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## Themed Paper – Original Research

# Health status of Afro-Asian refugees in an Italian urban area: a cross-sectional monocentric study



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## ABSTRACT

**Objectives:** The recent sociopolitical events in the Mediterranean and Middle Eastern areas have significantly impacted international migration flows. As disease prevalence and type are different among western and Afro-Asian countries, physicians dealing with refugees should be aware of their specific health needs. We aimed at evaluating the health status and disease history of refugees at their arrival in the urban area of L'Aquila (Italy).

**Study design:** This is a monocentric cross-sectional study.

**Methods:** Refugees hosted at the local reception center in L'Aquila (Italy) between July 2014 and December 2014 were cross-sectionally evaluated for anamnestic, clinical, and laboratory features. A subset of randomly selected participants underwent further assessments (screening for tuberculosis, hepatitis B/C, human immunodeficiency virus, syphilis; ambulatory blood pressure measurement [ABPM]) to better define their health status.

**Results:** Ninety-three adult male refugees ( $27.34 \pm 7.41$  years) from Africa (76%) and Asia (24%) were enrolled. Overall, the most prevalent diseases according to the International Statistical Classification of Diseases and Related Health Problems 10th revision affected the digestive tract (15.6%) and musculoskeletal apparatus (14.4%). The analysis by continent of origin did not show significant differences in the distribution of diseases, although a trend toward some differences was observed. African refugees had a significantly greater prevalence of viral hepatitis (hepatitis B virus,  $P = 0.004$ ; hepatitis C virus,  $P = 0.007$ ) compared with Asians. Hypertension, as detected by ABPM, was uncommon. No written vaccination history was available.

**Conclusions:** Health issues of our sample of Afro-Asian refugees span both non-communicable and communicable diseases, requiring attention for the safety of the individual and the community. National health systems should provide adequate information and shared guidelines for health professionals regarding identification and management of refugees' health needs.

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## Introduction

According to the United Nations High Commissioner for Refugees, global forced displacement has seen accelerated growth in recent years.<sup>1</sup> As an example, by year-end 2014, 59.5 million individuals, that is, 8.3 million more than the previous year and the highest annual increase in a single year, were forcibly displaced worldwide as a result of persecution, conflict, generalized violence, or human rights violations.<sup>1</sup> This dramatic increase can be explained by the new and continuing, unresolved conflicts in the Middle East and Africa.

The health problems of newly arrived refugees to Europe are similar to those of the rest of the population, although some groups may have a higher prevalence of specific diseases. Data from the World Health Organization (WHO) indicate that their most frequent health issues include accidental injuries, hypothermia, burns, gastrointestinal illnesses, cardiovascular events, pregnancy- or delivery-related complications, and violence-related mental disorders, whereas the prevalence of communicable diseases appears to be related to their country of origin and their socio-economic conditions.<sup>2</sup> Infections with pathogens that are rare, or even unheard-of, in Europe are not uncommon among refugees.<sup>3</sup> In addition, they arrive in their new countries with a variety of immunization needs: while some individuals may have received vaccinations in their country of origin, others may lack specific clinical records or may not have received immunizations.<sup>4,5</sup>

Among European countries, Italy has been actively involved in hosting refugees, with an increase in their total number from 6962 individuals at the end of 2000 to 140,277 at the end of 2014 (corresponding to 0.01%–0.23% of the Italian population and 0.52%–2.8% of total foreign residents).<sup>1,6</sup> Although people likely to arrive in Italy during the migration surge are predominantly young adults in good health, their forced temporary living conditions within closed or semi-open communities can expose them to communicable diseases. In addition, people escaping from poverty and low socio-economic conditions can be at higher risk for specific diseases. As a consequence, physicians dealing with refugees should be aware of their specific health needs, to protect their health, as well as the health of the entire community.

We conducted a monocentric observational study aimed at evaluating the health status of refugees on their arrival in the urban area of L'Aquila (Italy) for a better understanding of their health needs and consequently, the correct identification of the appropriate diagnostic and therapeutic strategies for the individual and the community's safety. Data from recent literature were then reviewed to define what the status was regarding the health issues of refugees and measures taken by host countries to deal with this unprecedented challenge.

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## Methods

The Italian National Healthcare System guarantees free access to emergency care and essential therapies to refugees and promotes their inclusion into preventive medical treatment programs, in fulfillment of the universal right to

health.<sup>7,8</sup> A cross-sectional study was, therefore, conducted on refugees hosted at the reception center for male refugees in L'Aquila (central Italy) between July 2014 and December 2014. They were referred to the local first-level clinical center for general examination and consented to take part in the study. Participation was completely voluntary, and signed informed consent was obtained from each participant in their respective mother tongue. Cultural mediators provided linguistic assistance throughout the study. Each participant had regularly registered with the Italian National Health System. This research fulfilled the principles stated in the Declaration of Helsinki<sup>9</sup> and obtained approval from the local institutional review board.

The study aimed at analyzing medical history, as well as clinical and biochemical features of refugees. Therefore, the following information was collected: personal and family anamnesis; vaccination history; physical examination data, including the measurement of arterial blood pressure (BP); laboratory test results, inclusive of complete blood count, renal function panel, uric acid, glycolipidic profile, and transaminase and urine analysis. A subset of participants, representative of both continents of origin, underwent further microbiological and clinical assessments to better define their health status: specifically, screening tests for tuberculosis (TB), hepatitis B virus (HBV) and hepatitis C virus (HCV), human immunodeficiency virus (HIV), and syphilis, as well as ambulatory blood pressure measurement (ABPM) were performed. These participants were randomly selected using a computerized program. The first clinical consultation was operated by the community general practitioner (GP), and further laboratory and clinical analyses were performed at the city hospital. Mantoux tuberculin skin test (TST) for TB screening was performed according to current guidelines.<sup>10,11</sup> Specifically, 5 tuberculin units were injected intradermally in the forearm of subjects and read within 48–72 h by a trained physician, who evaluated the size in millimeters (mm) of the palpable induration in the site of injection, if present. The test was considered positive if an induration  $\geq 10$  mm was observed in those from high TB prevalence countries<sup>12</sup> or if criteria for different cutoffs were met, according to current recommendations.<sup>13</sup> Chest radiography was performed in those with positive results to the TST.<sup>13</sup> HBV infection was investigated by qualitative determination of serum hepatitis B surface antigen (HBsAg) and confirmed by the presence of specific circulating antibodies (hepatitis B surface antibodies) using immunoassay (IA) technique. Screening for HCV infection was performed by determination of specific serum antibodies (HCVAb IA). HIV infection was tested using a combined antigen/antibody test for HIV p24 antigen and relative antibodies by enzyme-linked immunosorbent assay technique. Screening for syphilis was performed with a treponemal test, namely *Treponema pallidum* hemagglutination assay (TPHA). Test results were communicated to refugees, and in cases where results were positive, individuals were referred to the infectious disease unit of the city hospital for further diagnostic assessments and treatment. In the presence of other signs and symptoms of specific diseases, participants were evaluated by the GP and then referred to the appropriate diagnostic workup and therapy, in accordance with current guidelines.

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