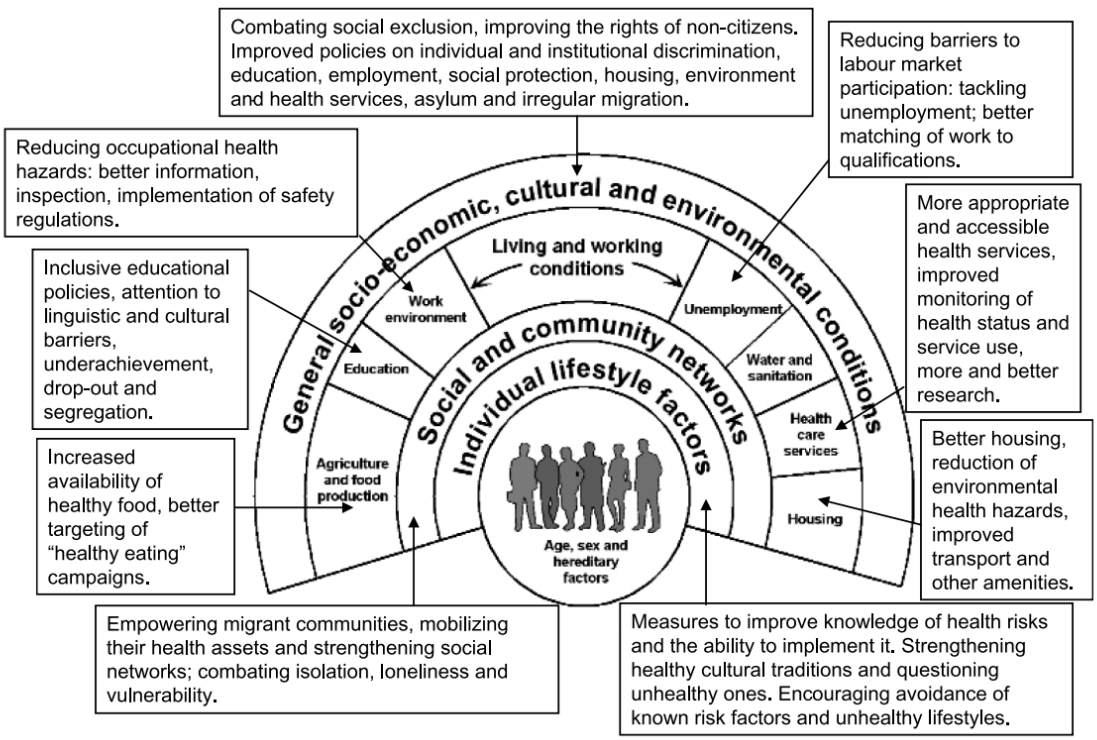
Module 5 Unit 1: Non Communicable Diseases

1. Background

- To date, research with refugee populations has overwhelmingly focused on communicable diseases or mental health, with relatively little research attention to other conditions.
- On the other side, a large body of research has found a 'healthy immigrant effect', although it tends to decline as the years in the host country increase. Refugees is an especially vulnerable group compared to other immigrants (Díaz E et al, 2015).
- Some studies show that the health of immigrants after 20 years of stay, converge to that of the native born population in terms of reporting a chronic condition.
- There is currently a growing interest in redesigning health care organizations, and primary care in particular, to improve the quality of care for chronic diseases and to garantee their equitable management. In chronic conditions, disparities can take effect cumulatively at various times as the disease progresses: in its genesis, or when it is still only latent (in terms of exposure to risk factors), and after it has been recognized (in the expression of the demand for), as well as when care is provided (in the diagnostic treatment and monitoring process). Such disparities lead to health inequalities that affect the prevalence of a chronic disease and its negative outcomes and related mortality rates.

Ruiz a Gini R et al J Epidemiol Community Health *Prevalence of chronic diseases by immigrant status and disparities in chronic disease management in immigrants: a population-based cohort study.* BMC Public Health 2013, 13:504.

Figure: Policy measures tackling the determinants of health for migrants.



Source: Migration and health in the European Union. European Observatory of Health Systems and Policies. 2011.
Adapted from WHO Regional Office for Europe (2010).

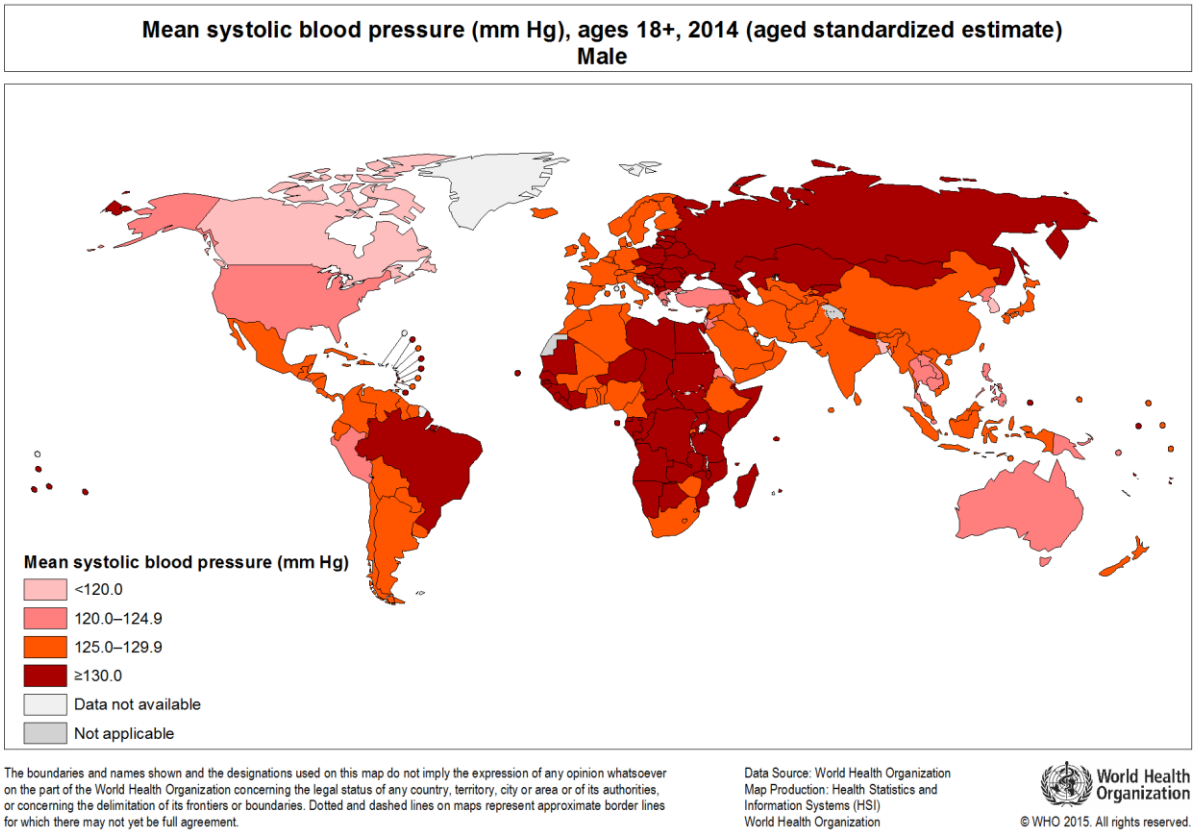
2. Cardiovascular disease

	Cardiovascular risk factors in refugees	

- Refugee status may be associated with higher stress levels.
- Introduction to the Health Care System affects to their health seeking behaviour: access to health care is poorer than access for local population.
- Ethnic variations in cardiovascular risk factors contribute to the different burden of cardiovascular disease, but social disadvantage (inverse social gradient and inequity gap) is an independently predictor.

Hypertension

Sub-Saharan origin populations have higher prevalence than European-origin white people



Cardiovascular disease

- Incidence and mortality levels appear to vary substantially between migrants from different countries of origin.

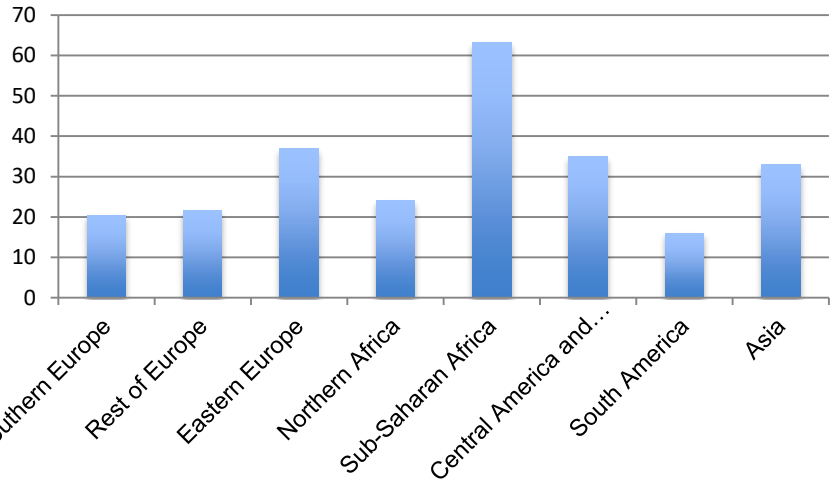
Coronary disease and Stroke

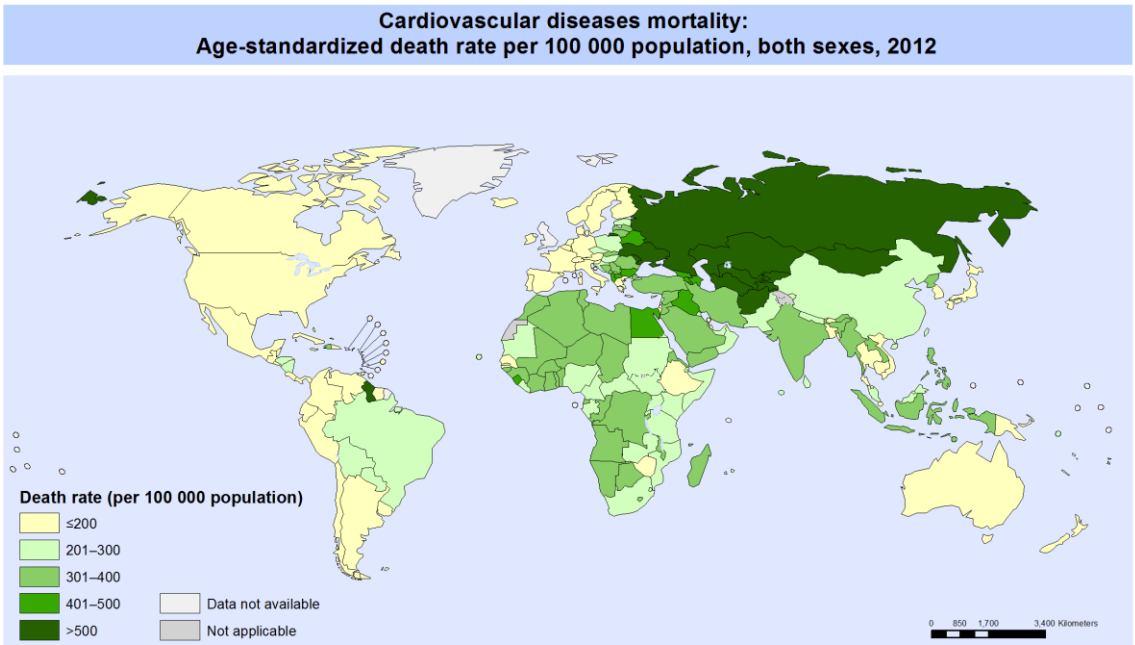
High prevalence of coronary disease among people from South Asia and Eastern Africa

High incidence and mortality of miocardial infarction and Stroke among people from Western Africa

Modesti PA et al. *Cardiovascular health in migrants: current status and issues for prevention. A collaborative multidisciplinary task force report.* J Cardiovascular Med. 2014; 15 (9).

Mortality rate (death/100 000-year) from cardiovascular diseases in immigrants residing in Madrid 2000-2004
Regidor et al, 2009





3. Diabetes

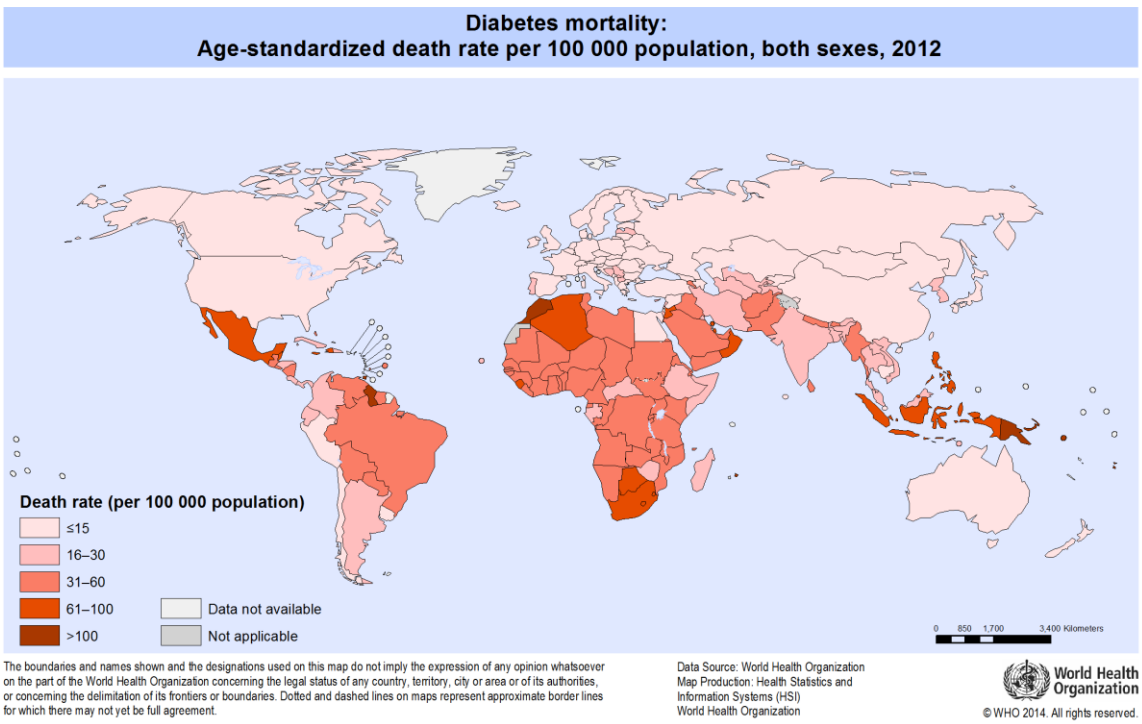
- The available data suggest that diabetes mellitus incidence and prevalence rates are higher among migrants locally born residents. They are also at greater risk of serious outcomes and mortality when they develop the disease.
- Genetic predisposition, changing enviroments and insufficient medical control are some of the causes of the increased risk.
- Neighbourhood deprivation can increase the risk of diabetes in refugees (White JS et al, 2016). Once again, social determinants impact on health outcomes.

Points of intervention

- Access to healthcare services
- Dietary adaptation
- Lifestyle changes
- Self-management competence
- Adherence to treatment regimens

Carballo M. *Migration and diabetes: a poorly recognized challenge.* Public Health Aspects of Migration in Europe. 2015; 5.

Irahim M et al. *Recommendations for management of diabetes during Ramadan: update 2015*. BMJ Open Diabetes Research and Care. 2015;3.



4. Cancer

- Studies have reported that cancer incidence and mortality of nearly every major cancer type is lower than native populations of European host countries.
- The precise level of risk varies strongly between different migrant groups, because of the differences in the degree of exposure to specific risk factors.
- Many studies in some groups of migrants also find more incidence and mortality rates for other cancer related to infectious disease: stomach cancer, nasopharyngeal cancer, hepatic cancer, Kaposi's sarcoma, cervical cancer and some lymphomas (Arnold et al. 2010).
- Patients who are from an ethnic minority, are young or are female, have to wait longer to be diagnosed and referred to a cancer specialist (Lyratzopoulus G et al. 2012).

Remember

- Coverage for cancer screening programmes is sometimes reported to be lower among migrants and ethnic minorities.
- This is particulary worrying where prevalence is elevated among such groups. However, where prevalence is lower, screening may have less priority.

European Observatory on Health Systems and Policies Series. *Migration and health in the European Union.* WHO 2011.

5. Congenital diseases

Sickle-cell anaemia

The geographical specificity and hereditary nature of these diseases suggests that both are likely to be present in communities with large numbers of migrants from the Mediterranean Basin, the Caribbean and Africa

Thalassemia

Thalassemia, which is primarily a blood disease found in people in the Mediterranean region, is also being seen in the UK among migrants and ethnic minorities of Middle Eastern and Cypriot origin. There is increasing evidence that it is relatively common among migrants of Pakistani, Chinese and Bangladeshi origin

5. Congenital diseases: inherited anemias

- Inherited hematologic disorders are common among many refugee populations and should be considered in any refugee who has anemia detected on screening, even if other potential causes exist (e.g., iron deficiency, particularly if not corrected with therapy).

Sickle-cell anaemia	Globally, 80% of people affected by sickle cell disease live in or have origins in central Africa. The condition also affects people from Central and South America, the Arabian Peninsula, Middle East, India, and eastern Mediterranean.
Thalassemia	Globally, most people with thalassemia are born in or are descended from populations in eastern Asia, the Philippines, Indonesia, India, Pakistan and the Middle East.
Glucose-6-phosphate dehidrogenase deficiency	G6PD deficiency is the most common inherited enzyme deficiency, affecting over 400 million people globally. The geographic distribution of this condition matches that of the thalassemias listed above, but the condition is particularly common in Southeast Asia.

CDC. *General Refugee Health Guidelines.* 2012 (last updated 2014). Available from: http://www.cdc.gov/immigrantrefugeehealth/guidelines/general-guidelines.html