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lack of health system resources, limited health literacy, or social pressure to bear children.

Methods: To investigate the beliefs and motivations regarding RHD and reproduction, we conducted a mixed methods study of 75 women living with RHD in Uganda. Qualitative transcripts from three focus groups were analyzed using qualitative description and health behavior models. Quantitative survey data were analyzed using means, medians, and frequencies.

Findings: The focus group participants ranged from 22-59 (median 35) years of age, with a median of two children. Several themes emerged from the focus groups, including pregnancy as a calculated risk, black-and-white recommendations from physicians, reproductive decision-making controlled by male partners or in-laws, the financial burden of RHD, and considerable stigma against RHD patients. The survey participants' age range was 15-55 (median 33) years, most were unemployed or homemakers (63%), and had few children (40% had no children). All survey participants were told by a physician that their hearts were not strong enough to support a pregnancy. 58% were on warfarin, and only 12% were using contraception while taking warfarin. All survey participants felt that society would look poorly on a woman who cannot have children due to a heart condition.

Interpretation: Health programs targeting RHD in Uganda must pay special attention to women of reproductive age in order to better serve their needs in a manner that is both medically effective but also culturally sensitive. There are opportunities for improved family/societal education programs and community engagement, leading to better outcomes and patient empowerment.

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Abstract #: *2.005_NCD*

Emotional Distress Screening Tool as a Predictor for Medical Utilization and Disability: A Retrospective Analysis of Refugees Resettling in Syracuse, NY

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Background: Major depression, PTSD, and anxiety disorders rank among the most common disorders in refugees, challenging clinicians and public health professionals. The Refugee Health Screener − 15 (RHS-15) is a validated screening instrument for emotional distress and is used as a diagnostic proxy for PTSD, anxiety, and depression, however the clinical and social utility of the tool is lacking.

Methods: Refugee resettlement guidelines require a health screening in the domestic medical exam (DME) within the first 90 days in the US. As part of a process-improvement at Upstate Medical University, the RHS-15 was integrated into the DME. Aims: Determine the prevalence of emotional distress in newly resettled adult refugees; relation of the RHS-15 score with utilization of medical services during the first year of resettlement; and determine the predictive value of RHS − 15 for refugees seeking disability. A retrospective chart analysis of adult refugees aged 18 − 64 whom received a DME between 6/2013-4/2015 was conducted.

Findings: A DME was provided to 392 refugees aged 18 - 64 years and 91% (356) completed the RHS-15. Refugees originating from the Middle East (Iraq/Afghanistan) had the highest prevalence of emotional distress (49.3%) and Ukraine had the least (16.7%).

RHS-15 scores were reported as negative (0-11), positive (12-15), and highly positive (>16). Adult refugees with negative, positive, and highly positive RHS-15 scores attended 3.1 (SD = 2.2), 4.4 (SD = 2.6), and 5.7 (SD = 3.8) mean visits to a primary care physician, respectively ($p < .000$); and 1.6 (SD = 2.5), 2.8 (SD = 3.3), and 4.4 (SD= 4.7) mean visits to non-primary care services (excluding OB), respectively ($p < .000$).

11% (43/392) of refugees considered themselves disabled from unlimited work duty. Refugees who considered themselves disabled were 5.1 times more likely to score a positive RHS-15 score (≥12) compared to refugees without disability (95% CI 2.1-8.8). Negative predicted value equaled 96% while positive predicted value for the screening tool equaled 19%.

Interpretation: RHS-15 scores can predict medical utilization in the first year of resettlement. Disability is highly associated with increased emotional distress. The RHS-15 screening tool has negative but not PPV as a predictor for a resettled refugee seeking disability from unlimited work duty.

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Addressing Long-term Primary Care and Mental Health Concerns in Marginalized, Underdeveloped Communities

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Program/Project Purpose: When Himalayan HealthCare (HHC) was founded in 1992, the remote mountain communities of Northern Dhading District were suffering from extreme poverty and neglect. Though located only 60 km northwest of Kathmandu, the villages have no road access and some require a three-day walk with passes of 14,000 feet. There was no funding from the Nepal government, which was preoccupied with civil war and political instability, or from international organizations which focused aid on Western Nepal. HHC found mortality and morbidity rates above the national average, prevalent alcoholism and domestic violence and only 15 children enrolled in school in the village of Tipling.

Structure/Method/Design: HHC takes a tri-pronged approach to improving quality of life through healthcare, education and income-generation opportunities. Our interventions include:

- Support for village clinics to provide long-term medical and dental care, nutrition, family planning, patient referrals and more;
- Mental health outreach, including social work intervention related to domestic violence;
- Literacy training;
- Women's empowerment programs on disease prevention, nutrition and domestic violence prevention;
- Vocational training for local youth and professionals to become doctors, dental hygienists, medical technicians, health providers, carpenters, weavers and more;