Istituto Nazionale per la promozione della salute delle popolazioni Migranti e per il contrasto delle malattie della Povertà INMP

NIHMP National Institute for Health Migration and Poverty

Promozione della salute e contrasto delle disuguaglianze
Diabetes and migration study

18 Febbraio 2010

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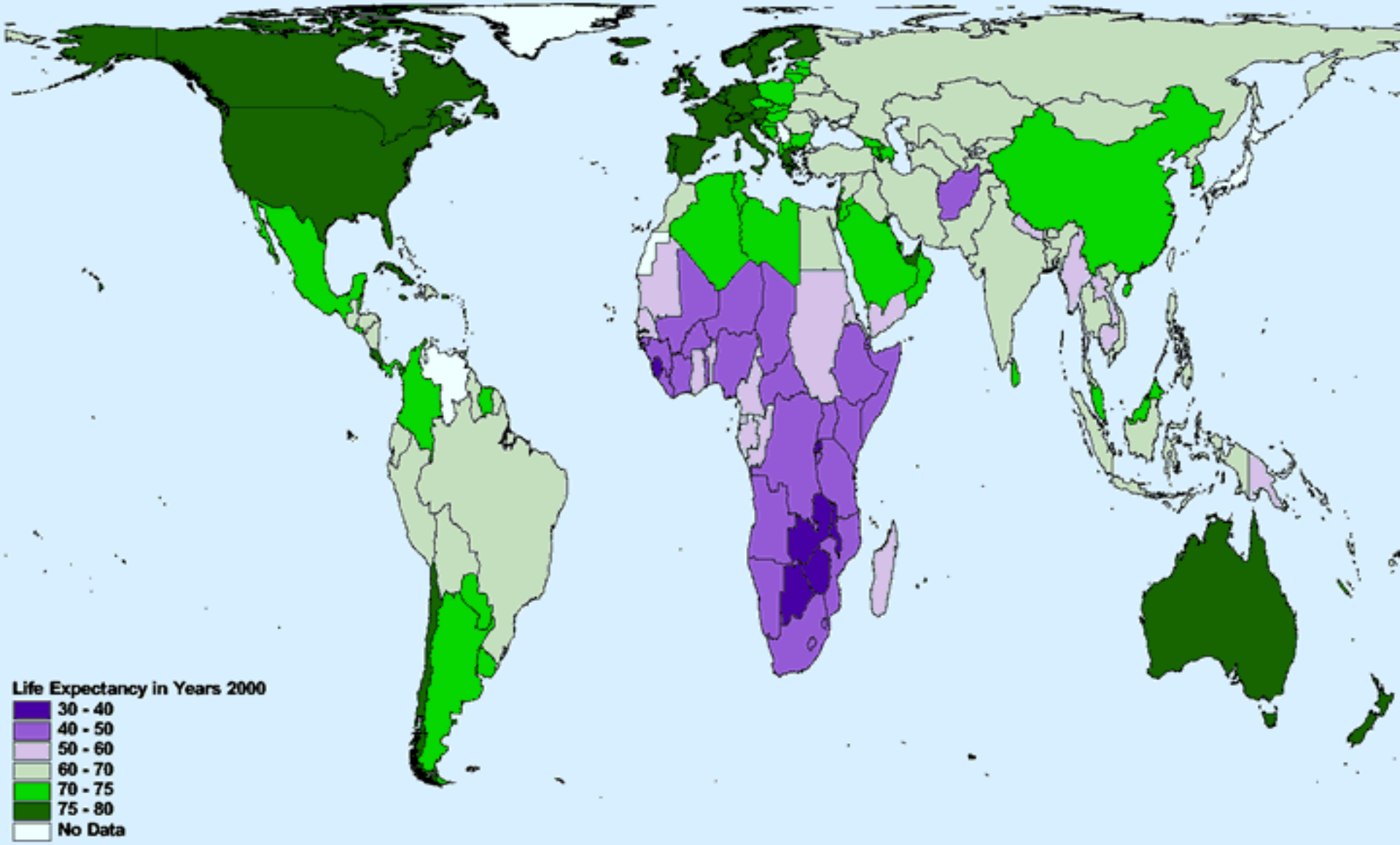
Istituto Nazionale per la prevenzione della salute delle popolazioni Migranti e il contrasto delle malattie della Povertà (INMP)

Life Expectancy at Birth 2000



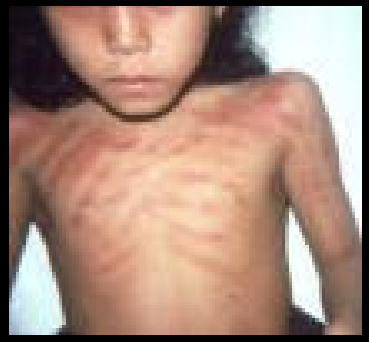
UC Atlas of Global Inequality
www2.ucsc .edu/atlas
Created 11 July 2002

G.Macciocco,

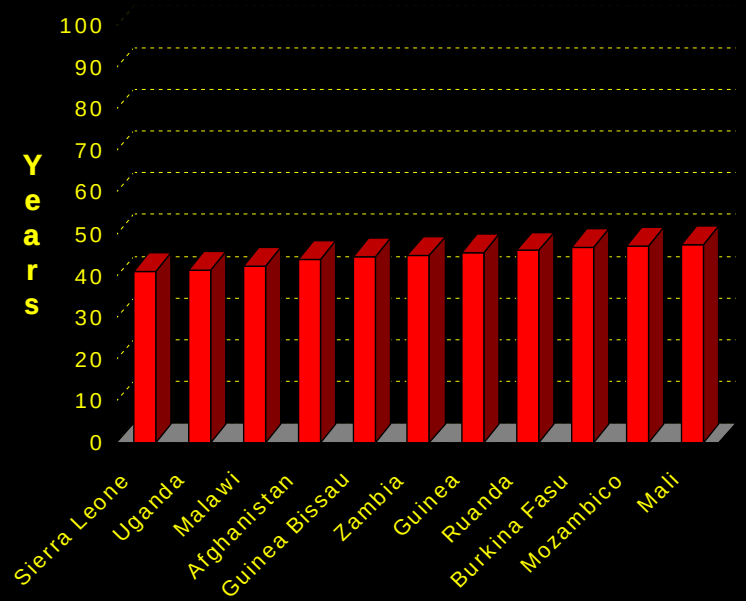
Data Source: World Bank
World Development Indicators 2001 CD-ROM

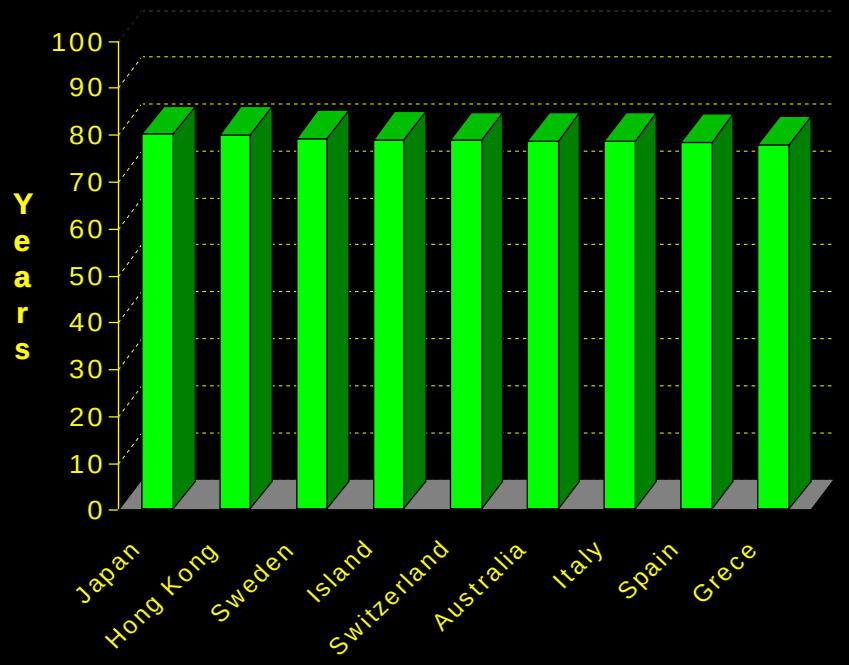
Aspettativa di vita alla nascita

Nei PVS ogni persona ha un'aspettativa di vita di non più di 47 anni

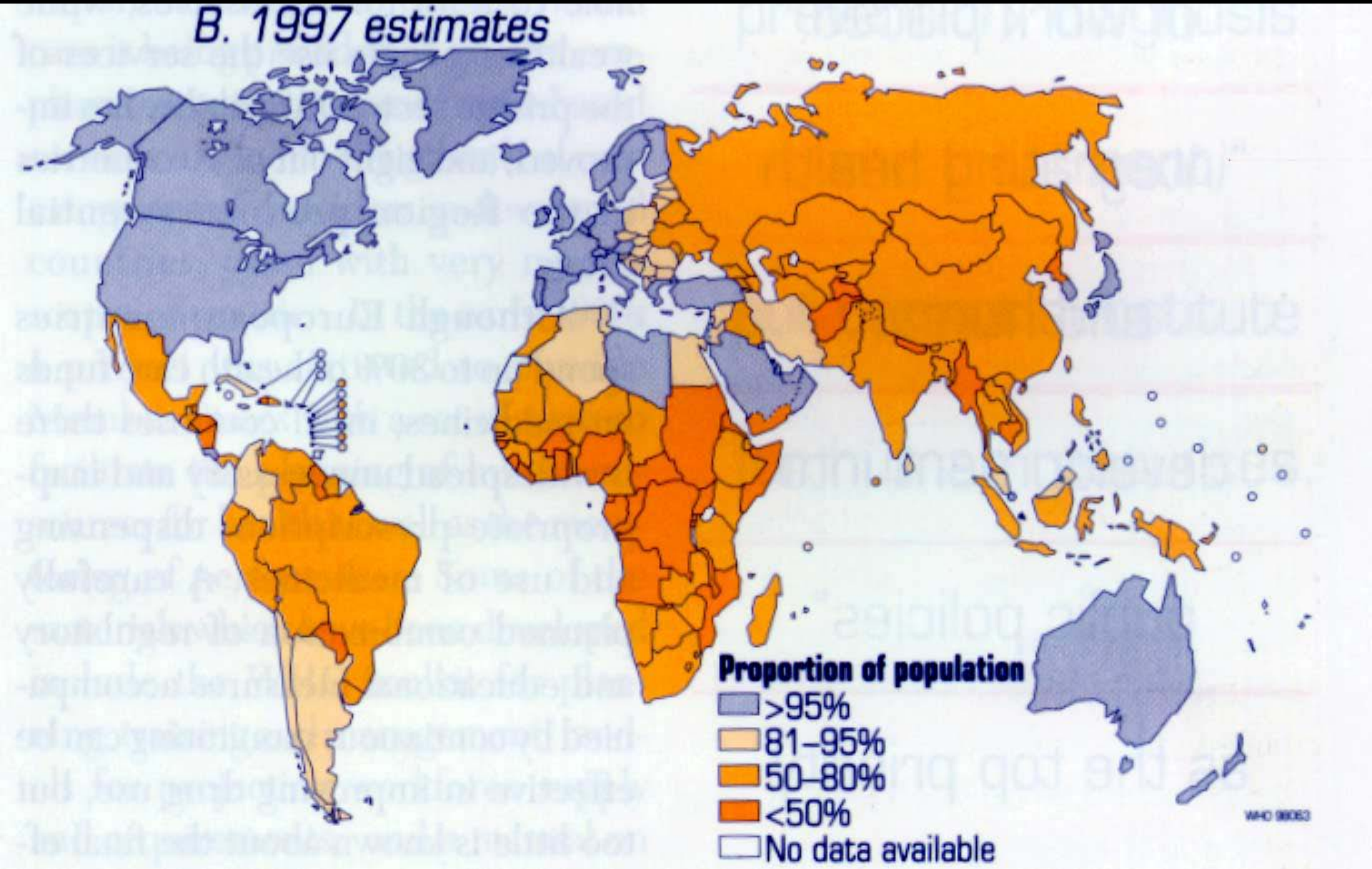


Nei paesi sviluppati ogni persona ha un'aspettativa di vita di circa 80 anni





POPOLAZIONE CON REGOLARE ACCESSO AI FARMACI ESSENZIALI

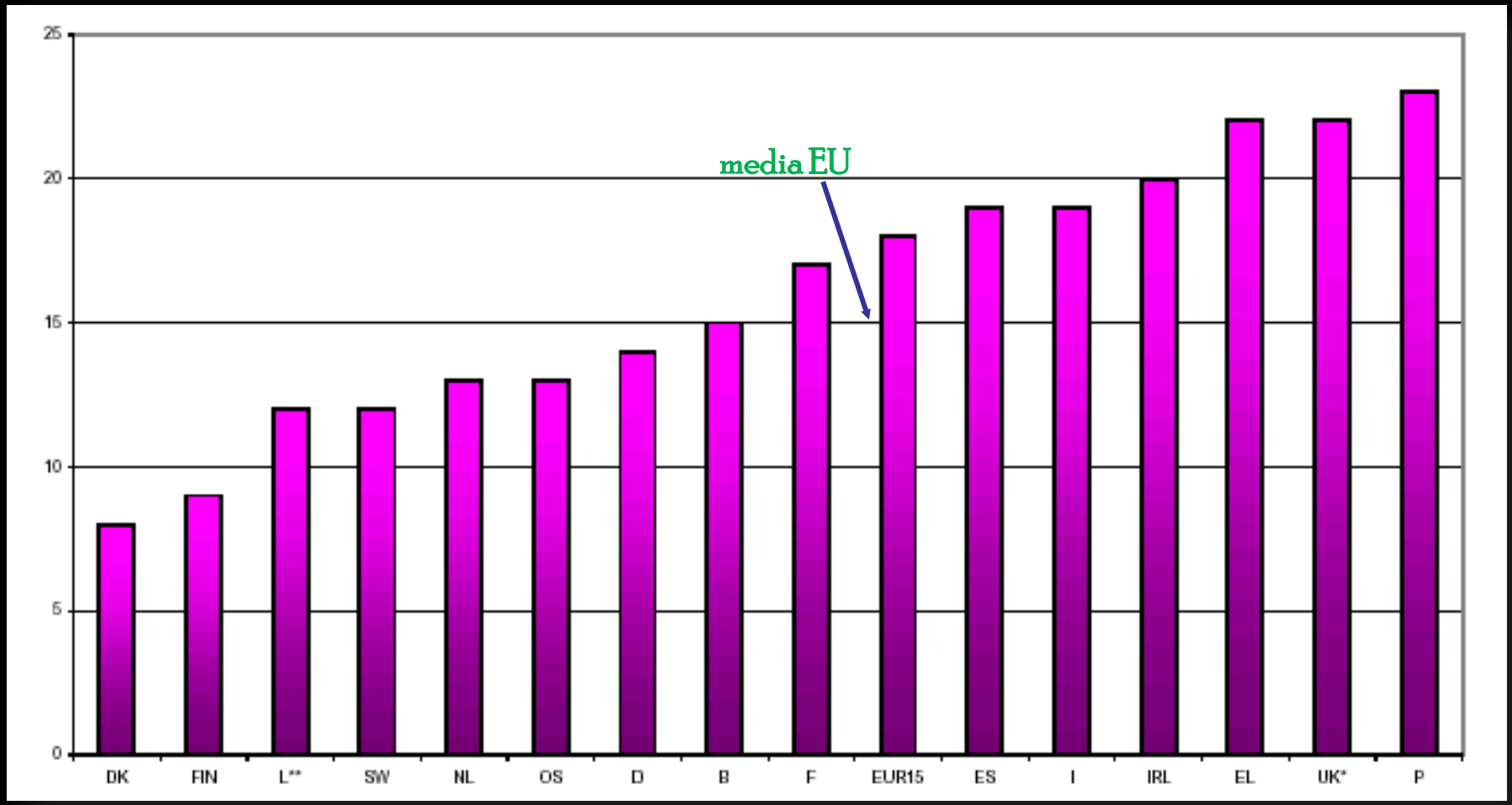


Povertà e salute

Esiste un circolo vizioso tra povertà e salute:

- La povertà è causa di malattie
- Le malattie possono essere causa di povertà

Nell'Europa occidentale 60 milioni di persone (18%) a rischio di povertà e di esclusione sociale



Glasgow, *Scozia*

10 anni di differenza

nell'aspettativa di vita

67 ⟷ **77**

Torino, *Italia*

8 anni di differenza nell'aspettativa di vita

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- Contrasto delle malattie della povertà
- Promozione della salute della popolazione migrante

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LA NOSTRA MISSION

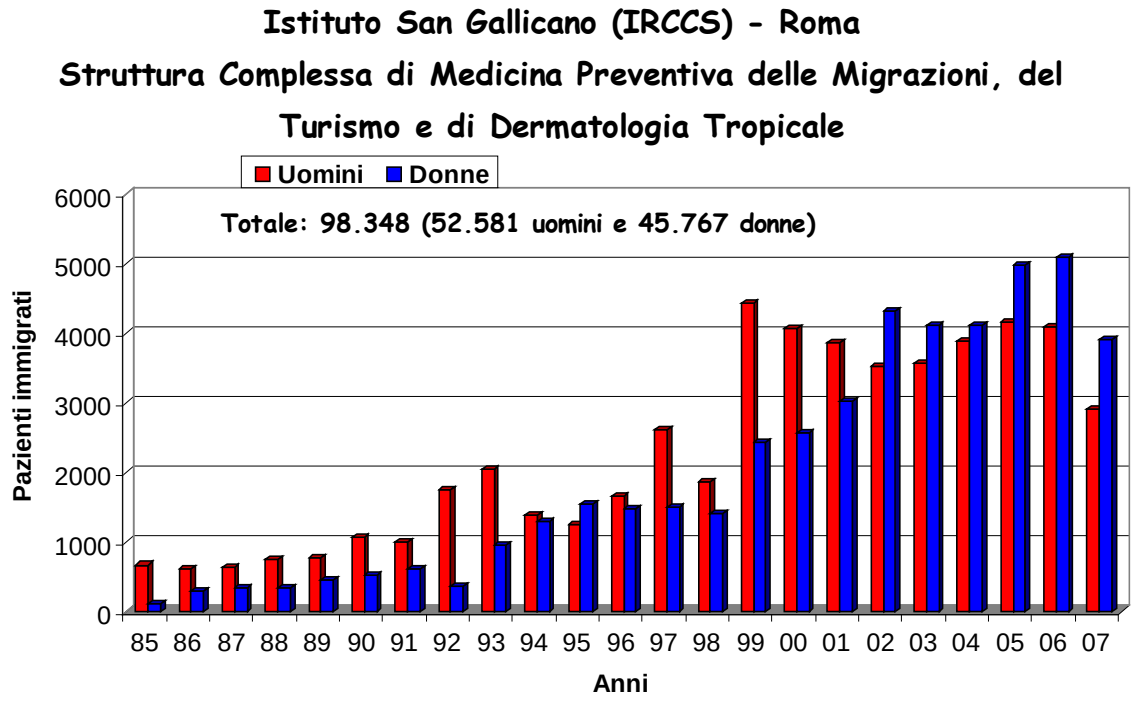
- ridurre le diseguaglianze nell'accesso ai Servizi Sanitari e nella qualità delle cure per gli immigrati e per le fasce deboli della popolazione

- sviluppare programmi specifici di ricerca finalizzati al monitoraggio dei problemi legati alla salute di queste popolazioni

- promuovere la collaborazione tra Istituti di Ricerca nazionali ed internazionali finalizzati al miglioramento della salute dei soggetti a rischio di emarginazione

- formare operatori socio-sanitari in questo ambito

Popolazione Umana Mobile Gennaio 1985 – Dicembre 2009



Dal 1° Gennaio 1985 al 31 Dicembre 2009 più di 99.000 immigrati "irregolari" hanno effettuato una prima visita nella nostra struttura.

Da più di 20 anni accogliamo, visitiamo, curiamo e studiamo le fasce di popolazione a maggior rischio di esclusione sociale:

Immigrati “irregolari” (adulti e bambini)

Rifugiati/Richiedenti Asilo Politico

Persone senza fissa dimora

Vittime della Tratta

Nomadi

Vittime di tortura

Donne con mutilazioni genitali

Pensionati a reddito minimo

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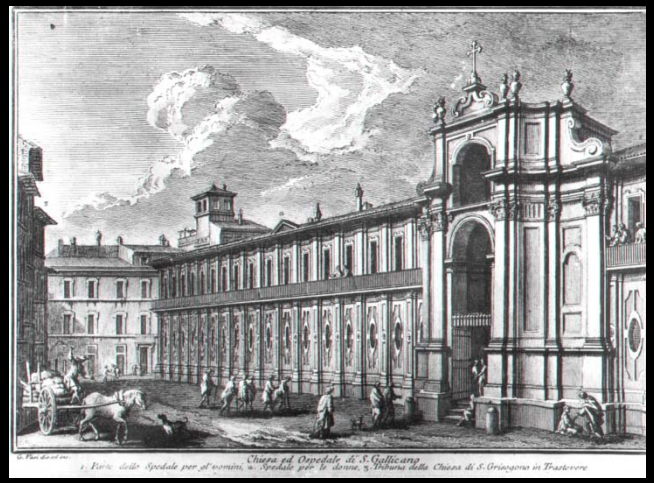
Modello di intervento



multidisciplinare
(dermatologi, internisti, infettivologi, pediatri, ginecologi, psichiatri, psicologi, antropologi, semiologi, infermieri, assistente sociale)

interculturale
(utilizzazione di 35 mediatori linguistico-culturali e formazione specialistica in ambito socio-sanitario)

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- 20 medici (dermatologi, internisti, infettivologi, pediatri, ginecologi)

- 5 psicologi
- 2 biologi
- 2 sociologi
- 3 antropologi
- 2 assistenti sociali
- 6 infermieri
- 35 mediatori culturali
- 3 avvocati

Epidemiology of diabetes

- The number of people with diabetes in the world is expected to aproximately double between 2000 and 2030 (from 171 million to 366 million), with the greatest increase in developing countries

Wild S. et al. Diabetes Care 27: 1047-1053,2004

- The quality of diabetes care generally remains suboptimal worldwide

Garfield et al. Diabetes Care 26 (9): 2670-74, 2003

Migration and diabetes

- Migrants now constitute about 10% of the populations of most Western European countries

- Diabetes represents a major threat to the health of migrants, who appear to be at higher risk of developing diabetes than non-migrants

Carballo M., Siem F., Diabetes Voice 2006

Migrants with diabetes

- Between 1 January and 30 September 2009, 4671 immigrants were examined, with a 4.9% prevalence of diabetes (East Europe 52,7%, Africa 23,3%, Asia 15,8%, South America 8,2%)

Migrants with diabetes

- The diagnosis concerned 65.7% of male patients and 34.3% of the females
- Type 2 diabetes had a definitely higher prevalence compared to type 1 (86.9% versus 13.1%)
- Age of patients ranged from 20 to 79 years
- We found an 18% prevalence of obesity

Migration and diabetes study

Aim of the study:

- to analyze and compare possible inequalities in access to health services and in quality of care between diabetic migrants and non-migrants

- second phase: development of proposals for effective public health strategies, guidelines and health care providers training

Countries involved: Norway, Ireland, Switzerland, Austria, Germany, Greece, Italy, Portugal, Spain, United Kingdom

Methods

Standardized questionnaires for three groups of patients:

- Migrants with type 2 diabetes (50 pat.)
- Non-migrants with type 2 diabetes (50 pat.)
- Migrants without diabetes (30 pat.)

Focus groups: 26 participants including physicians, cultural mediators, nurses, anthropologists, social workers, nutritionists

Questionnaires and focus groups

- Lifestyles and risk factors for diabetes in migrant and non-migrant patients
- Awareness of the disease and health education
- Doctor-patient relationship and adherence to the therapy
- Access to health services
- Management of diabetes

Questionnaires

- Patients selected and contacted for the study were those observed at our outpatient Department (except for Italian patients,partly followed in other hospitals)

- Questionnaires were supplied by cultural mediators

- Compliance was good in all the 3 groups examined except for patients coming from Bangladesh (language difficulties)

Lifestyle and risk factors for type 2 diabetes

Emerging findings:

- Diet: when migrants come to Italy, maintain for some time the same nutritional habits that they had in their country of origin

- Often, however after some time they adapt to a “modernization” of their diet, characterized by foods high in saturated fat, simple sugars and poor in fiber, which are widely available and relatively inexpensive

Stress and diabetes

Immigrants are subjected to a notable burden of stress in their migratory journey

Stress could be a risk factor for type 2 diabetes?

- Would hyperalimentation under stress lead to obesity?
- Is there on the contrary a reduction of caloric imput under stress?

- In some migrants we observed overconsumption of foods under stress, others instead showed reduction of caloric imput under stress

Doctor-patient relationship

- There are certainly linguistic and cultural barriers between migrants and italian physicians
- Most migrants feel that health care personnel did not try to understand their situation and support them
- In many cases doctors have not been trained in cross-cultural medicine, have a vision of the disease based on a biological reductionism or have a paternalistic attitude towards immigrant patients

Awareness of the disease

- On the other hand migrants often lack the awareness of the importance of diabetes as a disease and as a risk factor for serious health complications

- Migrants were more likely to believe that diabetes was genetically founded; most of them were less likely to relate diabetes to obesity, lack of exercise, eating behavior

Educational level

The educational level of respondents is an important determinant:

– Better educated respondents were more aware of the factors affecting diabetes and felt more able to manage their condition

Adherence to the therapy

- Constant changes of residence (changes of city in the search for work, return to one's native country)
- Absence at doctor's check for fear of losing their job
- Lack of the cultural concept of chronic disease
- Refusal to accept the disease
- Fears with regard to the possible side effects of drugs
- Dietary rules often difficult to accept
- Lack of family support

Management of diabetes

Emerging findings: migrants were

- less able to keep their appointments with health care personnel
- less able to control their nutritional intake and their physical activity
- less able to check their blood sugar level
- not less able to adhere to prescribed pharmacological treatment

- In all of these findings, the educational level of respondents was an important determinant

Access to national health service

- Access to health services has improved for migrants, but it is still not on par with that for italians
- That often means a delayed diagnosis, with development of complications which are in many cases present at the time the disease is discovered
- Most migrants were diagnosed with their type 2 diabetes well after they had migrated and settled in host countries

Access to national health service

Reasons for low access for migrants:

- Complex bureaucratic procedures
- Long waiting lists
- Ignorance of health workers about current legislation
- Difficult communication with health workers
- Lack of informational material
- Operating hours not compatible with working hours

Conclusions

- Newer systems of care and newer ways of thinking are needed to tackle a complex disease such as diabetes

- Interventions for improving the quality of care must be at three levels:

- System level
- Provider level
- Patient level

Proposals

- System level:
- collaboration with patient associations
- cooperation between public and private structures, and also between national and international institutions
- screening for unrecognized diabetes in high-risk individuals and early diagnosis
- integration of the prevention programmes for diabetes with those for other chronic diseases (in particular C-V diseases)

Proposals

- Immigrants level:
- multiple risk factors interventions
- improving screening for diabetes in pregnant women
- health education campaigns must also be carried out in schools and places where immigrants meet and must also include the distribution of multi-lingual information material

Proposals

- Healthcare provider level:
- cooperation between primary and secondary care
- training of health workers in cross-cultural medicine
- multidisciplinary approach for diabetes, with the use of linguistic-cultural mediators in health structures