



## Complex narratives of health, stigma and control: Antimicrobial resistance screening among non-hospitalized refugees



A. Kamenshchikova<sup>a,b,\*</sup>, P.F.G. Wolffs<sup>c</sup>, C.J. Hoebe<sup>c,d</sup>, J. Penders<sup>c,e</sup>, K. Horstman<sup>a</sup>

<sup>a</sup> Department of Health, Ethics and Society, School of Public Health and Primary Care (CAPHRI), Maastricht University, Postbus 616, 6200, MD, Maastricht, the Netherlands

<sup>b</sup> Research Centre for Policy Analysis and Studies of Technologies (PAST-Centre), National Research Tomsk State University, Tomsk, Russian Federation

<sup>c</sup> Department of Medical Microbiology, School of Public Health and Primary Care (CAPHRI), Maastricht University Medical Center (MUMC+), Maastricht, the Netherlands

<sup>d</sup> Department of Sexual Health, Infectious Diseases and Environmental Health, South Limburg Public Health Service (GGD South Limburg), Heerlen, the Netherlands

<sup>e</sup> Department of Medical Microbiology, School of Nutrition and Translational Research in Metabolism (NUTRIM), Maastricht University Medical Center (MUMC+), Maastricht, the Netherlands

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### ABSTRACT

Antimicrobial resistance (AMR) is often presented as a major public health problem globally. Screening for AMR usually takes place in clinical settings. Recent developments in microbiology stimulated a series of studies focusing on AMR in communities, and particularly in travelers (any mobile individual), which was argued to be important for identifying potential public health risks. Against this background, microbiologists have become interested in non-hospitalized refugees as one of the traveler groups. However, this attention to refugees has provoked some professional debates on potential stigmatization of refugees as dangerous “others”. To contribute to these debates, and to explore the idea of AMR screening of non-hospitalized refugees from different perspectives, we conducted a qualitative study among four groups of stakeholders who were chosen because of their associations with potential microbiological screening: microbiologists, public health physicians, public health nurses, and refugees. The study took place in a Dutch city from June to August 2016 and had 17 participants: five microbiologists, two public health nurses, four public health physicians, and six refugees. While microbiologists and public health physicians demonstrated a de-contextualized biomedical narrative in arguing that AMR screening among non-hospitalized refugees could be important for scientific research as well as for AMR prevention in communities, public health nurses displayed a more contextualized narrative bringing the benefits for individuals at the center and indicating that screening exclusively among refugees may provoke fear and stigmatization. Refugees were rather positive about AMR screening but stressed that it should particularly contribute to their individual health. We conclude that to design AMR prevention strategies, it is important to consider the complex meanings of AMR screening, and to design these strategies as a process of co-production by diverse stakeholders, including the target populations.

### 1. Introduction

The ever-increasing global level of antimicrobial resistance (AMR) is often presented as a major public health threat, resulting in an estimated number of human deaths that will dramatically increase from 700,000 in 2015 to 10 million in 2050 if left unresolved (O'Neill, 2016). AMR is defined by the WHO (2015) as an evolutionary process of development of microorganisms that acquire the ability to withstand antimicrobial drugs, thus making treatment of infections ineffective, and increasing the risk of resistant microorganisms spreading among

people, animals, and the environment. Microbiologists cite different sources of the emergence and dissemination of AMR, such as misuse of antibiotics in humans, animals, and the environment; mobility of human populations between regions and between care facilities (Selgelid, 2007).

Microbiological studies have focused on the emergence, control, and prevention of AMR within health practices. Scientists have studied the prevalence of resistant microorganisms in different groups of patients, for instance, in pediatric and intensive care units (Gaspari et al., 2006; Khurana et al., 2017). Based on similar studies, countries have

\* Corresponding author. Department of Health, Ethics and Society, School of Public Health and Primary Care (CAPHRI), Maastricht University, Postbus 616, 6200, MD, Maastricht, the Netherlands.

E-mail address: [a.kamenshchikova@maastrichtuniversity.nl](mailto:a.kamenshchikova@maastrichtuniversity.nl) (A. Kamenshchikova).

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developed their national guidelines on the prevention of AMR in hospital settings. For instance, the Netherlands developed a so-called “search and destroy” policy for AMR, that involves AMR screening of all hospitalized patients and isolation of those patients who are considered to be at risk groups (Kluytmans-Vandenbergh et al., 2005). Such risk groups include patients who received treatment in a foreign hospital within two months prior to hospital admission in the Netherlands, and farmers and members of their families who have contact with pigs, calves, or chickens (Werkgroep Infectiepreventie, 2017).

Recently, microbiologists in the Netherlands (Arcilla et al., 2017), Sweden (Tangden et al., 2010), and Australia (Kennedy and Colliqnon, 2010) conducted AMR studies among non-hospitalized populations such as international travelers (where “travelers” are understood as people who move from one territory to another, crossing national borders regardless of the purpose of their travel), and showed that travel can contribute to the dissemination of resistant bacteria from endemic to non-endemic parts of the world (Penders et al., 2013). In this regard, since 2014, refugees have attracted the attention of microbiologists and public health professionals as a mobile demographic group traveling between geographic areas (de Smalen et al., 2016; Heudorf et al., 2016).

Refugee studies on AMR have been conducted among hospitalized refugees upon their admission to clinics (Reinheimer et al., 2016; Tenenbaum et al., 2016). For example, in their research on AMR among hospitalized refugees in Germany, Reinheimer et al. (2016) showed that 61% of 143 refugees carried AMR, compared to 17% in the German population. Based on these data, the authors proposed that refugees admitted to hospitals be required to undergo a compulsory AMR screening, which entailed a departure from regular AMR control practices in Germany (we have to add, however, that since the end of 2016, individuals that have been in a refugee center in the past two months are screened for AMR upon hospital admission in the Netherlands and several other European countries, including Germany). Other scientists have also suggested that AMR screening should be compulsory for refugees admitted to hospitals (de Smalen et al., 2016; Maltezou et al., 2017). Considerably fewer studies (Angeletti et al., 2016; Heudorf et al., 2016) have been conducted among healthy refugees (“healthy” and “non-hospitalized” will be used as synonyms for the remainder of the article), and therefore the data on the prevalence of AMR among healthy refugees is scarce.

AMR screening involving both healthy and hospitalized refugees provoked discussions about vulnerability and potential stigmatization of refugees as subjects of AMR screening (Walter et al., 2016). The question of stigmatization of refugees with regards to AMR has been analyzed by social scientists and anthropologists. For instance, in their analysis of politics of AMR in the UK, Brown and Nettleton (2016) demonstrate how the political discourse of AMR is framed in the concepts of “trauma” and “catastrophe”. They argue that the meaning of AMR in British politics has been shifted from being understood as “biological resistance” into “resistance of economies”, creating a platform for articulation of new political discourses, which associate the “catastrophic” threat of AMR with politics of immigration. In addition, the same authors, in their analysis of debates about antibiotics and AMR that take place among “lay people” on a popular online forum, showed how debates on antibiotics resistance became entangled with debates on public politics and personal responsibility (Brown and Nettleton, 2017). AMR, they argue, provokes a moral reflection on biopolitical responsibility of citizens for their individual immunary practices, such as antibiotic use, hygiene, or immunization (Brown and Nettleton, 2017). Other scholars have analyzed the use of the notion of responsibility with regard to carriers of communicable diseases like SARS, Ebola, and HIV, transforming victims into agents (Wald, 2000, 2007). In his work, Wald reflects on the theory of Mary Douglas (1966) who described how the dichotomy between “dirty” and “pure” relates to the distribution of power in society. Douglas explained that social order entails the construction of controlling mechanisms that restrict

potential dangers and “sources of disorder” caused by “others”, and the dirt-pure dichotomy helps to facilitate that.

These studies show the complex relationship between health, stigma and control as a fruitful lens to study AMR screening among refugees as a traveling group. Discourses of catastrophism and responsibility for acquisition of AMR may create a potential danger that refugees coming from endemic areas are held responsible for disseminating resistant bacteria to host countries and imposing a danger upon other people. AMR screening of refugees can be seen as a mechanism that helps to control the dangers coming from “others” who bring potential threats to the bacterial order of a host community. From the perspective of these studies, discussion about AMR screening may construct refugees not merely as people seeking asylum but as bodies polluted by foreign bacteria (Chandler and Hutchinson, 2016). Therefore, when speaking about AMR screening of refugees, it is important to analyze the complex meanings of such an intervention.

Current debates regarding justification or non-justification of AMR screening among non-hospitalized refugees take place in scientific journals between different scientists (Kempf and Heudorf, 2016; Walter et al., 2016). Refugees, however, do not often have a voice in these debates. The present article aims to fill that knowledge gap and to explore the voices of different professionals as well as refugees regarding the idea of AMR screening. For this purpose, we conducted a qualitative study involving microbiologists, public health physicians, public health nurses, and refugees. We explored how these four groups give meaning to potential voluntary AMR screening among healthy refugees, and how they consider the possible rationale, benefits, and harms of such screening. To be sure, when discussing AMR screening, we mean voluntary microbiological screening among non-hospitalized refugees. Although we acknowledge the complexity of the concept, for our study we opted for a broad definition of screening. When discussing it with participants, we spoke about AMR screening as a broad practice that included collection of stool samples for research and/or public health purposes.

## 2. Methodology

We studied four stakeholder groups who are already involved with health issues of refugees, and who potentially could be involved in AMR screening among healthy refugees: microbiologists, public health physicians, public health nurses, and refugees originating from Syria. Refugee participants included both people who had already obtained their official status of refugees and received their residence permits, and those who were still in the process of applying for asylum. The study was conducted in a Dutch city from June to August 2016. It involved a variety of qualitative methods, including observations of participants in their daily life and professional activities, in-depth interviews, group interviews, and informal discussions with participants. We decided to use qualitative methods as they provided us with an opportunity to analyze in-depth meanings that different stakeholders gave to the phenomenon of AMR and to the idea of AMR screening of refugees.

### 2.1. Research participants

Microbiologists who participated in the study had experience working with AMR in clinical (diagnosis, therapy, and prevention) and research settings, including microbiological screening of travelers. At the time of our study, two microbiologists were actively involved in developing a research proposal for AMR screening of non-hospitalized refugees in the Netherlands. Therefore, the interviews and discussions were of particular interest for them.

The public health physicians and nurses have practical experience and knowledge in working with hospitalized patients who carry resistant bacteria, as well as experience in working with national AMR prevention programs. In addition, participants from these two groups have experience in communicating with refugees in the context of

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