Healthcare Guidelines for Care of Refugees

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Conflict of Interest Statement

- I do not have an affiliation (financial or otherwise) with a pharmaceutical, medical device or communications organization.
Objectives

- Discuss the barriers for refugees in accessing healthcare.

- Use the Canadian Collaboration for Immigrant and Refugee Health guidelines in practice for assessment and screening of refugee patients.

- Discuss the importance of family physician care for refugees.
• Healthcare guidelines for care of refugees
• MUN MED Gateway program
• Being a family doctor to refugees
Healthcare Guidelines for Care of Refugees

- Immigrants-voluntary, economic, work, family reasons
- Temporary residents – migrant workers, students, etc

- Humanitarian migrants- refugees and refugee claimants (24,000 to Canada in 2013)
  - ~ (100-150 to NFLD & Lab /year)
  - Eritrea, Bhutan, Central African Republic, Sudan, Kosovo, Iraq, Ethiopia, Myanmar
Canada accepted less than 1% of the world's refugees in 2013 (0.96%) - a smaller percentage than it did in 2012 (2.10%)

In 2013 ----- 5790 GARS, 6396 PSR, 8149 claimants

Total ~24,000 in 2013 (27,000 in 2012)

50 million refugees worldwide in 2014 (most since end second world war)

Immigration medicals

- Compulsory
- Refugees bear cost individually
- Exam done outside Canada if sponsored
- Exam in Canada if in Canada when seek asylum
- Screening only to assess potential burden of illness and limit public health risk.
- No clinical prevention services
- Ongoing surveillance only for TB (children < 13 not screened), syphilis, HIV
Refugees Have Lower Level of Health

- Longitudinal Survey of Immigrants to Canada (LSIC)
- Significant decline health status within 2 years arrival
- Decline greater for women
- More risk if limited proficiency English or French
- Men: refugee status, discrimination, living in Vancouver
- Women: age, healthcare access problems, social isolation
Decreased risk poor health if:
- frequent interaction with friends
- not in low income family
- own a house rather than renting

- Immigrants with social network more likely to see physicians and access healthcare.

- Country origin - lack of primary health and preventative care
- Disease exposure in home country, living conditions, genetic predispositions.
Some subgroups increased risk:
southeast Asians – IHD and CVA
Caribbeans – DM, infectious disease, liver cancer (men)
Migrant workers particularly vulnerable (estimate = 200,000)
• Risk infectious disease and re-exposure with return visits to home country, eg TB
• Inherited disorders, eg hemoglobinopathies
• Increased rates stomach, nasopharyngeal, liver cancers in some, than Canadian borne patients
• Prostate and breast cancers increase in some populations after migration to Canada
• Economic deprivation, poverty more common refugees
• Adverse health produced by violence, torture, trauma
• Determinants of health
Factors affecting accessibility to healthcare services

- Language, translation services
- Cost - fear cost as in country of origin, hidden costs
- Geographic accessibility
- Transportation
- Community awareness/health beliefs
- Cultural sensitivity/barriers
Health Issues

- Anemias
- Hemoglobinopathies - sickle cell, thalassemias
- Contraceptive needs
- Women’s health
- Hypertension
- IHD
- Nutritional issues
- Mental health
Health Issues

- Child health
- Immunization
- TB screening
- Isolation
- Interpretation
- Education
- Family left behind
- poverty
Canadian Collaboration for Immigrant & Refugee Health recommendations (CCIRH)

- [www.cmaj.ca](http://www.cmaj.ca) (clinical practice guidelines)
Hepatitis B & C

- Screen adults/children where prevalence > 2%, Africa, Asia, Eastern Europe
- Decreases disease severity, incidence hepatocellular cancer, transmission Hep B
- Refer if Hep B positive, US and alpha FP Q 6 months
- Screening/treatment reduces development liver failure, NNT=19
- Offer vaccination for those negative, 20-80% immigrants non-immune when from high prevalence country
HIV

- Screen all adolescents/adults, with informed consent, reduces morbidity/mortality.
- Link to treatment centers if positive
- Higher prevalence sub-Saharan Africa, Caribbean, Thailand
- Refugee may know of positive status but limited knowledge treatments, screening, options
TB

- Screen all from endemic areas ASAP with TB skin test
- Tuberculin test positive - Assess if latent or active TB, sputum for AFB + CXR
- High index suspicion, look for symptoms (fever, wt loss, fatigue, cough, night sweats, lymphadenopathy etc)
- High incidence - sub Sahara Africa, Asia, Central and South America
- Special attention to children < 5, screen for latent TB, if infected then high risk active TB, hard to diagnose this age
- Increased risk: HIV, transplant, contact with active case, hematological malignancy, DM, chronic renal failure, chronic steroids
Other Infectious diseases

- No stool screening in asymptomatic patients
- Serology for strongyloides if from SSA or SE Asia, schistosomiasis from SSA
- Be alert for malaria if fever within 3 months
“When you are still alive, Still you can make it”

- https://www.youtube.com/watch?v=6vgVfqsHqhQ&list=PLD11D1DD6D2DF49F9&index=6
Depression

- High index suspicion
- Access to care may be an issue
- Reluctance to discuss emotional issues
- Often present with somatic complaints
- No routine screening for PTSD
- Exposure to torture strongest predictor PTSD in refugees
Post-traumatic stress disorder

Forty percent (40%) of Canadian immigrants and refugees from countries involved in war or with significant social unrest have been exposed to traumatic events before migration.

Most (estimated at 80%) individuals who experience traumatic events heal spontaneously after reaching safety.

Empathy, reassurance and advocacy are key clinical elements of the recovery process.
CCIRH Guideline

- Do not conduct routine screening for exposure to traumatic events, because pushing for disclosure of traumatic events in well-functioning individuals may result in more harm than good.

- Be alert for signs and symptoms of post-traumatic stress disorder (unexplained somatic symptoms, sleep disorders or mental health disorders such as depression or panic disorder).
Mental Health

- Risk factors:
  - imprisonment
  - violence
  - death / missing family members
  - poverty
  - isolation
  - racism
  - language abuse

- Protective factors:
  - economic security
  - access support services
  - education opportunity
  - family support
  - participation community group
Focus on factors that help after migration to Canada

Refugees identify factors most important to mental health:

- Income/social status
- Employment
- Housing
- Social inclusion
- Family

- Education
- Personal resources
- Access to health services
- Culture
- Language/literacy
Factors related to migration that affect mental health

Children:

• Age and developmental stage at migration
• Separation from caregiver, Stresses related to family’s adaptation
• Disruption of education
• Exposure to violence
• Difficulties with education in new language
• Separation from extended family and peer networks
• Exposure to harsh living conditions (e.g., refugee camps)
• Acculturation (e.g., ethnic and religious identity; sex role conflicts; intergenerational conflict within family)
• Poor nutrition
• Discrimination and social exclusion (at school or with peers)
• Uncertainty about future
Iron deficiency anemia

- Screen with CBC, ferritin if low, children and adults
- Higher prevalence anemia in immigrant, refugee children
- Inadequate diet, frequent infections, low iron stores at birth
- Women: high parity, low iron diets, parasitic infections
- Treat with iron
- Watch for other causes, may need smear, HGB electrophoresis, G6PD deficiency
Oral health

- Screen for dental pain, use NSAID for pain relief
- Examine for dental caries and oral disease using pen light
- Referral to dentist as needed
- Higher prevalence dental caries immigrant teens
Vision health

- Age appropriate screening and correction with glasses
- Screening in children very important
- High prevalence refractive errors in immigrant population but economics may prevent uptake of referral
Women’s health

- Screen for unmet contraceptive needs
- High prevalence unmet needs
- Cultural sensitivity
- Recommend HPV vaccination ages 9-26, issues with payment coverage
- Low cervical screen rate (40-60%) in immigrant women
- Pregnancy: higher social isolation, higher morbidity and SGA infants, remain alert for risks in unregulated work environments, sexual abuse especially in work migrants
Interpreters

- No child interpreters
- Not relying on family members for interpreters
- Professional training - CANTALK
- Particularly with mental health issues and CYFS issues, medical appointments
Gateway sessions

- Pairs of medical students work together with trained interpreters to take medical histories.
- Supervised by family physician, public health nurse
Gateway sessions

- Screening- BP, Wt, growth charts for children, vision, hearing, oral exam
- Referral as needed
Gateway sessions

- TB skin tests
- Histories/screening entered into database, patients matched with family doctors.
Gateway sessions 2009-2014

- 206 sessions
- Screenings added to sessions in 2012
- 525 student volunteers involved in sessions
- 576 refugee participants
Gateway’s additional projects

- Vitamin D program
- Car seat program
- Participation in ANC health fairs
- Annual holiday festivity
- Cooking Together
- Young adults group
- Refugee WW project
Being a Family Doctor to Refugees

- Start with the patient - remember the person and their family
- No need to be content expert
- Read and research
- Learn from others
- Phone and email consults
- Opportunity for advocacy - IFH cuts