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VIEWPOINT

Health care for refugees

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Background

Refugee outflows originate from man-made events, the latter generally political in nature. Refugees typically have a history of persecution and/or human rights abuses in their home countries. The United Nations definition, coined over 50 years ago, states that refugees are people who flee their country because of a well-founded fear of persecution for reasons of race, religion, nationality, political opinion or membership of a particular social group. A refugee either cannot return home or is afraid to do so.[1] Women and children make up a high proportion of the refugee population worldwide.

Asylum seekers are people who have left their homeland but have yet to receive official recognition as refugees. Internally displaced persons, however, are still within their country's borders. People falling under any of these headings may have suffered the same experiences, yet those in the latter group in particular are frequently out of reach of international assistance.[2] In the present article the term refugee will be used generically to denote anyone of refugee-like background.

Historically, countries of the Asia Pacific region have both produced and hosted significant refugee movements. Causes in the last half-century have included World War II, partition of the subcontinent in 1947, and war in the area previously known as Indochina. Over one million people fled Vietnam between 1975 and the late 1980s, dispersing throughout the region to China, Thailand, Malaysia, Singapore, Brunei, Indonesia, Macau, Hong Kong, the Philippines and Australia.[3]

Some events continue to have an impact on the region. The Soviet occupation of Afghanistan led to several million Afghan refugees fleeing to Pakistan and Iran, many of whom remain there today. Other examples are thousands of Bhutanese refugees living in Nepal and Sri Lankan Tamils living in India. More recently, in August 1999, violence erupted in East Timor surrounding the referendum on independence from Indonesia, creating a new flow of people to West Timor.

Currently there are nearly nine million 'persons of concern' to the United Nations High Commissioner for Refugees (UNHCR) in the Asia Oceania region. This represents almost half of the global total.[4] Refugee issues are thus highly relevant to health professionals working in this region. The present article outlines the key health impacts and management issues for health professionals who may see refugee patients as part of their everyday practice.

Physical and psychological trauma

The refugee experience can have a major impact on health. Refugees may have endured a number of adverse situations in their country of origin, during their flight, or while in exile seeking asylum.[5–8] A number of these are listed in Table 1.

Health problems

Many health problems presenting to the practitioner will be similar to those seen in the local population. However, there is a greater risk of a number of conditions as outlined below.[9–13]

Psychological disorders, including anxiety, depression, and post traumatic stress disorder (PTSD) are common given the almost universal exposure to distressing situations. The three domains of PTSD are intrusive phenomena, phobic avoidance of situations, and hyper-arousal. The management of this condition in the primary care setting is described elsewhere.[14] Some refugees may require assistance from specialized torture and refugee trauma services where those services exist.

Torture is unfortunately still a common practice in many countries, including some in the Asia Pacific region.[15] Types of torture include blunt trauma, electric shocks, burns, penetrating injuries, suspension,

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Table 1 Adverse life events which may impact on the health of refugees

Life events
Long-term persecution, repression and deprivation
War or civil unrest
Separation from, and loss of, family and friends
Imprisonment without trial, actual or threatened beatings, torture and rape, or witnessing of same
Overcrowding, poor hygiene and under-nutrition, particularly if imprisoned or in refugee camps
Poor health care, due to
Destruction of infrastructure
Disruption to preventive and curative services
Limited access to health services while fleeing or in exile

Table 2 Common health problems among persons of refugee background

Psychological problems, including PTSD, anxiety or depression
Injuries due to hostilities or torture
Poor dental health, a result of poor nutrition and diet, lack of fluoridated water, dental hygiene practices, and limited dental care
Infectious diseases, including ongoing risks from tuberculosis and chronic intestinal parasites
Under-immunization in children and adults
Under-managed chronic conditions such as hypertension, diabetes and chronic pain
Delayed growth and development in children, including deficits in hearing and speech

PTSD, post traumatic stress disorder.

asphyxiation, sexual torture and psychological torture. The physical and psychological consequences of torture can be complex. On top of the impact on mental well being, common physical ramifications include musculo-skeletal pain, immobility, scarring, disfigurement, nerve damage, sensory and other organ damage, genital damage, head injury and damage to the jaw and teeth.[10] However, in many cases objective signs are few. Psychosomatic disorders may of course result and it can be difficult to differentiate between these and actual physical consequences.[10]

Other conditions to be aware of in refugees are listed in Table 2.[9,11–13]

Refugees however, are not a homogenous population, and wide variations in health status will occur depending on country of origin, experiences of human rights abuses, duration of exile and many other factors.

Access to health services

There are a number of reasons why refugees may have greater problems in accessing health services compared with the general population and with other migrants.[16,17] These include poorer local language skills, financial constraints, lack of trust, and unfamiliarity with the local health system. Health professionals may not have the knowledge and skills to adequately deal with unfamiliar or torture-related health conditions. A number of resources have been developed to assist general practitioners and others in managing survivors of torture and refugee trauma.[18]

Management issues

Special consideration is often required when managing people with refugee backgrounds. There may be mistrust of government and authority figures, including medical staff. Health professionals are sometimes implicated in torture or other human rights abuses.[5] Heightened anxiety during medical consultations may exist, especially if physical examination or procedures such as electrocardiography are involved. These factors can have a negative impact on communication and compliance.

A sensitive approach to history taking should be adopted. This can include the use of *abstract empathic inquiry* to elicit information while minimizing distress to the patient.[18] A question might start *'I understand some people in your country were mistreated by the authorities . . . was your family affected in this way at all?'*.

Health issues may be complex, and a gradual, staged approach to management is useful. This may include deferring the discussion and management of certain issues until the patient is ready to address them. It can take time for adequate trust to develop. Allowing the patient to be in control of what happens is one way of promoting this. In addition, notions of medical confidentiality and informed consent may be new, or may have been eroded by past experiences. These principles should be explained and emphasized.

If the patient and health worker do not share a common language, trained interpreters are a valuable resource. Where available, they can facilitate accurate communication and can act as cultural advisors.[16] Friends and family members may interpret poorly and make it difficult to raise sensitive matters. In Australia, medical practitioners in private practice, and all health workers in the public system, are fortunate enough to have access to on-site and telephone interpreter services.

Normalizing the symptoms that result from torture and refugee trauma is important.[18] Many patients think they are going mad, rather than having a common response to major, stressful experiences. If medication is used for any condition, the reason and

dosage instructions need careful explanation. If referral is contemplated, it is important to ensure the patient understands and consents to the referral, and to sharing of relevant information with the other provider.

Health professionals dealing with refugees may feel challenged by listening to the stories of injustice and suffering. The individual worker needs to be aware of his or her own potential responses to this, and to find ways to cope with this type of work through peer support or other mechanisms.[18]

The role of advocacy

Given the special health needs of refugees and their history of human rights abuses, health professionals can act as important advocates to help ensure the provision of adequate health care. This may involve lobbying hospitals, specialists and others to provide free or low cost care.

At a broader level, medical bodies and individual health professionals can advocate for more humanitarian government policies towards refugees and asylum seekers, on the basis of potential negative impacts on their well being. A recent international review of the mental health consequences of deterrence policies concluded that the 'medical profession has a legitimate role in commenting on the general and mental health risks of imposing restrictive and discriminatory measures on asylum seekers . . .'.[19]

Doctors and other health professionals can also play a useful role in advocating internationally for peace, human rights, social justice and other principles that, when not present, help create the conditions that cause refugees to flee.

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