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Refugees and healthcare services

GLOBAL HELSE

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Encounters between refugees and healthcare services represent 'Global Health' in our own backyard. Healthcare professionals find these encounters challenging and have little research evidence to inspire the development of relevant services. A new research network for refugee health in Norway aspires to engage students from health professions in this evolving research field.

In light of the 'refugee crisis' that began in 2015, the University of Oslo started the initiative 'Academic Dugnad'. The aims of the project were to share knowledge about refugee-related issues and to support refugees to enter academia. The University of Tromsø – The Arctic University of Norway (UiT) launched a similar initiative and 'The Research Network for Refugee Health' is one of the resulting projects, which was started by the authors of this article and colleagues from the General Practice Research Unit at the university.

The network aims to contribute with research grounded in, and with implications for, everyday health care for refugees. The basic concept is to establish a network of healthcare workers and researchers who collaboratively develop small-scale, locally relevant research projects addressing refugee health. Students of medicine and other health professions are invited to choose to write their master thesis on refugee health and healthcare services. Secondly, they are encouraged to communicate results back to the healthcare workers as a means to better manage the challenges that they experience.

Launched in April 2016, the network now comprises almost 20 members from health professions and social sciences, benefits from connections to the Norwegian Centre for Migration and Minority Health (NAKMI) and the Norwegian Institute of Public Health (FHI), and has seven projects running or in the planning stage. Project topics include how the local refugee health team and general practitioners communicate; the follow-up of infectious diseases among refugees; how the gender of doctors and refugees impacts the clinical encounter; and the national screening programmes and refugees.

In this article we present some perspectives and key assumptions, which we identified in the process of establishing the network. The article is meant to serve as an informative introduction to the field of refugee health research, but should also be read as an invitation to a critical discussion of our perspective.

Refugee health in Norway

Migration is an integral part of human activity and development. Sometimes people are forced to leave their country to escape from unbearable life circumstances – due to war, violence, famine, disease or political climate (1). There is no reason to believe that forced migration – migration to escape persecution and conflict (2) – will stagnate in the century to come. The legal status of these forced migrants may vary and they may be referred to as 'asylum seekers' or 'illegal immigrants' or 'refugees'. However, we will address them all as 'refugees' in the following because they have a history of fleeing a country in common.

Refugees may have been exposed to physical and mental trauma, and may have lived under unhealthy conditions prior to and during their flight (3). Even though we lack a comprehensive understanding of refugees' health status (4, 5), we know that they carry a greater risk of suffering from or developing complex somatic and mental health problems (4, 6).

In Norway, the municipalities are responsible for providing health care suitable for early identification and follow-up of somatic and mental health (7, 8). Moreover, all but undocumented migrants have a legal right to health care in line with the Norwegian population. However, a recent rapport from the International Organization for Migration questions the degree to which refugees actually receive the care they are entitled to (9).

Also, healthcare professionals working in asylum centres, with refugees or in health centres for undocumented migrants have repeatedly called for action to improve health care for refugees, as have the Norwegian Medical Association and researchers in the field. It is difficult to say whether the good will and resources necessary are always present, but to improve healthcare services, policy-makers and clinicians also require knowledge about the existing challenges and underlying mechanisms; yet research on refugee health is still sparse (4, 5).

The challenges of culture

'Culture', 'cultural differences' between refugees and healthcare professionals, and lack of 'cultural competency' among healthcare professionals are frequently highlighted barriers to effective, quality care for refugees (4). Language barriers, which may be managed – yet not entirely overcome – through the use of professional interpreters (10), are only one aspect of the rather complex phenomenon of 'culture'. Indeed, cultural aspects in health additionally comprise multiple ways to understand health and illness, to explain bodily sensations and symptoms, and an understanding of unwritten rules of how to navigate a healthcare system correctly and how to behave as a patient (11, 12).

Likewise, a healthcare professional's cultural awareness and competency must have a broader meaning than merely skills in how to work with interpreters. 'Cultural competency' means also to be interested in the patients' cultural background, to appreciate diversity, and to be aware of the risk of discrimination for minority groups. Importantly, being culturally 'aware' means also to be aware of one's own culture, and to understand that neither 'their' or 'our' culture is right or wrong.

Thus, relying on an oversimplified understanding of 'culture' carries the risk of blaming 'culture' as the main reason for difficulties experienced in providing healthcare for refugees. For instance, contrary to the assumption that asylum seekers were unwilling to attend the health assessment in a Swedish municipality, a research project on that subject revealed that the reason for non-attendance was the lack of clarity in the invitation letters which were therefore easy to misunderstand (13). Moreover, it is important not to confuse

awareness about 'the other's culture' with discrimination and stereotyping. For instance, doctors who (falsely) assume that a patient from an African country has a low literacy level are more likely to give the patient less comprehensive health information (14, 15).

Overall, the above 'challenges of culture' that we have described highlight two easily overlooked aspects. First, the focus on cultural differences can widen the gap between 'others' and 'us', and overshadow the fact that 'also healthcare systems and healthcare professionals themselves have a culture' (16). Second, maybe more importantly, understanding 'culture' as the main reason for malfunctioning healthcare services may overshadow the importance of social class and economic factors for health inequalities (17).

A step towards backyard medicine

Refugee health is an important research field – not only because the patients in this heterogeneous group have health issues that are both quantitatively and qualitatively significant, but also because studying refugees' health may give insight into underlying mechanisms that influence health and illness in a broader sense. Refugees are in fact just one of several marginal groups in our society for whom marginalisation, stigmatisation and social isolation can impact both health status and the management of illness. In other words, groups for whom structural violence can cause and sustain preventable and treatable health problems, at the same time creating barriers to adequate healthcare.

We can regard these groups – including drug users, the homeless, prison inmates, children from vulnerable families, ethnic minorities, indigenous people – as groups who – in a sense – occupy the backyards of our society. Therefore, we suggest employing the term 'backyard medicine' to remind ourselves that there are important, yet less visible, determinants of health – such as mechanisms that link political and economic power and sociocultural norms to health and to the management of health – affecting marginal societal groups like refugees.

A better understanding of refugees' challenges with regard to health care may have a potential to *magnify* challenges related to social and structural inequalities, and links between politics, power and health, that we find elsewhere in our society's 'backyard'. The anthropologist Heide Castañeda even finds that research on refugee health can 'observe social inequality by highlighting the body as a site for inscription of politics and legitimacy' (16).

Moreover, broadening healthcare professionals' understanding of the above-outlined mechanism underlying health and illness through studying refugee health, may also have a positive impact on how they act in the clinical encounter. Research indicates that doctors are often unaware how we unwittingly use power in the therapeutic relationship (18, 19).

Moreover, diffuse complaints about pain, fatigue or cognitive deficits, or compliance issues, can often cause frustration among healthcare professionals, especially when doctors try to approach such issues with biomedical, scientific logic. Instead, being curious about the patient's social context and cultural background, and being aware of its relevance for the cause and management of a presented (health) problem, can ease the management of 'difficult' patients for the satisfaction of both patient and doctor.

The innovative potential

A final potential of refugee research relates to innovation. Challenging cultural blind spots is a key factor in successful innovation. Studies of innovation indicate that the necessary first movers are the ones who travel the most, come into contact with new ideas, and produce new ones inspired by experience outside the ordinary (20). From that perspective, refugees – and migrants in general – represent a potential resource for innovation.

The need for innovation in health and welfare services is increasingly recognised (21), but for an innovation to develop and become valuable it needs to be acknowledged by local

individuals and integrated into strong local networks (20). Here, 'innovation' is not the high-tech innovation that calls for entrepreneurship and patents, but 'everyday innovation' and 'service innovation', where local leaders and teams develop ideas together and look for ways to change and improve everyday practices. By involving local stakeholders – clinicians, patients and community leaders – in the development and performance of the projects, we hope to realise their inherent innovative potential. As the first research reports are published in 2018, we can begin to discuss how to achieve this aim. By involving students who write about refugee health in their master's thesis, we hope to increase awareness about complex sociocultural and political aspects in health and healthcare in future health professionals.

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