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HYPERTENSION AMONG REFUGEES: A DISEASE OF RISING PUBLIC HEALTH CONCERN

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Abstract

After the war in Syria, Lebanon became among the top countries hosting for refugees. Many public health issues started to be raised with non-communicable diseases (NCDs) being high on the list. Providing health care for refugees is not easy since it requires huge resources, continuous follow-up encounters, and an extensive financial support. Reports show that NCDs are a health priority in Syrian refugees, and hypertension is the most prevalent one affecting more than half of the older Syrian refugees in Lebanon. This creates an enormous burden on the host community health system that needs effective interventions. While Lebanese citizens favor the private sector for seeking health care, better attention and support is to be given to the public sector for better coping with the needs of both refugees and host community, including the implementation of the new guidelines developed by the Lebanese Ministry of Public health in order to decrease the cost of care for NCDs and limit the rate of complications. However, there are barriers encountered when attempting at fulfilling the refugees' health needs. A multisectoral approach involving different stakeholders is essential to ensure the readiness of the host health system and enhance the solidarity of the host community towards refugees

Keywords

Hypertension, refugees, public health

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ABSTRACT: *After the war in Syria, Lebanon became among the top countries hosting for refugees. Many public health issues started to be raised with non-communicable diseases (NCDs) being high on the list. Providing health care for refugees is not easy since it requires huge resources, continuous follow-up encounters, and an extensive financial support. Reports show that NCDs are a health priority in Syrian refugees, and hypertension is the most prevalent one affecting more than half of the older Syrian refugees in Lebanon. This creates an enormous burden on the host community health system that needs effective interventions. While Lebanese citizens favor the private sector for seeking health care, better attention and support is to be given to the public sector for better coping with the needs of both refugees and host community, including the implementation of the new guidelines developed by the Lebanese Ministry of Public health in order to decrease the cost of care for NCDs and limit the rate of complications. However, there are barriers encountered when attempting at fulfilling the refugees' health needs. A multisectoral approach involving different stakeholders is essential to ensure the readiness of the host health system and enhance the solidarity of the host community towards refugees.*

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1. INTRODUCTION

In the past decades, millions of people have left their countries and sought asylum elsewhere. According to the United Nations High Commissioner for Refugees (UNHCR, 2009), the number of forcibly displaced people worldwide was 65.6 million by June 2017, among them were 22.5 million refugees. Lebanon has ranked third among the top countries hosting for refugees (UNHCR, 2009). The world nowadays is progressively urbanizing, and refugees try to seek habitats in cities where better career and educational opportunities can be found (Amara & Aljunid, 2014).

Health issues related to population movements in the region are a central concern for the World Health Organization (WHO) and non-governmental organizations that are giving a particular attention to health and other human rights owing to the vulnerability of the refugee population. Following the political crisis in North Africa and the Middle East, the WHO Regional Office for Europe, in collaboration with the Italian Ministry of Health, have created the PHAME project (Public Health and Migration in Europe) in April 2012. Its goals are to strengthen the capacity of health systems to meet the needs of refugees and migrants and people of the host countries; to promote health interventions to ensure meeting the needs of refugees and migrants; to improve the quality of health services provided; and to optimize the use of health resources in the host countries.

The Syrian war that started in spring 2011 has changed the population dynamics at the regional level, leading to more displaced people to Turkey, Jordan, and Lebanon. Locally, following the huge influx of Syrian refugees to Lebanon, many public health issues started to be raised, with non-communicable diseases (NCDs) being among the ones on the top of the list (CDC, 2016).

NCDs are the major cause of death worldwide, particularly in developing countries (2). The most common refugees' health issues comprise mental illnesses, infections, suboptimal children vaccination, and poorly controlled NCDs (Lawrence et al., 2003). The latter are currently of an increasing public health concern especially in areas of conflicts (Spiegel, 2010). For example, during the Iraqi and Balkan crises, chronic NCDs were among the most difficult public health issues to control in view of the limited resources in war situations leaving the refugees with unmet healthcare needs (Smith, 2003).

Most of the countries that host refugees give particular attention to communicable diseases such as tuberculosis or HIV, in contrast to NCDs that are usually neglected by the patients who are concerned by other issues and basic needs like finding jobs, nutrition, or preparing documents to adjust their legal status. NCDs are also overlooked by the healthcare providers due to the lack of sufficient resources (UNHCR, 2009).

Providing healthcare for refugees concerning NCDs is not easy since it needs extensive resources, continuous follow-up visits, and a huge financial support. Additionally, the legal status of some refugees and the security problems are among the barriers that hinder the refugees from seeking adequate healthcare services (Amara & Aljunid, 2014).

Moreover, a recent study done in the United States (US) showed significantly increasing odds of NCDs with increasing length of stay in the US among adult refugees, mainly for type 2 diabetes mellitus and hypertension (OR 1.07, 95% CI 1.00–1.14) (Golub et al., 2017).

NCDs are considered among the priority health conditions in Syrian refugees according to the Center for Disease Prevention (CDC, 2016). Hypertension is the number one NCD as revealed in a survey done among Syrian refugees in Jordan showing a hypertension prevalence of approximately 11% (Doocy et al., 2015). Additionally, some morbidities are related to hypertension in a way or another, such as cardiovascular complications and end-stage renal disease that is caused by hypertension in 21.1% of the cases (CDC, 2016).

The results of the survey done in Jordan go in accordance with the results of a study done in 2013 on Syrian refugees in Lebanon. The latter showed that around two-thirds of Syrian refugees think that they have a poor health status, and 60% of them have hypertension (Strong, Varady, Chahda, Doocy, & Burnham, 2015). It also revealed that almost all Syrian elderly refugees said they were unable to afford the adequate medical treatment for their chronic conditions, and only 3% of them had the financial ability to provide themselves with basic medical care such as medications

2. MAIN TEXT

2.1 Risk Factors

Risk factors of hypertension are well established, and like other NCDs, these risk factors can be well addressed by many preventive interventions. Aside from the non-modifiable risk factors, like genetic and ethnic predisposition, life style interventions that aim to achieve a healthy diet, control tobacco use, promote physical activity and control salt intake remain the mainstay of hypertension control. (Amara & Aljunid, 2014)

These risk factors can be usually controlled among native communities easier than refugee communities, where the disorganized nature of the latter communities and the limited resources make the task more complicated. Moreover, the interventions that are most effective in certain communities may not be the ideal in others. This issue originates from the fact that risk factors vary between different communities, where for example it has been shown that Iraqi and Palestinian refugees have higher risk factors of non-communicable diseases than other refugee populations, talking here about developing communities. (IFHS 2006/07)

2.2 Burden of Disease

Although the burden of non-communicable diseases affects many countries, developing countries remain on top of the list, given the socio-economic transitions. (Boutayeb, 2006)

This effect is also noted among the refugees communities that come from developing countries, where WHO was able to prioritize three NCDs (Cardiovascular diseases, diabetes and chronic respiratory diseases), to be among health issues of high concern.

Hypertension has been identified to be the most common chronic disease among Syrian population. A household cross-sectional survey was done in 2014 to characterize prevalence of NCDs among Syrian refugees in Jordan. Among adult household members who are eighteen years or older, the reported hypertension prevalence was the highest amongst non-communicable diseases, reaching 10.7 % with a 95% CI (9.8–11.7). This percentage increased significantly to reach 52.1%, 95% CI (46.5–57.7) among older population who are sixty years or older. (Doocy, Lyles, Hanquart, Team, & Woodman, 2016)

Almost similar results came from another study done at Lebanon, and targeted older Syrian refugees in 2015, where hypertension was also the leading non-communicable disease with a point prevalence of 53% and a 95%CI (46%-61%). (Strong et al., 2015)

2.3 Public Health Interventions

In general, studies have shown that Syrian refugee population, particularly in Lebanon and Jordan, access primary health care at a similar frequency of the host community (Doocy et al., 2015) (Strong et al., 2015).

This suggests that they are able to receive the needed care. However, this might not be enough to achieve an ideal control of hypertension risk factors. Non communicable diseases require an opportunistic case finding approach for an optimized management at the public health level. (Amara & Aljunid, 2014) The latter approach is not actually being implemented systematically, given the disorganized nature of the urban refugee population. (Amara & Aljunid, 2014)

Studies also reported that, in addition to primary health care centers, pharmacies were considered a destination for refugees to seek medical care related to NCDs, hence leading to an escape from adequate physicians' care.

In general, refugees were found to seek care in hospitals less than the Lebanese population (9.2% versus 2.8%) except for cardiovascular diseases. When comparing the expenditure of refugees on cardiovascular diseases in hospital care to other conditions for which hospital care is needed, payment on cardiovascular diseases is considerably higher than that of all other conditions (98\$ versus 58\$). This can be explained by the fact that refugees are seeking hospital care after having complications and advanced conditions. The latter can be due to lack of medication compliance or inability to pay for the medications. Despite the support offered to refugees by different non-governmental organizations and the health coverage provided by UNHCR, there remains a huge financial burden on refugees as compared to host community as demonstrated in a study done in Lebanon. (UNHCR, 2017)

Hereafter, NCDs are of a continuously rising health concern in the Middle East especially after the Syrian conflict, which creates an enormous burden on the host community health systems such as what is currently happening in Lebanon where refugees are choosing the services provided by the government, whereas the Lebanese citizens are favoring the private sector despite the harsh economic situation. Better attention is to be given to the public sector in Lebanon so that it can cope with the needs of both refugees and host community. A good example is the new guidelines set by the Ministry of Public Health in Lebanon aiming at decreasing the cost of care for NCDs and decreasing the rate of complications. (Doocy et al., 2016)

Jordan's experience with refugees has encouraged the production of the "DOTS" monitoring system for patients with hypertension. This intervention is one of a kind that was reported in the region. The study reports on a quarterly cohort monitoring system where the reports emerging from this system can be helpful not only for management of hypertension, but also for the assessment of hypertension incidence, the patients' prognosis and long-term outcomes. This can also show the trending of the patients seeking healthcare services and needed equipment and medications. (Khader et al., 2012) Although this study was done on Palestinian refugees, but it can also be useful in the context of other nationalities who have similar living conditions.

2.4 Barriers

The burden of NCDs is in continuous rise (Spiegel, 2010), which creates obstacles for refugee host countries in providing adequate healthcare services (Mokdad et al., 2005). This is mainly due to the complicated nature of NCDs management needing continuous follow-up visits, availability of medications, laboratory tests, diagnostic imaging, and other services that are necessary for adequate NCDs management (Mokdad et al., 2005).

Nevertheless, the financial burden is not the only barrier encountered when trying to fulfil the refugees' health needs. Other barriers reported are the refugees' unawareness of services, unavailability of transportation, poor perception of their health problems magnitude, long waiting time, and the negative attitude of staff towards refugees. (Doocy et al., 2015). This emphasizes the importance of undergoing awareness campaigns for refugees about the available services, and about different health issues, especially those requiring medical interventions (Doocy et al., 2015). This is particularly important to deal with the dissatisfaction felt by both refugees and host community, created by the perceived feeling of inequality in access to health services with the increased load on the health sector. Hence, this will help in enhancing the solidarity of the host community towards the refugees', especially in countries where the conflicts don't seem to have a definitive solution in the foreseeable future (Doocy et al., 2015).

2.5 Gap in the literature

In the retrieved articles, there were varied methods used to assess the prevalence of NCDs among refugees. These studies show some methodological limitations at different levels, in sampling due to difficulty of having a representative sample of refugees, in data collection, especially with self-reported data, leading to inaccurate estimation of diseases. In addition, language and cultural barriers and ethical issues are other factors that contribute to inaccurate data about refugees (Amara & Aljunid, 2014). Moreover, the definition of NCDs was not standardized in all studies, and there were different age groups included in the different studies. A study done by Doocy et al. clearly revealed an effort to rectify the pitfalls in refugee research (Doocy et al., 2016).

Despite the fact that UNHCR has adopted a unified health information system classifying NCDs as per ICD 10, different parties are being involved in data collection.

Unluckily, no single method as decided to be best used for refugee research, although there are some tools that were redesigned to be used among refugee population, such as the Hopkins symptom checklist, and Harvard Trauma Questionnaire (Amara & Aljunid, 2014). Organizing refugees into subgroups according to certain criteria such as area of origin is suggested to be useful (Amara & Aljunid, 2014).

3. CONCLUSIONS

Non communicable diseases, particularly hypertension, are significantly prevalent among refugee populations. The latter fact poses a considerable challenge to health care systems. Providing treatment is not the only challenge, but also the case finding and providing adequate follow up. The burden is pronounced in low to middle income countries, where the host community usually suffers from inadequate health services provision. Conflicts may arise due to health disparities that are exacerbated in such conditions. A multisectoral approach involving different stakeholders is essential to ensure the readiness of the host health system and enhance the solidarity of the host community towards refugees.

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