The health of recent migrants from resource-poor countries

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Abstract

The care of recent migrants from resource-poor countries requires careful consideration by healthcare providers. Innovative approaches are required to reduce the significant inequalities in health compared to the UK-born population and long-term migrants. Primary care physicians are best positioned to improve early diagnosis of imported infections such as tuberculosis, HIV, malaria, hepatitis and helminth infections to avoid the high cost of emergency presentations with advanced disease. Culturally sensitive approaches are required when managing stigmatizing diseases. Common non-communicable diseases should not be neglected. The issue of providing free healthcare to undocumented migrants is a political one; where individuals do have entitlement to care, it should be provided effectively.

Keywords HIV; illegal migrants; malaria; mental disease; migrants; parasitic worms; poverty; primary care; screening; tuberculosis

Introduction

Around 8% of the UK population was born abroad. Most current migration is from non-tropical countries including Eastern Europe; most current tropical migration is from India, Pakistan and the Caribbean. In recent years there has been an increase in migration from conflict-affected areas such as Sierra Leone, Sudan and Somalia. The proportion of all migrants seeking asylum is low (5.7%) and falling.

The prevalence of chronic infections is higher within populations that have migrated from low- and middle-income countries to the UK. Disease burden predominantly reflects infection rates in migrants' countries of origin, exacerbated by socio-economic deprivation and inequalities in healthcare access in the inner cities where many migrants settle.[1] In 2005–2006, 86% of newly registered migrant domestic workers reported working over 16 hours a day; 70% reported psychological abuse, 23% physical abuse and 71% food deprivation.

The majority of people in the UK who have migrated from resource-poor countries have documented entitlement to citizenship. Undocumented migrants (referring to people who reside in the country but without the required documentation and processing of their migration status) have access to limited NHS care. However, they are often denied access to all healthcare through misunderstanding and prejudice.[2] The Project London Clinic, run in the East End of London by Doctors of the World UK (http://doctorsoftheworld.org.uk/pages/hours-and-location), helps marginalized people to access health services to which they are entitled. They offer advice across the UK. Three-quarters of their clients need help with GP registration; most have been refused access previously (Box 1).

In order to deliver effective healthcare to migrants, these inequalities in access to healthcare as well as their wider health needs must be appreciated (Box 2). Non-communicable diseases are more prevalent in some groups of migrants than in the UK as a whole, and should not be overlooked. It is important to identify those most vulnerable migrants, who are often marginalized and unaware of their entitlement to care. These include asylum seekers and refugees, unaccompanied children, people who have been trafficked, undocumented migrants and low-paid migrant workers.

Tuberculosis (see also *MEDICINE* 2012: 40(6): 340–345 and 2014: 42(1): 18–22)

The incidence of tuberculosis (TB) in the UK has risen over the last two decades and an increasing proportion of cases are non-UK born (74% in 2011). TB is also commoner among UK-born people of South Asian, Black African and Chinese ethnicity, suggesting some ongoing transmission within ethnic communities (Figure 1). It is particularly important to consider the diagnosis in recent migrants, as half of all imported cases occur in people who have migrated to the UK within the last 5 years. However, the lifetime incidence in migrants never falls to as low as that in the UK born. Prevalence is highest in urban centres and is associated with deprivation.

A number of factors make the diagnosis and management of TB in migrants more complicated than in the UK born. Migrants are more likely to have extra-pulmonary tuberculosis, which is more difficult to diagnose, and both drug resistance and HIV co-infection are more common. Stigma contributes to delayed presentation.

Screening for active TB infection is recommended in people born in areas with an incidence above 40 cases per 100,000, including EU accession countries such as Estonia, Lithuania and Romania. Most screening takes place in primary and secondary care settings. Pre-entry screening is being piloted in several countries as a proposition to supersede current targeted port-of-entry screening at Gatwick and Heathrow airports.

NICE guidelines include care pathways for screening and Bacillus Calmette–Guérin (BCG) vaccination of new entrants to

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Case study

A 28-year-old Eritrean woman presented in labour at 7 months' gestation. She had not booked her pregnancy, and had no GP. She spoke little English and had no relatives. On arrival, she was informed that she would have to pay for her care, but was admitted as an emergency. She was unaware of her HIV status. No interpreter was available. Following an emergency caesarean section, her baby required intensive care. Urgent HIV and hepatitis B tests were negative. On the postnatal ward, she was seen by a midwife who arranged an interpreter service and did a full assessment of her mental health, finding her to be at risk of postnatal depression. She was informed that as an asylum seeker she was entitled to free maternity care and all other NHS services. The midwives explained how to register with a GP. Following discharge, she was followed up by a health visitor who put her in touch with a support group.

Box 1

the UK within primary care and other settings. Management priorities (Box 3) are summarized in the Public Health England (PHE) Migrant Health Guide.

HIV

HIV should be considered in all people accessing healthcare who have migrated from countries of high endemicity. Updated information on global HIV epidemiology is available from UNAIDS (http://www.unaids.org/en/dataanalysis/knowyourepidemic/). In 2011, 57% of new heterosexually acquired cases of HIV in the UK were in migrants from sub-Saharan Africa. Clinicians should consider the patient's country of origin and be aware of indicator diseases (see issue on HIV and AIDS *MEDICINE* 2013: **41**(8)) to prompt opportunistic testing in the emergency department and in acute medicine setting. In UK high-prevalence settings (listed in PHE local authority data: http://www.hpa.org.uk/webc/HPAwebFile/HPAweb_C/1228207184991), universal testing is recommended in primary and secondary care to reduce stigma and to promote early diagnosis. Most diagnoses are made in the context of emergency admissions with advanced disease or antenatal screening.[3] Opt-out antenatal HIV testing in the UK reduced the proportion of undiagnosed vertical transmissions from 18% in 2000 to around 1% currently. Point-of-care testing (POCT) is used increasingly in settings where individuals are at risk of being lost to follow-up.

A patient with a positive HIV test should be referred immediately to specialist HIV services. This should happen regardless of immigration status (Box 4). There is no convincing evidence for 'health-tourism' for HIV treatment; the average time to HIV diagnosis in new arrivals in the UK is greater than 9 months.

Malaria

The incidence of malaria infection in the UK is particularly high among people from first- or second-generation migrant families visiting friends and relatives (VFRs) in countries endemic for

Barriers to timely and effective healthcare in recent migrants from resource-poor countries

Eligibility to healthcare. Asylum seekers are entitled to free primary and secondary care. Failed asylum seekers and undocumented migrants are entitled to free primary care at the discretion of the provider and to free care for emergency treatment, family planning, treatment for communicable diseases, diagnosis and treatment of HIV, and mental healthcare if detained under the Mental Health Act 1983, or for treatment as part of a court probation order (National Health Service (Charges to Overseas Visitors) Regulations 2011).

Cultural: perceptions of the doctor–patient relationship can be different on both sides. Patients can have different expectations based on their experience in other countries. Doctors can misinterpret culturally sensitive complaints; for example, in some cultures, somatization may be more common in psychosocial disorders. Various country-specific cultural beliefs and practices can affect health, for example, withholding colostrum when breastfeeding, early weaning of infants onto solid food and female genital mutilation.

Language: speak clearly and slowly when speaking to people for whom English is not a first language, and take care when using family members as interpreters; people may not wish to disclose confidential information in front of their family. The General Medical Council recommends using interpreting services wherever possible. In practice, access to in-consultation interpreters is variable, and telephone interpreting services are commonly used instead. It is important to use these services sensitively, as there may be anxiety on the part of the patient that the interpreter may know them or their family. Save sensitive discussions for when an in-consult interpreter is available. Avoid using euphemisms when referring to stigmatizing diseases as this can cause misunderstanding.

Dispersal programmes for refugees result in interruption of treatment, particularly important in the case of chronic infections such as HIV and hepatitis B and C, and also in poor continuity of healthcare and loss to follow-up. When caring for a dispersed patient, it is important to contact previous healthcare providers for a history of previous treatment.

Poverty: asylum seekers, failed asylum seekers and undocumented migrants are not permitted to work in the UK so are often destitute; many other migrants are poor. Accessing healthcare is often considered less important than finding enough money to live on, resulting in late and emergency presentations to the NHS.

Stigma: fear of the social implications of certain diagnoses (e.g. HIV, tuberculosis) within one's own cultural community results in delayed presentations to healthcare services, and patients may be reluctant to talk about certain aspects of their illness. It is very important to approach consultations sensitively, with an awareness of this. An additional stigma is that patients may be perceived as health tourists by the wider UK population, despite a lack of evidence for this.

Box 2

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