Migration and Health

Aspects and challenges while providing medical care for refugees

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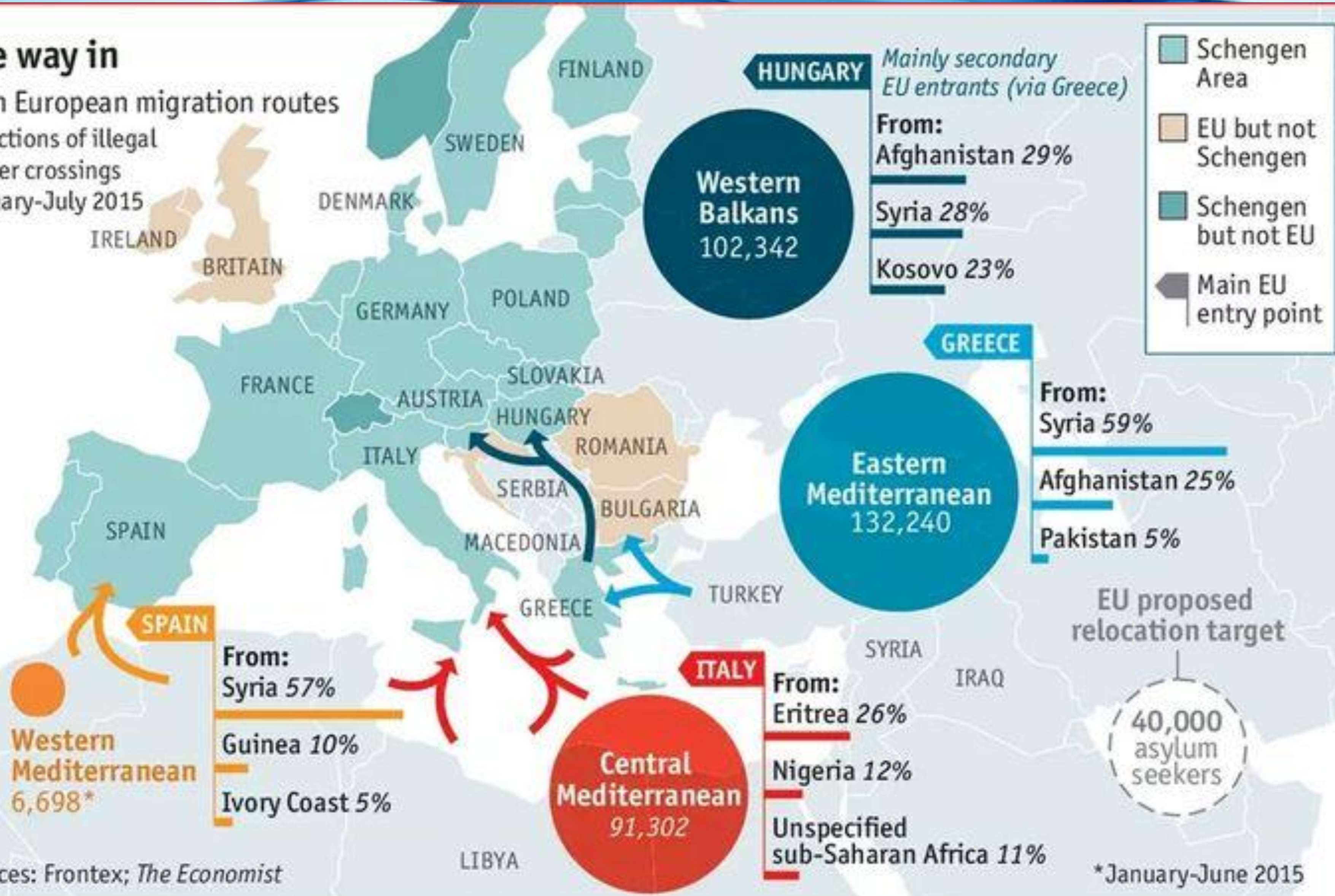
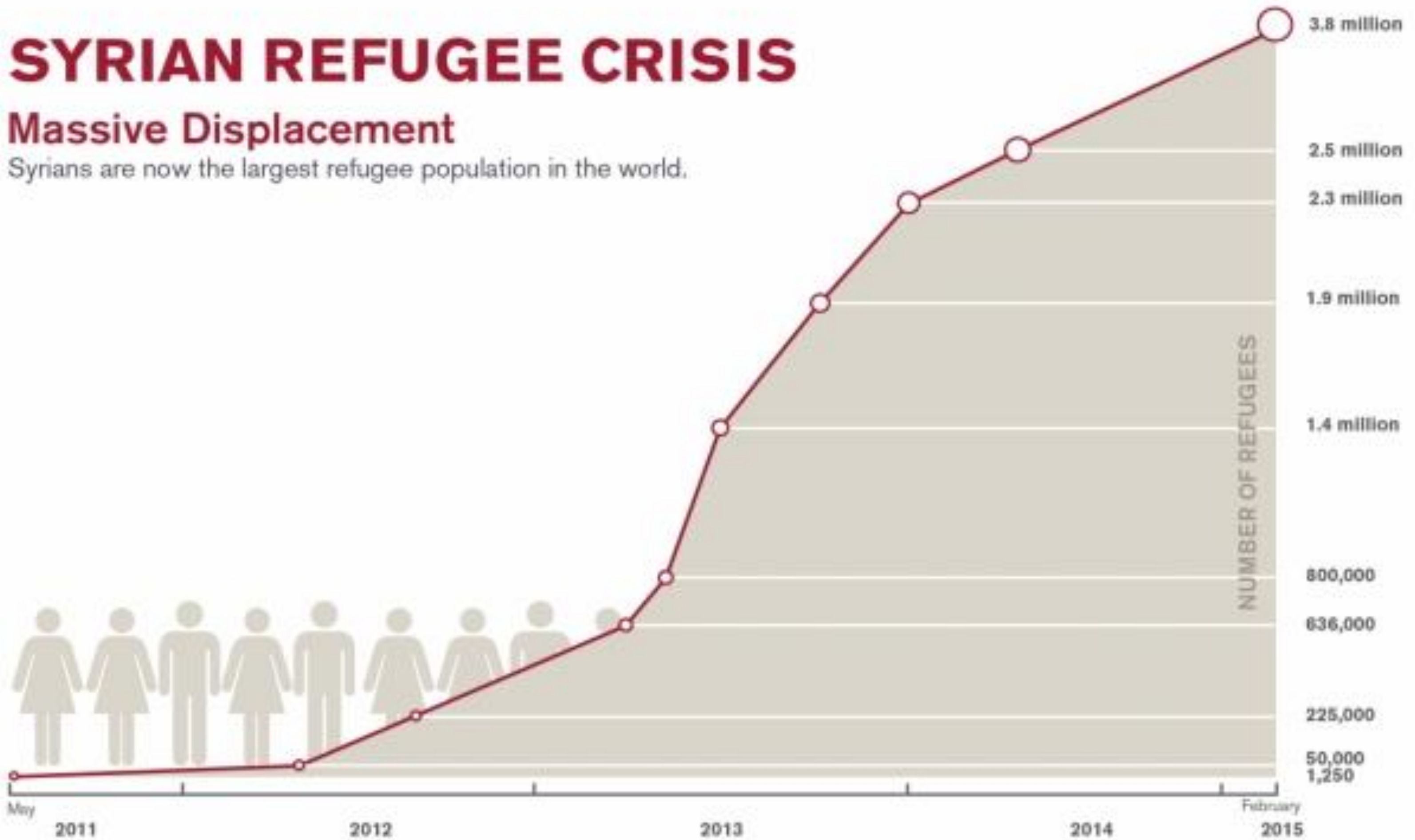
Understanding the journey…


The way in
Main European migration routes
Detections of illegal border crossings January-July 2015
FINLAND
SWEDEN
DENMARK
IRELAND
BRITAIN
GERMANY
POLAND
FRANCE
SLOVAKIA
AUSTRIA
HUNGARY
ROMANIA
ITALY
SERBIA
BULGARIA
SPAIN
MACEDONIA
GREECE
TURKEY
SYRIA
IRAQ
LIBYA
HUNGARY
Mainly secondary EU entrants (via Greece)
Western Balkans 102,342
From:
Afghanistan 29%
Syria 28%
Kosovo 23%
Schengen Area
EU but not Schengen
Schengen but not EU
Main EU entry point
GREECE
Eastern Mediterranean 132,240
From:
Syria 59%
Afghanistan 25%
Pakistan 5%
EU proposed relocation target
40,000 asylum seekers
SPAIN
Western Mediterranean 6,698*
From:
Syria 57%
Guinea 10%
Ivory Coast 5%
ITALY
Central Mediterranean 91,302
From:
Eritrea 26%
Nigeria 12%
Unspecified sub-Saharan Africa 11%
Sources: Frontex; The Economist
*January-June 2015
Economist.com


SYRIAN REFUGEE CRISIS
Massive Displacement
Syrians are now the largest refugee population in the world.
3.8 million
2.5 million
2.3 million
1.9 million
1.4 million
800,000
636,000
225,000
50,000
1,250
NUMBER OF REFUGEES
May
2011
2012
2013
2014
February
2015
MercyCorps

Refugee definition

Refugee: "a person who is unable or unwilling to return to his or her country of nationality because of persecution or a well-founded fear of persecution."

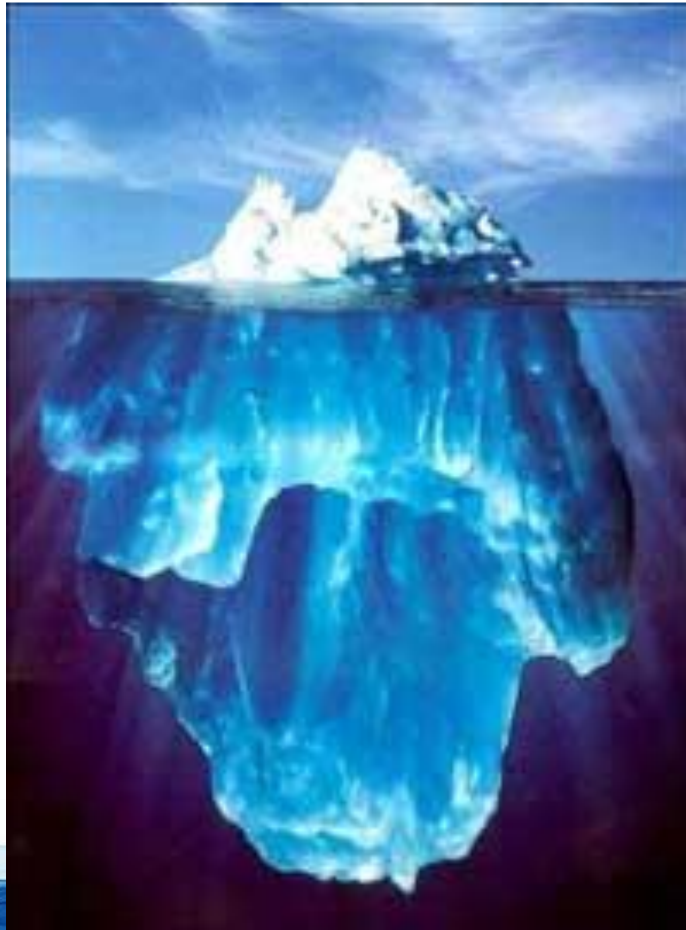
- Race
- Religion
- Nationality
- Political opinion
- Membership in a particular social gro

The Phases

- Preparatory (Pre-escape)
- Migration (Escape)
- Stay in a refugee camp
- Overcompensation
- Intergenerational and cultural conflict stage
- Decompensation
  - Voluntary repatriation
  - Local integration
  - Resettlement in another country

Information from Sluzki CE. Migration and family conflict. Fam Process 1979;18:379-90.

Health care



External

Internal

Food
Music
Language
Visual Arts
Festivals
Performing Arts
Literature
Holiday Customs
Flags
Games
Dress
Nature of Friendship
Values
Notions of Beauty
Religious Beliefs
Body Language
Norms
Etiquette
Rules
Gender Roles
Learning Styles
Expectations
Leadership Styles
Attitudes towards Social Status
Notions of 'Self'
Perceptions
Attitudes towards Age
Notions of Modesty
Thought Processes
Views on Raising Children
Importance of Space
Concept of Fairness
Approaches to Problem Solving
Notions of Cleanliness
Importance of Time
Assumptions

Not only symptoms…

- Boredom
- Shock
- Depression
- Anger
- Hope mingled with disappointment
- Adjustment to new living conditions
- Hopelessness
- Fear of the unknown
- Culture shock
- Survivor’ s guilt
- Helplessness
- Powerlessness
- Self-doubt
- Struggle to meet survival needs
- Confusion

Case 1

59yrs old male patient, black

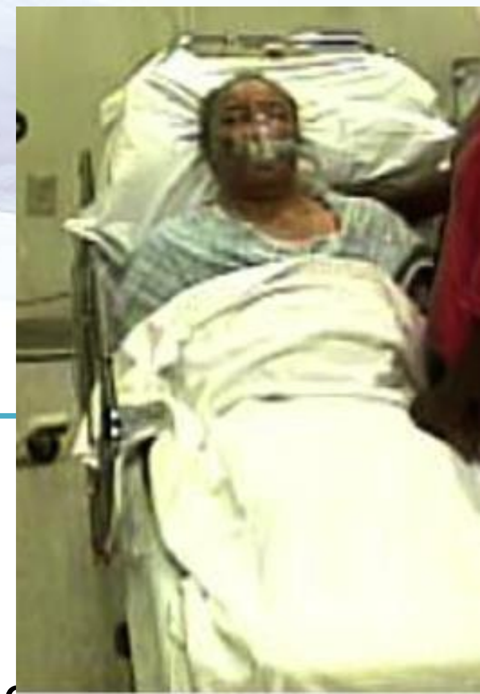
Presentation: reduced vigilance, septic shock, global heart failure

Anamnesis: impossible (pt does not answer), no companion,
no information of relatives

MH(documents): implantation of PM 2weeks ago in Napoli

Social: citizen of Genua (?), resident of UK (?)

Case 1



PE

L: crackles both sides
A: quiet bowel sounds, slightly distended, no resistance
H: AF, PM in situ, bil.edema
N: GCS 6, intubated
GU: anuric, hyperkaliaemia, kidney failure

ICU,

Intubation,

Isolation

Lab values

CRP 380, PCT 80, Krea 400, Lactate 9, BNP 3000 …

Case 1

Diagnostic steps

Cardiology	Rheumatology	Neurology	Pneumology
Endocarditis? Valvulopathies? LV/RV malfuncion? TTE TEE ECG	Autoimmune disease? ANAs, ANCAs, RF, anti-GBM, immunoglobulines, CCP	Epilepsy? EEG Encephalopathy? MRI PNS? LP	TBC? Bronchoscopy Pneumonia? BAL with bacterial, viral and fungal analysis

Case 1

Diagnostic steps - infectiology

Bacteriology	Virology	Fungi
Bacterial: Brucellosis, Bortella, Listeria, Pneumococci, Legionellas, Neisseria, Leishmaniasis. Chlamydia, Mycoplasma TBC spot	HSV, EBV, Influenza, RSV, CMV, Rhinovirus, hMPV, PIV, adenovirus, Polio, Hep, HIV	TBC? Bronchoscopy Pneumonia? BAL with bacterial, viral and fungal analysis

Plus…
CT Thorax-Abdomen-Pelvis
LP for TBC, bacteria, viruses

Case 1

Treatment

Bacteriology	Virology/Fungi	others
<u>Amoxicillin</u> **Clarithromycin** **Meronem** **<u>Tazobactam</u>** **Clarithromycin**	**<u>Acyclovir</u>** **<u>Fluconazole</u>**	Prednison Heparin Propofol/Fentanyl Cordarone Levosimendan • Haemofilter! • 1:1 nurse care • Delirium prophylaxis and therapy • Physiotherapy

Plus…
Social services
Total duration: 55 days at ICU

Case 1

What was missing to avoid overdiagnosis/overtreatment or underdiagnosis/undertreatment?

1. Anamnesis!
- country of origin?
- Travel history
- Animals?
- Medical history inc. meds?
- Recent complaints?
- Family history?
- Environmental history (work)?
- Social history?
- Alcohol? Nicotine? Drugs?

2. insurance?

3. patient wish?

4. allergies?

Case 2

35yrs old male patient, refugee from Syria

Presentation: lower left back pain, fatigue

Anamnesis: renal cell cancer, resected in Syria,
pt. under peroral chemotherapy

Social: lives with wife and 2 children in provided asylum.

Case 2

PE

L: ok
A: ok
H: ok
N: ok
U: renal cell cancer progressive disease

Oncology department (outpatient),

Professional translator

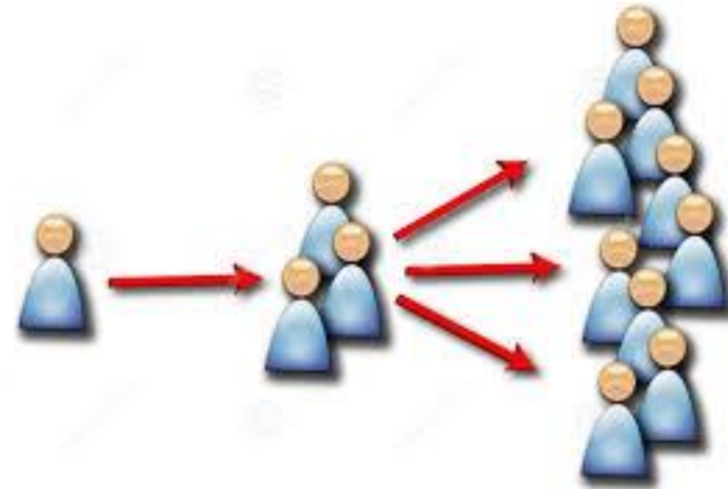
Case 2

After the first visit

initially	After a week	After several weeks	After several months
Patient finished his chemotherapy pills -> during fleeing no new pills provided, pause of 6months -> progressive disease Regional insurance for refugees provided pt with new pills now and assured ongoing oncological outpatient care	Repeated visits to oncology department due to pain -> continuous adjustment of analgesia management -> opioids	Multiple emergencies calls and visits to ER due to pain, multiple hospitalizations and repeated CT scans (stable disease) -> each time good and quick response to opioids and each time long, almost daily discussions with the patient and his family	after repeated hospitalizations -> psychologists with professional translator aboard

Case 2

After the first visit



Case 2

What was missing to avoid overdiagnosis/overtreatment or underdiagnosis/undertreatment?

1. Anamnesis!

- What are the current conditions of the patient?
- Does he understand how to take medicine? Is he incompliant?
- Why did he flee his country?
- What was his profession?
- What are his fears concerning his prognosis?
- Why is he repetitively returning to the hospital?

Group work

Group work

Group 1	Group 2	Group 3	Group 4
Physicians encountered problems	Background factors in caring for refugees	Refugees as “somatisizers”	recommendations for refugee’s health screening
Solutions	Refugees expectations for treatment and compliance	health problems caused by psychological and physical reasons	common health problems associated with region of origin

Group 1

CULTURAL BARRIERS

SOCIAL ISSUES

LANGUAGE BARRIERS

LEGAL ISSUES

SPOUSAL AND CHILD ABUSE

PREVENTIVE HEALTH AND SAFETY ISSUES

INFECTIOUS AND ENDEMIC DISEASES

Group 1

Physicians encountered problems

Solutions

Group 1

CULTURAL BARRIERS

Cultural barriers between physician and refugee patients can affect the outcome of the encounter.

-improper to ask an authority figure any questions

- nodding heads and smiling -> directives are understood?

-improper to maintain eye contact while talking to authority figures,

- looking down -> fear of residence status?

-medical procedures -> body parts "sacred", blood loss "irreversible"

-belief systems vs illness -> arise from physical or metaphysical/supernatural forces

-disparities in quality of care

Group 1

CULTURAL BARRIERS

-maintain respect for the patient while providing health care

-some cultural practices should be respected, but education needs to be implemented to assure health according to the standards of this society

-act according to the standards of the host country

- patient's family, not the patient, is told the diagnosis
- female circumcision
- Patient’s family decides about the treatment limitations/plan etc.

Group 1

LANGUAGE BARRIERS

Barrier in anamnesis, treatment plan and follow up.
Because of the sensitive nature of some health issues, it is not desirable to use children or the spouse of a patient as translators.

-medically trained interpreters are preferable -> not express own views, emotions and beliefs during the translation.
-monitor patients' facial expressions
-speak slowly, repeat often and in different ways
-ask the patient to repeat back the directives to assess understanding

Group 1

SPOUSAL AND CHILD ABUSE

- women are subservient to men
- added freedom in the host country may alter the family's dynamics
- alcohol is often a partner in crime
- violence is often hidden

-> be cognizant of the possibility of abuse in refugee families
-> identify resources in the community to assist these families
-> networking with schools is important
-> adequate time explaining to the family alternate ways of disciplining children
-> women at risk need to be told about actions to take and phone numbers to call

Group 1

PREVENTIVE HEALTH AND SAFETY ISSUES

-preventive health care may be a new concept for refugees
-immunizations.

-> discuss with patients safety issues
-> recommen immunizations according to sandards
-> discuss safety of children (barfoot, hygiene etc)

Group 1

INFECTIOUS AND ENDEMIC DISEASES

-physicians may feel insecure treating some conditions,
e.g. tuberculosis and parasite infections.

-> consider the risk of malaria in pregnant women
-> consider the possibility of congenital transmission
-> malaria needs to be considered even in refugees who have been living in the host country a few years when they present with cyclic unexplained fever
-> HIV infection screening repetition
-> STDs and HIV education

Group 1

SOCIAL ISSUES

-adjustment is very difficult the first years
-nomadic societies and create problems when they move from one place to another (separated from their supporting local shelter, food, clothing, social services, schools)
-frequent moves impede the continuity of medical care (llow-up, such as pregnancies, malnutrition, domestic violence and psychiatric disorders)
-communicable diseases such as tuberculosis, STDs and intestinal parasites
-Depression due to solitude, no social network etc
-General living conditions, conflicts within the refugees group

Group 1

SOCIAL ISSUES

-> weigh the risk of causing dependency and passivity
-> delegate social issues to social services
-> never involve into intergroup-conflicts
-> a take-it-for-granted attitude on the part of the refugee
-> encourage to participate in the provision of support for others in the community

Group 1

Physicians encountered problems

Solutions

Group 1

LEGAL ISSUES

-> delegate to responsible persons

Group 2

Background factors in caring for refugees

Group 2

The cultural, socioeconomic and educational background, whether urban or rural origin, pastoralist/nomadic or agropastoralists, etc.
The root causes of the patient's relocation as a refugee (i.e., war, violation of human rights, repression, famine)
General health status of individuals within the home country; patterns and incidence of endemic infectious diseases and malnutrition
The use of traditional medicine—concepts and understanding of health and if related to certain health practices; stigma linked with mental illness; foods preferred; habits, such as smoking, alcohol, sexual behavior and drugs
Understanding of torture and rape as expressed by victims in different cultures and societies
The appropriateness and adequacy of basic needs in transit camps and host country/sponsoring agencies
Ability to adapt socially and biologically to new conditions; and, attitudes toward other ethnic minorities, or different groups (clans, tribes) within their own population

Group 2

Refugees expectations for treatment and compliance

Group 2

- Refugees often expect Western physicians to cure everything immediately.
- Illness is an unavoidable part of life, and they may delay seeing a physician.
- Urgency with regard to getting prescriptions filled, such as antibiotics, may not seem important to some, while others require the maximum level of diagnosis and treatment, even if not needed.
- Beliefs and expectations of the healing roles of witch doctors and priests from homelands.
- Cultural beliefs regarding the etiology of illness (e.g. weakening of nerves, an imbalance, an obstruction of chi, failure to be in harmony with nature)
- Distrust of and unfamiliarity with Western medicine

Group 2

Refugees expectations for treatment and compliance

Group 2

- ✓ Supervised administration of some medicine (i.e., tuberculosis prophylaxis)
- ✓ When prescribing an antibiotic, tell to finish the medicine, especially since the usual custom is to take medicine only until the pain or symptom is gone.
- ✓ It may be preferable to prescribe as few medicines as possible at a single visit, with extra time given to help the patient understand the treatment protocol.
- ✓ Address the beliefs system and try to ask the patient whether and how his/her expectation is?

Group 3

Refugees as “somatisizers”

health problems caused by psychological and physical reasons

Group 3

- issue is complex, because the way illness is expressed va
- refugees may fear stigmatization and deportation if they are found to have symptoms of “craziness” and thus may attempt to avoid such diagnoses
- it may be culturally appropriate to express illness in terms of physical symptoms rather than the psychodynamic constructions of stress

Group 3

Refugees as "somatisizers"

health problems caused by psychological and physical reasons

Group 3

- ❖insomnia,
- ❖memory loss,
- ❖headaches,
- ❖poor concentration
- ❖nightmares
- ❖anxiety,
- ❖depression
- ❖fatigue
- ❖symptoms of increased arousal

Group 4

recommendations for refugee's health screening

Group 4

AREA	*SPECIFIC SCREENING RECOMMENDATIONS*
General history	Family status, trauma, anxiety, depression
Nutritional status	Dietary history, health habits (including use of tobacco and illicit substances), hemoglobin or hematocrit, height and weight
Physical examination	Blood pressure, oral and skin examination, signs of trauma
Infectious disease, review of previous immigrations	Check stool for ova and parasites, hepatitis serology, VDRL and HIV (as indicated)
Cancer	Age-appropriate screening for cancers that are often not screened for in Third World countries (e.g., Papanicolaou smears)

Group 4

common health problems associated with region of origin

GEOGRAPHIC REGION	HEALTH PROBLEMS	SCREENING METHOD
Global	Tuberculosis	PPD
	Trauma/rape/torture/PTSD	History, physical examination
	HIV disease	HIV enzyme immunoassay
	Measles, mumps and rubella, diphtheria, pertussis and tetanus	Update immunizations
	Hepatitis B	HBsAg
	Intestinal parasites: amebiasis, giardiasis, ascariasis, strongyloidiasis, hookworm, trichuriasis, enterobiasis	Stool analysis for ova and parasites
	Malnutrition/growth delay	Height and weight
	Neonatal tetanus	Clinical suspicion
	Rheumatic heart disease	Physical examination
Latin America	Malaria	Thin and thick blood smears
	Intestinal parasites (helminthic infection, amebiasis, giardiasis)	Stool analysis for ova and parasites, transparent tape prep
	Chagas' disease (South American trypanosomiasis)	Physical examination
	Leischmaniasis, onchocerciasis, lymphaticfilariasis, cysticercosis, schistosomiasis, echinococcosis	Clinical suspicion, urine and stool examination
Africa	Malaria	Thin and thick blood smears
	Sickle cell	Peripheral blood smears, hemoglobin electrophoresis
	Intestinal parasites (helminthic infection, amebiasis, giardiasis)	Stool analysis for ova and parasites
	Diarrheal illnesses	Physical examination
	HIV-related diseases	HIV enzyme

Clinical red flags

Vit D deficiency		Rickets, bone pain, muscle pain, late fontanelle closure (low dairy)
TB (active vs latent)		Prolonged cough, fever, night sweats, poor growth
Anaemia		Irritability, lethargy, developmental delay (high dairy)
Gastrointestinal infections		Diarrhoea, abdominal pain, epigastric pain, vomiting, poor appetite, poor growth
Heavy metal toxicity		Traditional medicines, developmental delay, gastrointestinal upset
Mental Health Concerns		Behavioural disturbance: sleep, eating, play, somatisation

Merci!