Training and Information Pack

Health and Well-being 3:

General health and well-being

TS4SE
a not for profit co-operative

Improving Access to Health Care for Migrants

November 2011


Contents

Introduction

'Migration experience, gender, age, income and education levels, conditions in the country of origin and in the UK all combine to play a large part in health status.'
Health and Migration in the North West of England. (2008)

It is difficult to make generalisations regarding the health of migrants and refugees in the UK today.

Migrants come from many countries – their individual health will be a reflection both of the general health in their country of origin – and the reasons and experiences that have brought them here. For forced migrants (refugees and people seeking asylum) there are a broad set of common experiences which can impact health, but not every exile will have experience of torture, war injury, or other trauma.

The diversity of origins of today's migrants make a patient centred approach essential – get to know your patient – ask questions and don't assume!

This unit is introductory and a guide to the general health issues affecting migrants, it is NOT a manual for migrant health, there is a wealth of resources and information available on line – further information and resources can be found in the resources and links section of the toolkit.

Learning objectives

The practitioner will:

- To gain insight into the effect of migration on health
- To understand the particular health problems migrants may have
- To consider ways to address these issues

Key points

Health needs vary with the reason for migration: Most migrant workers and international students will be young and healthy; refugees and people seeking asylum, who have been forced to migrate in order to be safe, will have more complex needs as exile is always stressful.

Health behaviour and health seeking activities: will also vary with the reason for migration, and with the standard of health care in the country of origin, which may be high-tech medicine, or a non-existent health infrastructure due to war or poverty.

The UK health care system is unique to the UK: all new migrants will be unfamiliar with the way we do things here – for more details please see the training module looking at barriers

Migrant Populations

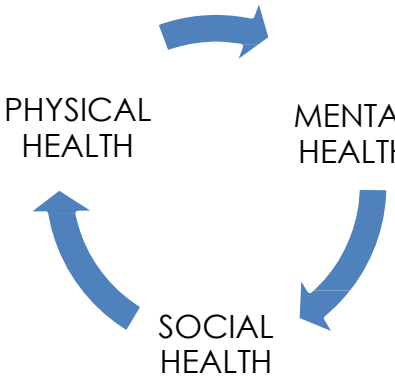
The majority of migrants to the UK are young and healthy, international students or migrant workers from the other developed countries coming to paid employment.

The elderly, frail and ill are unlikely to make such a demanding and hazardous journey, although longer-standing UK migrant populations are ageing, and the Gateway Protection Programme may assist elderly, frail or disabled refugees to settle in the UK. However, the numbers coming into the UK through this programme are small.

Family joiners may include elderly relatives with age-related health problems.

The stresses of exile

There is growing evidence suggesting that the health of migrants declines after some time in the host country due to causes related to poverty, social exclusion and psychological distress. Diagnoses of TB, for example, increase after two years in the UK.



Physical, mental and social aspects of health are inextricably linked; the relationship between poverty, social exclusion and ill health is well documented.

Migrants vary enormously in their social and material circumstances, but many remain considerably socially disadvantaged, even after several years in the UK.

People seeking asylum whose claims have been finally rejected are destitute, with no recourse to public funds and no legal means of providing for themselves.

Destitution has an extremely adverse effect on health.

- The stress of exile and homesickness may lower an individual's resistance to disease. The most obvious individuals to whom this statement applies are refugees and people seeking asylum, but migration to a strange and foreign land is always stressful, no matter what the reason for leaving home.

Consider the role of the emotions in pain; physical pains may have a psychological or emotional basis; it may be easier to talk about physical pain than emotional distress.

Practicalities

UK health systems are unique to the UK, and will be unfamiliar to many migrants.

- The concept of primary care is almost unknown in the developing world, and most migrants will not understand the need to register with a GP as the necessary way access health care.

An HC2 form may be required to allow free health care. This will have been issued by the UKBA to people seeking asylum.

Appointments for people requiring an interpreter will take more time, as everything must be said twice.

- Trying to dispense with an interpreter can lead to lack of communication and possible misdiagnosis.

There is a need to explain services to new arrivals, both to enable the individual migrant to access the health care most appropriate to his/her need, and also to reduce inappropriate use of health services such as A & E.

- Time spent on building trust and explaining services to new arrivals should save time and money in the longer term by reducing inappropriate use of emergency services and being able to get to the heart of the problem more quickly.

Factors affecting health

Remember:

Health may not be a high priority compared with employment problems, studying or the progress of an asylum claim.

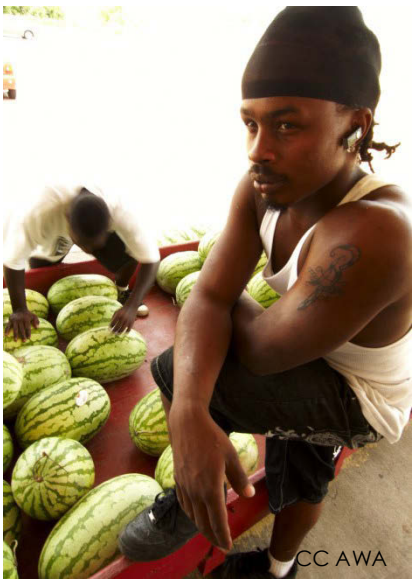
Migrants may have different patterns of health-affecting behaviour such as alcohol consumption, smoking and diet. These patterns may be more, or less, healthy than those of the indigenous population.

Health-affecting behaviours may change over time as the individual adapts to life in the UK.

There is a risk of substance abuse as a coping strategy.

Primary health care is unusual in global terms. In most countries of the developing world the procedure is to go directly to the doctor, specialist or traditional healer of your choice, and pay for services. The system of GPs as gateways into the health care system is unique to the UK. Screening may not be a familiar concept, and nor will the extended role of the nurse. You will need to explain yourself and your role from first base.

There are cultural differences in the understanding of illnesses, and sometimes these understandings can present problems with providing care. For example the significance of epileptic fits can be determined by the patient's culture.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Nutrition

Many migrants will be well nourished, coming as they do from affluent countries, and having the resources and the inclination to cook meals from fresh food.

However, nutritional status will also depend on the individual migrant's life experiences and psychological distress; an asylum seeker may have had a long and hazardous journey with little access to healthy food and drink.

Sadness and depression have an effect on the individual's ability to shop, cook and eat.

In many parts of the world preparing and eating food is a communal experience, a time when all the family get together to talk, share experiences and troubles. This may not be possible for a migrant, and eating alone may reinforce all that they have lost.


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Men from many countries will have no experience of cooking for themselves. Preparing food is carried out by the women of the family, and men have to learn to feed themselves as a matter of urgency.

Here is a practical example of such a project in Salford Lancashire:

Refugee men's cookery report (click icon to open)

'I had problems with food. Now I eat much better, and my children enjoy my cooking. I cooked for a friend, and that made me feel so good.'

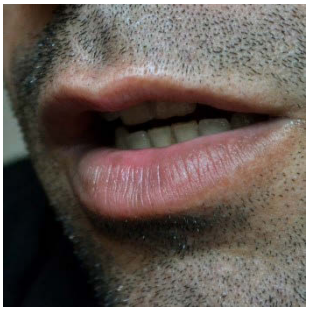
Man from Zimbabwe on Salford cookery course for men.

The food culture in the UK, with the emphasis on shopping in supermarkets rather than the stalls of street markets, and the reliance on ready-meals, will be unfamiliar to migrants from the developing world, and may make feeding themselves more difficult. (Maffia 2007)

Communicable disease

Communicable diseases are not likely to be the primary health issue for most migrants. Most communicable diseases in migrants will be the same as those for the indigenous population – coughs, colds, flu etc.

Rates of TB, HIV and Hepatitis B and C are higher among people born outside the UK, but these rates are still low, and rates of these diseases among migrants to the UK are lower than the prevalence in their country of origin.



There is little evidence of spread of communicable diseases from migrants to the wider population, especially during normal social contact.

Migrants remain at increased risk for a significant length of time. This is probably a combination of infection in the country of origin, transmission within minority communities in the UK, travel to the country of origin and socio-economic circumstances in the UK. (Health and Migration in the North West of England: an Overview 2008)

Tuberculosis (TB)

In 1993 the World Health Organisation (WHO) declared TB a global emergency. In 2004 there were 9 million cases worldwide, resulting in 1.7 million deaths.

TB in the UK has increased slightly in recent years, with the majority of new cases in people born outside the UK

- 48% of cases of TB in people born outside the UK are non-pulmonary and therefore not infectious. TB should be considered as a possible diagnosis for unusual physical symptoms.
- The majority (82%) of new entrants to the UK who develop TB do so at least 2 years after arrival, 56% at least 5 years after arrival. The median duration of stay prior to development of TB is 4 years.

There is no evidence of transmission of TB from new entrants to the indigenous UK population.


TB Alert is an international NGO working with the NHS to promote awareness of TB among the communities most likely to suffer from the disease. Click on the picture for a link to their web-site

Why is there a delay in the development of TB amongst migrants in the UK?

Social conditions	**TB is a disease of poverty and living in overcrowded conditions, and vulnerable migrants are among the most deprived in UK society.**
Delay in diagnosis.	**All migrants from areas of the world where TB is endemic should be screened for TB. However, this does not always take place, and procedures are not infallible. Consent must ALWAYS be sought.**
Dormancy of the disease.	**This is part of the reason; TB is endemic in many parts of the world, and exposure to the disease is almost inevitable. TB can lie dormant for many years, and can be activated by the stresses of life.**
Difficulty in accessing medical care.	**The UK health care system is different from that of most countries, and the need to register with a GP is not well understood. It can also be extremely difficult for some groups of migrants, for example asylum seekers whose claims have been fully refused, to register with a GP.**

Reasons for low transmission rates of TB from new migrants to the wider population

Lack of interaction between migrants and the wider population.	**Probably.** **TB requires prolonged close contact.**
The indigenous population is generally in better health.	**Possibly.** **There are plenty of pockets of deprivation among people born in the UK, and some migrants are healthier than some English people.**

HIV/AIDS

There remains considerable stigma attached to a diagnosis of HIV, which is often still seen as a death sentence. Sufferers may be isolated and become subject to taboo. This may lead to people being reluctant to undergo testing.

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- The number of non-UK born individuals living with HIV in the UK has risen.
- The majority of non-UK born individuals diagnosed with HIV in 2010 were from Sub-Saharan Africa. However, the rates in the migrant population in the UK are much lower than the rates in the country of origin.
- The majority of cases of HIV in black Africans from sub-Saharan Africa are acquired through heterosexual contact in their country of origin.
- In the North West, use of specialist hospital services by HIV positive asylum seekers differs little from HIV positive persons who are not asylum seekers, but they do use voluntary sector services more.
- HIV/AIDS spreads faster where there is poverty, lawlessness and social instability. HIV prevalence rates among combatants in the Democratic Republic of Congo, for example, were estimated at 60%.
- Rape, of men as well as women, may be used as a method of torture or as a tool of ethnic cleansing.
- The risk of HIV transmission in intercourse which results from sexual violence is much higher than during consensual sex.

Hepatitis B

As Hepatitis B is spread in the same way as HIV/AIDS, the considerations given above apply to this illness as well.

- In the UK acute hepatitis B mainly occurs in young adults (aged 15-24) and is acquired through drug use and sexual exposure.
- Chronic hepatitis B occurs mainly in migrants from endemic countries.
- The WHO estimates that there are 350 million people living with chronic Hepatitis B, mainly in the developing world.
- Transmission within the UK gives rise to only a small proportion of new chronic infections.

General Public Health

Migrants should not be thought of as vectors of disease; rather as a group of people public health messages do not reach. This case study carried out in Manchester in 2009 during the Swine 'Flu pandemic illustrates the need to deliver effective public health messages to migrants: *Swine Flu and the Kurdish Community in Manchester*

Reflective Learning Exercise

Read the short scenario below and consider the possible responses to the questions – turn to the next sheet for a discussion of the possible issues and some guidance on how to approach the situation.

Edouard, a 20 year old young man from the Democratic Republic of the Congo in Africa, he is currently seeking asylum in the UK.

Edouard has recently been allocated housing in your area of practice. He had no choice about where he was sent to live by the Home Office, and this is his second move.

Edouard is a frequent visitor to your clinic and keeps returning to the local GP practice with a variety of physical complaints.

He is quiet and polite and a "model" patient.

His first language is Lingala, but he speaks fluent French and a little English.

Q. Why does he keep coming back? Is it:

1. Because he likes coming to the surgery?
2. Because he has time on his hands and nothing better to do?
3. Because his needs are not being met?
4. Because he has lots of different health problems?

Possible responses and considerations

Because he likes coming to the surgery?

Possibly

The surgery may be one of the few places where he feels safe and treated with respect and dignity.

However, it is more likely that his needs are not being met, and he keeps returning in search of a solution.

Because he has time on his hands and nothing better to do?

Possibly, but unlikely

He will certainly have time on his hands, but it is unlikely to be the reason he keeps returning.

Because his needs are not being met?

Possibly the cause

The health needs of people who have fled war and violence are complex, the Democratic Republic of the Congo is a violent and unstable country.

The various aches and pains may be somatizations – it is easier to talk about physical pain than emotional distress.

They symptoms may be manifestations of injury acquired in violence or torture, or disease, infection or illnesses you may be unfamiliar with (common are intestinal parasitic infections not know in the UK).

There may also be communication problems – his little English and polite manner may have led practitioners to believe he does not need an interpreter.

Because he has lots of different health problems?

Quite possibly

He may have health problems as a result of his experiences in the home country – un- or under-treated war wounds, torture etc. Or he may have some tropical illness which is unfamiliar and has been missed.

Additionally, the stresses of exile and poverty can lower resistance to disease.

You can help him to help you to understand his health problems, but you need to consider how his needs differ from those of the indigenous population.

Here's how you can dig a little deeper and assist Eduoard…..

Use an interpreter, and learn how to work with interpreters.

Allow extra time. If the appointment is for a standard length of time, explain this and invite Eduard to come for a longer appointment.

Ask him about his life, both here and in Africa. Showing an interest will give Edouard time to relax and get to know you, and will help to build trust, without which real communication will not happen.

You will then have a chance to get some idea of the baseline of his health. Is his health different now from how it was in the country of origin? In what ways? Why?

Are there any obvious issues/problems in the UK which you could help with, or signpost him to?

For example, is he lonely, knowing nobody who speaks his language? Are there problems with housing?

You may not get any nearer to uncovering the roots of his problems with one session; invite him back.

This may seem very time-consuming, but will be time-saving in the long run, if you can uncover, and effectively treat or alleviate the problems. People do not expect miracles, or for you to be the answer to all their problems; showing an interest can be the best medicine of all.

There is evidence that time spent explaining the UK health care system to migrants when they first arrive reduces later demands on primary care. McFarlane

'When I first came to the UK I kept going back and back to my doctor. She was so kind, and listened to me, and now I hardly need to go back to see her at all!' Pakistani woman in Salford


Remember

- Most migrants are young and healthy; health stresses vary with the reason for migration.
- However, the stresses of exile, including poverty, loss, disappointment, racism and isolation may lower the individual's resistance to disease.
- Migrants may find accessing the complicated UK system of health care problematic.
- It can take time to uncover health problems; time invested when people first arrive should reduce demands on primary care in the future.