Mig-HealthCare Roadmap & Toolbox

NCD's and Chronic Conditions

Co-funded by the European Union's Health Programme (2014-2020)

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NCD's and Chronic Conditions

1. Magnitude of the problem

Prevalence of Non Communicable Diseases

The notable rise of the prevalence of Non-Communicable Diseases (NCDs) has been characterised as "the slow motion disaster" by the World Health Organization (WHO). NCD's are the leading cause of death worldwide (3 in 5 people). Globally, 32 million people died in 2016 due to cardiovascular disease, cancer, diabetes or chronic respiratory disease. The probability of dying from these causes was about 18 per cent in 2016 for people between 30 and 70 years of age).

WHO estimates that 70% of deaths throughout the world are attributable to NCDs including cardiovascular diseases, diabetes, lung disease and cancer. Despite the perception that these diseases only affect affluent societies, the reality is that cardiovascular disease, diabetes, cancer and chronic respiratory diseases are now a global problem in which the poor and the vulnerable suffer the most. People from low and middle-income countries are particularly affected by NCDs. Risk of illness under the age of 70 years in low socioeconomic countries is attributed mainly to NCDs (WHO 2018 a).

Given the high burden of NCDs on societies, the WHO has formed a Global Monitoring Framework in the WHO Global Assembly in 2013, to monitor, track and prevent these diseases globally. The management of NCDs has also been included in the 2030 agenda of sustainable development goals - Goal 3: Ensure healthy lives and promote well-being for all at all ages.

2. Reference to the problem concerning migrants/refugees

NCDs among migrants and refugees

NCDs in newly arrived migrants and refugees are lower compared to the native population although as duration of stay in the host country increases so does prevalence and incidence of NCDs (WHO, 2018).

Refugees and migrants who suffer from NCDs are more vulnerable to the stress caused by the migration journey and are more prone to disease complications because of adverse conditions and inability to access suitable health care. The International Red Cross estimates that people who live under crisis or emergency situations experience two to three times higher acute complications related to pre-existing health problems (IRC, 2018)

According to the WHO the refugee and migrant journey can increase symptoms or cause a life-threatening deterioration among those suffering from NCDs. Vulnerable people such as older people and children are mostly at risk.

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Complications among migrants /refugees suffering from NCDs according to the WHO (2018) can be a result of:

- Physical injuries: factors such as secondary infections and poor control of glycaemia, compromise management of acute traumatic injuries;
- Forced displacement: loss of access to medication or devices, loss of prescriptions, lack of access to health care services leading to prolongation of disruption of treatment;
- Degradation of living conditions: loss of shelter, shortages of water and regular food supplies and lack of income add to physical and psychological strain; and
- interruption of care: due to destruction of health infrastructure, disruption of medical supplies and the absence of health care providers who have been killed, injured or are unable to return to work; and
- Interruption of power supplies or safe water, with life-threatening consequences, especially for people with end-stage renal failure who require dialysis.

As the prevalence of NCDs increases so will the healthcare related costs required to treat the adverse effects, expected to be more evident among vulnerable groups such as migrants and refugees. Given the fact that NCDs are chronic, as life expectancy increases the duration of related expenditures is projected to last for a substantial number of years, which in the financial scarcity situations, is an unbearable burden. Especially in the case of vulnerable groups, such costs can only be met by the state healthcare and insurance providers, whereas indeed there are more cost-effective ways of disease prevention which could levitate such high costs. (EU Ageing Report 2015)

In a 2018 survey study of 1,286 migrants and refugees in 10 countries across Europe within the MigHealthCare project, 13.3% of participants reported suffering from chronic respiratory disease, 9.4% from diabetes, and 2.7% from cancer and strokes. Additionally, 15.9% of migrants reported gastrointestinal disease, 14.2% reported ear, nose and throat diseases, and 13.4% experienced chronic problems from injury and accidents. Some migrants reported not having access to the healthcare services required for screening, preventing and treating NCDs. Of the participants in this study, 13.1% (n=142) reported needing medication that they were unable to take, and 28.1% (n=301) felt they had worse access to healthcare compared to local people. Only 5.1% of migrants reported having had a colonoscopy, and of the female participants, 20.4% had ever had a Pap Test and 12.8% had ever had a mammogram.

3. Reference to issues of particular interest

Diabetes

According to 2018 data from the WHO, refugees and migrants who live in Europe suffer and die more from diabetes than the European population (WHO, 2018). Other research indicates that people with limited access to diabetes medication and primary health services actually have higher rates of hospitalization and consequently boost hospitalization costs (Montesi, Caletti & Marchesini, 2016). In light of the continuous migrant/refugee flows the prevention and early treatment of diabetes benefits health care systems as opposed to under treatment and under protection. In addition the management of diabetes for migrants/

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refugees already suffering from the disease should be a priority through culturally and linguistically sensitive services at the community health care level.

Obesity

As duration in the host country increases and exposure to different diet patterns is extended migrants and refugees appear to have a greater risk of obesity compared to host populations, approximately 10 to 15 years after migration (WHO, 2018; Murphy, Robertson, & Oyebode, 2017). Early prevention and education concerning healthy nutrition is important in order to halt the spread of the obesity epidemic to migrants and refugees. Activities to promote healthy weight in migrant/refugee populations should be a routine service at the community health care level.

Cancer

There are no safe estimates about the number of migrants/refugees who enter Europe already suffering from cancer. What is known are the difficulties these patients face in terms of treatment management due to limited resources and high costs in many of the host countries (Saghir, et al., 2018). At the community level it is important for clinicians to identify problems early on and refer patients to appropriate care facilities. The role of NGOs in the management of cancer among migrants/refugees has been identified as crucial (Saghir, et al., 2018).

Concerning the development of cancer once settled in a host country research shows that migrants and refugees have lower incidence and prevalence rates - with the exception of cancers that are related to early life infections like cervical cancer (Leinonen, 2017; WHO, 2018). Nevertheless, it is projected that during their new settlement migrants/refugees will be diagnosed at a later cancer stage compared to the host population (WHO, 2018).

It is necessary to address cancer screening at the community level through culturally sensitive and linguistically appropriate services and raise awareness about the prevention of cancers such as cervical and breast cancer.

4. Important steps for the Health care sector

According to the WHO (2018) there are minimum standards of care for responding to the needs of refugees and migrants with NCDs. More specifically these include:

- Identifying individuals with NCDs to ensure continuing access to the treatment they were receiving before their travel.
- Ensuring treatment of people with acute, life-threatening exacerbation and complications of NCDs.
- When treatments for NCDs are not available, establish clear standard operating procedures for referral.

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- Ensure that essential diagnostic equipment, core laboratory tests and medication for routine management of NCDs are available in the primary health care system. Medications that are on the local or WHO lists of essential medicines are appropriate.

The WHO also sets key indicators for service providers in terms of NCDs among migrants/refugees:

- All primary health care facilities have clear standard operating procedures for referral of patients with NCDs to secondary and tertiary care facilities.
- All primary health care facilities have the necessary medications to continue pre-emergency treatment of patients with NCDs, including for pain relief.

5. Prevention

Preventing NCDs among migrants/refugees

It is a well-known fact that the major causes of NCDs relate to modifiable lifestyle determinants such as lack of physical exercise, unhealthy diet, tobacco consumption and excessive use of alcohol. The WHO has developed a set of 9 goals applying to all population groups to achieve by 2025 which fall under three major pillars: a) morbidity and mortality: 25% reduction of premature morbidity and mortality from NCDs, b) risk factors: 10% reduction of alcohol use, 10% reduction of physical inactivity, 30% reduction of salt/sodium intake, 30% reduction of tobacco use, 25% reduction of increased blood pressure, 0% increase of diabetes/obesity and c) national health systems response: 80% coverage of NCD essential medicines and technology, 50% coverage of drug therapy and counselling. (WHO, 2011)

Addressing modifiable lifestyle determinants is a challenge for health care providers especially when the patients are from different cultural and linguistic backgrounds. This roadmap includes tools to facilitate health care providers in effectively addressing related to NCD determinants.

Legislation for the management and prevention of NCDs provides the basis for the adoption of political initiatives and practices. The WHO framework adopted in the Global Health Assembly (2013), the SDGs 2030 agenda form a good starting point for national governance initiatives.

6. Examples of best practices

The Mig-HealthCare project reviewed and evaluated relevant interventions offered to migrants and refugees. This roadmap includes some examples that can be used in different settings also based on the evaluation process of the systematic review that was conducted by the Mig-HealthCare partners in 2018. More information about these and other promising practices can be found on the project's website http://www.mighealthcare.eu/ by accessing the report titled 'D5.1: Report on models of community health and social care and best practices'.

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I. Linguistically and culturally-sensitive cardiovascular disease (CVD) prevention program (Bader, 2006)

The program was developed for Turkish immigrant women and was evaluated through a pre-post evaluation design. The study developed a linguistically and culturally-sensitive cardiovascular disease (CVD) prevention program that included blood pressure readings and questionnaire responses regarding awareness of main CVD risk factors, awareness of cholesterol level, awareness of blood pressure and awareness of blood glucose The program reached female Turkish migrants and was effective in reducing their level of unawareness about CVD.

II. Community-based, culturally competent respiratory health screening and education (Siddaiah, 2013)

This program was implemented among Latino immigrants and evaluated through a pre-post design. It concerned a community-based, culturally competent respiratory health screening and education project. Results were based on screening and referral rates. High positive screening rates were recorded for both men (64%) and women (61%). Of the participants who screened positive and were advised to seek medical care, 52% did so. Community-based screenings provide an opportunity to access at-risk immigrant populations for health screening and education, and to facilitate referral and access to medical services.

III. Chronic Care model

This interesting chronic care model identified included simple recording forms to monitor elements of diabetes management (HbA1c levels, dietary pattern, activity levels and medication taking in a pictorial form to facilitate record keeping). Specific training of the health professional team on the cultural needs of the population, to increase the effectiveness of the approach and to decrease barriers to care and to increase patient activation and self-efficacy was implemented (Philis-Tsimikas & Gallo, 2014).

7. Toolbox

Please access our toolbox for additional tools related to the management of NCDs among migrants and refugees.

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