications before a late-2025 pause in processing.
    - Center for Immigration Studies

ACCORDING TO THE CDC, HOW MANY CASES OF ACTIVE TB ENTER THE US EACH YEAR BY DOCUMENTED IMMIGRANTS AND REFUGEES?

A	1000+
B	Between 500-999
C	Between 10-499
D	0-9

ACCORDING TO THE CDC

- **Active vs. Latent TB:** Only Active (Class A) TB renders an applicant inadmissible. Individuals with latent TB infection (non-infectious) are generally allowed to enter.
- **Mandatory Screening:** Immigrants and refugees undergo screening, including chest X-rays (for ages 15+) or TB blood tests (IGRA).
- **Treatment Requirement:** If active TB is found during the exam, the individual must complete treatment before they are cleared for travel to the United States.

ACCORDING TO THE CDC, WHAT PERCENTAGE OF NEW TUBERCULOSIS (TB) CASES IN THE UNITED STATES OCCUR IN NON-U.S.-BORN INDIVIDUALS

A	80%
B	70%
C	60%
D	50% or less

ACCORDING TO THE CDC

- Approximately 70% of new tuberculosis (TB) cases in the United States occur in non-U.S.-born individuals, with roughly 6,276 cases reported among this population in 2018, often driven by reactivation of latent infection shortly after arrival. While over 3 million immigrants and refugees are screened overseas, identifying thousands with TB-related conditions, the majority of cases originate from countries with higher TB
- **Case Proportion:** Non-U.S.-born persons accounted for 69.5% (6,276 out of 9,029) of all new U.S. TB cases in 2018.
- **Incidence & Timing:** TB incidence is highest among foreign-born persons within their first year of arrival, with 16.5% of non-U.S.-born cases occurring during this period, and up to 24.8% of multidrug-resistant (MDR-TB) cases.
- **Pre-Entry Screening:** During 2014–2019, overseas examinations screened 3.5 million people, identifying approximately 3.9% (139,688) with class A or B TB classifications, requiring follow-up.

WHICH RACE HAD THE HIGHEST TUBERCULOSIS CASES, PERCENTAGES, AND INCIDENCE RATES PER 100,000 POPULATION IN THE UNITED STATES, FROM 1993–2023

A	Black or African America
B	Asian (includes pacific islander up to 2022)
C	American Indian or Alaska Native
D	Hispanic or Latino

Year	Total cases	Hispanic or Latino			Non-Hispanic											
					American Indian or Alaska Native			Asian[2]			Black or African American			Native Hawaiian or Other Pacific Islander[3]		
		No.	(%)	Rate	No.	(%)	Rate	No.	(%)	Rate	No.	(%)	Rate	No.	(%)	Rate
2023	9,633	3,546	(36.8)	5.4	108	(1.1)	4.4	2,887	(30.0)	14.0	1,697	(17.6)	4.0	147	(1.5)	22.6
2022	8,332	2,834	(34.0)	4.4	114	(1.4)	4.7	2,846	(34.2)	14.1	1,322	(15.9)	3.1	156	(1.9)	24.5
2021	7,866	2,404	(30.6)	3.8	87	(1.1)	3.6	2,751	(35.0)	13.9	1,420	(18.1)	3.4	114	(1.4)	18.2
2020	7,170	2,125	(29.6)	3.4	78	(1.1)	3.2	2,582	(36.0)	13.2	1,411	(19.7)	3.4	115	(1.6)	18.6

TB by Race/Ethnicity: 1993–2023 | Reported Tuberculosis in the United States, 2023 | CDC

WHY THIS MATTERS IN TB CARE

- TB disproportionately impacts:
  - Refugees
  - Immigrants
  - Marginalized populations
- **Key Insight:** TB is not just a disease of the body, it is shaped by **social conditions, trauma, and access to care, LONG BEFORE ENTERING THE US.**

WHO ARE WE SERVING?

- ***Beyond the Label of "Patient"***
- Individuals with:
  - Histories of displacement
  - War and violence exposure
  - Interrupted healthcare access
  - Cultural and linguistic diversity
- **Reframe:** They are not just TB patients, they are survivors navigating unfamiliar systems.
  - They are our new neighbors
  - They are members of our community
  - They are human

THE WEIGHT PATIENTS CARRY

- **Layers impacting TB care: (My personal TB story)**
- Trauma (past & ongoing)
- Stigma (TB + cultural stigma)
- Fear of isolation or reporting
- Economic instability
- Family responsibilities
- **Critical Link:**
- Trauma → mistrust → delayed care → poor TB outcomes

FEAR IN TB TREATMENT

- ***What Providers Often Don’t See***
- Fear of:
  - Being reported (immigration concerns)
  - Isolation protocols (“Will I be separated from my family?”)
  - Long treatment regimens
  - Side effects misunderstood or ignored
  - Being judged
- **Clinical Reframe:**
- Non-adherence is often a reflection of fear, not defiance.

WHAT PERCENTAGE OF IMMIGRANTS AND REFUGEES COMPLETE TREATMENT FOR TB FOLLOWING DIAGNOSIS IN THE US?

A	20-24%
B	30-34%
C	40-44%
D	50-54%

TRAUMA AND THE BODY

- Chronic stress impacts:
  - Immune function
  - Memory and consistency (missed meds)
  - Trust in providers
- **TB-Specific Insight:**
- Trauma can directly affect **treatment adherence and outcomes**

SYSTEMS ARE NOT NEUTRAL

- The Role of Systemic Racism in TB Care
- **Hard truths:** Healthcare systems were not designed with these populations in mind
  - Misdiagnosis due to bias
  - Language barriers causing delayed care
  - Assumptions about “non-compliance” vs understanding barriers

If the system creates barriers, the burden should not fall on the patient to overcome them.

CULTURAL GAPS IN TB CARE

- ***Where Misunderstanding Happens***
- TB stigma in many cultures = shame, secrecy
- Western models:
  - Individual-focused
  - Time-limited
- Many cultures:
  - Family-centered
  - Faith-centered
- **Example:** Patient may prioritize **family honor** over disclosure

WHAT IS TRAUMA-INFORMED TB CARE?

- ***HTI Framework Applied to TB***
- **Recognize:** Trauma, fear, cultural context
- **Respond:** Safety, trust, clear communication
- **Refer:** Community + culturally aligned support
- **Core Principles in Action: Must be in this order**
- Safety → explain TB process clearly
- Trust → consistency in care team
- Empowerment → shared decision-making

WHAT IS CULTURALLY RESPONSIVE CARE?

- Not just language translation
- It is:
  - Understanding beliefs about illness
  - Respecting cultural values
  - Integrating faith and family
- **Key Shift:**
- From “compliance” → to “collaboration”

BRIDGING THE GAP: MODELS THAT WORK

- Paul Farmer & Partners In Health Pioneered the **"accompaniment model"**
- Treats patients *with* their full context:
  - Social support
  - Community health workers
  - Cultural humility
- Core belief: The idea that some lives matter less is the root of all that is wrong with the world.
- **Key Takeaway for TB Care:** Treatment succeeds when **people are supported, not just prescribed to**

PRACTICAL STRATEGIES FOR TB PROVIDERS

- ***What This Looks Like in Practice***
  - Use trained interpreters effectively
  - Normalize fears about TB
  - Ask: “What concerns you most about this diagnosis?”
  - Offer flexibility where possible
  - Include family or community leaders (when appropriate)
- **Micro-Shift:**
  - Sit down ⟶ slows power dynamic
  - Use simple language ⟶ reduces overwhelm

REFRAMING SUCCESS IN TB CARE

- ***Beyond Cure Rates***
- Success is also:
  - Trust built
  - Fear reduced
  - Patient dignity preserved

When we bridge culture and care, we don’t just treat TB, we restore dignity, rebuild trust, and save lives that systems too often overlook.

YOU'RE TURN

"What is one assumption I may be making about my patients?"

"How can I create safety in my next interaction?"

QUESTIONS & ANSWERS