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Health problems among UN refugees at a family medical centre in Ankara, Turkey

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Objectives **– Political lability in the Near East has brought about the migration of refugees from adjacent countries to Turkey in recent years. To provide an effective health service for refugees, a needs assessment has to be done. UN refugees referring to a family medical centre located in Ankara, Turkey, were therefore investigated for health problems.**

Design **– Medical records were studied retrospectively for age distribution, gender, origin, diagnoses, type of treatment and referral to a secondary health care setting.**

Subjects **– 212 refugees of different countries (mostly from Iraq, Iran and Palestine).**

Results **– Infectious disease was the most often diagnosed condition. Post-traumatic stress disorders could be observed in 12% of refugees.**

Conclusion **– The family physician must be careful not to misdiagnose these disorders during medical examination. Most disease can be diagnosed and treated in family practice. Special care must be taken in the case of mental disorders.**

Key words: **health problems, primary care, refugees, Turkey.**

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Refugees of every race and religion are found in every part of the world. In 1996, there were approximately 26 million refugees in the world, representing 1 out of every 220 persons (1). Turkey, long known as a country of emigration, has become a country of immigration and transit for many refugees and migrants. More than 2 million people have sought refuge in Turkey since the early 1980s, the majority considering Turkey as a temporary transit area (2).

Although Turkey is a country of first asylum for many refugees, articles dealing with the health problems of refugees are rare. The aim of this study was therefore to explore the health situation of adult refugees from a primary care perspective in Ankara, Turkey.

METHOD

We conducted a retrospective study from September 1997 to March 1998 in a private family practice centre (FPC) located in the centre Ankara, Turkey. Two full-time family physicians with four nurses and one laboratory technician are employed, and consultant medical specialists visit this clinic on-call. An integrated dental clinic serves for dental problems. Haemograms, basic biochemistry, microscopic urinary and stool analysis and microbiological cultures are performed in the laboratory. Patients visiting FPC are mostly wealthy and pay for their health care services; a small number are covered through private health insurance. This clinic is preferred because of shorter waiting times, a shorter patient list and better health care quality compared to governmental primary care health settings.

Refugees live in inner-city apartments and have to use public transportation to access the FPC. There are no refugee camps in Ankara. All health care and medication costs are covered by the UNHCR. No information on the target group could be gathered.

Information on age, sex, country, complaint, findings, clinical diagnosis, medication or procedure utilised, and the immediate and subsequent outcome of the visit was gathered from these records.

Refugees under the protection of the UNCHR had temporary access to the private primary care unit during this period. Examinations performed in this unit were just for actual illness conditions. Overseas examination before acceptance as asylum has not been performed in this facility. Therefore diagnoses were frequently based on clinical judgement, with occasional minimal work-up. Diagnoses of mental health problems were made in accordance with the DSM-IV diagnostic criteria (3). Language barriers were overcome with relatives, who helped translation. There was no access to skilled interpreters.

We had no sampling strategy; this was an unstudied and unknown population. We tried to see as many adult refugees as possible. Data collection was stopped after 6 months, when the contract with UNHCR ended.

Table I. Distribution of diagnoses of patients according to age groups and gender.

Diagnosis	19–35		36–50		Female		Male		Total	
	n	%	n	%	n	%	n	%	n	%
Infections										
URTI[1]	19	14	9	11	8	9	20	16	28	13
Gastroenteritis	12	9	3	4	5	6	10	8	15	7
UTI[2]	11	8	7	9	12	14	6	5	18	8
Acute bronchitis	9	7	3	4	2	2	10	8	12	6
Bacterial vaginosis/servisitis	8	6	2	3	10	12	-	-	10	5
Acute sinusitis	5	4	4	5	2	2	7	6	9	4
Chronic diseases										
Diabetes mellitus	3	2	2	3	1	1	4	3	5	2
CHF[3]	-	-	3	4	-	-	3	2	3	1
Asthma	6	5	-	-	3	3	3	2	6	3
COPD[4]	-	-	4	5	-	-	4	3	4	2
PTSD[5]	19	14	7	9	15	17	11	9	26	12
Musculoskeletal problems	6	5	11	14	7	8	10	8	17	8
Dental problems	6	5	7	9	5	6	8	6	13	6
Dermatological problems[6]	6	5	5	6	7	8	4	3	11	5
Eye problems	5	4	3	4	3	3	5	4	8	4
Peptic ulcus	4	3	1	1	2	2	3	2	5	2
Individual cases of: Head trauma, malignant melanoma, sickle cell anaemia, beta thalassemia, unstable angina pectoris, supraventricular tachycardia, bipolar disorder, epilepsy, polineuropathy	14	11	8	10	5	6	17	14	22	10
Total	133	63	79	37	87	41	125	59	212	100

[1] URTI: Upper respiratory tract infection.
[2] UTI: Urinary tract infection.
[3] CHF: Congestive heart failure.
[4] COPD: Chronic obstructive lung disease.
[5] PTSD: Post-traumatic stress disorder.
[6] Dermatological problems: *T. pedis*, dermatitis, *Verruca vulgaris*.

RESULTS

From September 1997 to March 1998, 212 refugee patients were seen. Eighty-seven patients (41%) were females and 125 (57%) males. Ages ranged from 19 to 50 years. The origins of the patients were Iraq (n = 138; 64%), Iran (n = 46; 22%), Palestine (n = 12; 6%), and countries like Afghanistan, Somalia, Ethiopia (n = 16; 8%). Their residence in Turkey ranged between 6 and 19 months.

The diagnoses differed according to age and gender (Table I). Since there were no data available on previous health, most serious, chronic disorders were diagnosed in the FPC. In some instances, former diagnoses, such as sickle cell anaemia, beta thalessemia, bipolar disorder, etc., could be retrieved from patient history.

Patients with dental problems were referred to the dental unit of the FPC. Seven patients needed dental prosthesis, four were diagnosed and treated for caries and two had gingival infections. Patients diagnosed for post-traumatic stress disorder (PTSD) were treated with psychotherapeutic agents; no further intervention could be done in the FPC.

One-hundred-and-fifty-three (73%) received medical treatment (24% prescriptions included antibiotics), 11 (5%) were treated surgically, mostly for skin reparation or ingrown toenails, 25 (12%) received a combination of treatment modalities (including physical therapy) and 22 (10%) received no treatment (refraction problems, dental procedures, etc.). Ten (5%) were referred to hospital for diagnostic and treatment matters (asthmatic attack, acute bronchitis, sickle cell anaemia, head trauma, unstable angina pectoris, acute exacerbation of chronic obstructive lung disease, etc.)

DISCUSSION

The number of refugees and asylum seekers has increased dramatically. One in six has a physical health problem severe enough to affect their life, and two-thirds have experienced mental disorders (4). Displacement can have profound effects in refugees. During the exile, cultural barriers, social degradation, guilt, social passivity and ideological alienation cause changes in identity and control, and increase

vulnerability to psychological stress and physical disease (5). One study has shown a very high prevalence (65%) of PTSD among refugees from Yugoslavia (6). Total rate of PTSD in our patients was 12%. The lower rate of PTSD in our population can be explained by the long period of residence of the refugees in Turkey. Most of the patients lived with their families for more than 6 months in Turkey and had hopes for receival from a third country (e.g. Canada, USA). In our study, female patients seemed to suffer more PTSD. Displacement is especially difficult for women, who sometimes have to take on new roles and responsibilities, including being heads of disrupted households (4). Underreporting symptoms, patient stoicism and cultural bias against admitting to mental illness can lead to a failure to diagnose mental disorders (7). No other mental disorder has been reported in this study. The reason might be that overlapping with symptoms present in other disorders, such as major depression and anxiety disorders, which can occur as a consequence trauma, can occur while diagnosing for PTSD (8).

Most health problems of refugees, especially parasitic and communicable diseases, are determined by the country of origin (9). In refugees from the Middle East (including Afghanistan), intestinal parasites, PTSD and dental caries are more prevalent; certain hereditary diseases, like familial Mediterranean fever and glucose-6-phosphate dehydrogenase deficiency, are diagnosed more commonly (7).

Upper respiratory tract infection and acute sinusitis were diagnosed more frequently in the younger age group. The appearance of communicable conditions might have resulted from the high seasonal prevalence of these infections. Musculoskeletal problems were more common in the older age group. Headaches, backaches and non-specific body pains are common in refugees and these might originate as consequences of trauma, muscular tension or emotional distress (4). Gastroenteritis was common in the younger group. In some cases, giardia lamblia and entamoeba histolytica could be found in stool examinations. Gastrointestinal symptoms have been reported in 25% of asylum seekers in Australia. The prevalence of peptic ulcus in our patients was about 4% in the younger age group. Factors precipitating this pathology, such as stress, *Helicobacter pylori* or drug use might be higher in this population (4).

Dental problems were more common in the older group. Most patients were in need of dental prostheses. In one study, 77% of the refugees had dental problems (10).

In conclusion, nearly half of the presented problems were fairly simple infectious disorders that could be treated by medication. Another common problem was mental disorders. Referral rates were low and most health problems could be managed at the FPC.

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