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Refugee Health, Ethics and Global Health Education: Time to Join up the Dots

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Abstract

While the health care needs of refugees can be considered a human right, asserting obligations to satisfy that right is a necessary but not sufficient step to ensure that they are met, and in addition to political will and social commitment, a well-trained workforce is also needed. All displaced persons have health care needs, and it is important for health care professionals to have the skills to be able to treat this vulnerable, diverse, growing population. When developing an overview of global health problems associated with the health care needs of refugees, it is important to be mindful of ethical and human rights considerations. Given the nature and scale of this problem, there is a moral case for making refugee health a key component in global health education programs, for instance, as part of nurses' continuing education and professional development. To this end, a set of twelve intended learning outcomes are offered, which could be adapted, as needed, and incorporated into new or existing programs.

Keywords: Global health, Education, Health care professionals, Ethics, Human rights, Refugees

Introduction

The aim of this paper is to address educational needs linking global health education, ethics, and refugee health. When refugees and displaced persons are detached from known sources of regular support, including access to health care, their health care needs go with them. While a moral burden falls on the international community to try and address these needs (regardless of someone's age, gender, ethnicity and country of origin), nurses and frontline clinical staff are the ones delivering hands-on care, often in difficult circumstances. To meet this obligation, clinicians need the right skills, and taking a standpoint of ethics and human rights, this paper makes a case for incorporating refugee health into all programs for global health education.

Refugees and displaced persons will have a range of health care needs, depending on their state of health and physical circumstances, whether living in camps and shelters or integrated into the community. While questions of access to health care and logistics are beyond the scope of this paper, a newly arrived asylum seeker in Northern Europe, for example, coming from a war-torn country such as Yemen or Syria or arriving in Southern USA after fleeing violence and persecution in Ecuador or Guatemala, could have layers of health care needs, not all of which are physical [1]. Whether nurses and Health Care Professionals [HCPs] are working in the field or in local neighborhoods, they may need to acquire skills to try and address these needs. Where global health forms part of the education and training of HCPs, consideration should be given to identifying and teaching requisite skills to help clinicians address the health care needs of refugees and displaced persons. Wherever HCPs work, it is possible that displaced persons will fall within the remit of their care, and with almost 80 million refugees and displaced persons worldwide, according to recent estimates (UNHCR, 2020), this situation cannot and should not be ignored. It is time to make the connections and join the dots linking refugee health, ethics and global health education.

Discussion

Refugee health encompasses the medical and welfare needs of all those forced to flee their homeland. Asserting health as a human right is a necessary but not a sufficient step towards making a practical difference, and regrettably, health care needs can easily be overshadowed by political considerations and

policies on immigration and border control [2,3]. Meeting the health care challenge requires resources and will-power as well as a skilled workforce, and while ethics is a relevant subject for every health care professional, those working in global health need to be especially mindful of ethical implications of the sensitive work they are doing. For instance, HCPs could come into contact with cultural practices contrary to their own professional norms; language and communication barriers could cause a range of difficulties, and hidden risks are sometimes associated with organizations tainted by corruption [4].

Furthermore, risks could arise from being in close contact with infectious diseases [5], which in the age of Covid-19, could apply to almost any health care worker, especially in camps and settlements where transmission rates are hard to control [6]. Overall, global health training and education should aim to address known risks to HCPs arising from working in challenging situations as well risks faced by displaced persons who are struggling to obtain adequate health care. Not all these problems can be solved through education, but HCPs should be prepared for working in difficult conditions and equipped to treat problems that may not normally be encountered in everyday clinical work.

Analysis

Nobody flees their homeland to become displaced unless life is endangered because of war, persecution or natural disaster, to name but some of the reasons for migrating. Arguing that there is a moral obligation on the international community to provide aid and/or give sanctuary to refugees is both self-evident and counter factual at the same time. Self-evident because it is a natural humanitarian response to offer help to those in need (in line with UN Sustainable Development Goals [7] and counter factual because of a backdrop of resistance towards allowing refugees the freedom to cross borders. This could apply, for instance, to the southern US border with Mexico, to borders between Myanmar, India and Bangladesh, or to points of entry into Europe where refugees risk their lives crossing the Mediterranean in dinghies [8].

At any point in their journey, an adult refugee could experience torture, a child could witness acts of violence or a woman could become a victim of sexual assault, and the impact of such experiences is hard to imagine. All refugees are vulnerable, including unaccompanied children at risk of exploitation and reliant upon help and protection provided by international agencies such as the United Nations High Commission for Refugees [UNHCR] and the frail elderly who lack the strength and stamina needed to cope with the emotional and physical demands of migration. HCPs have a critical role to play, and I agree that "health-care workers can lead the way, and encourage society as a whole, to reach out to our neighbors, not to turn our backs on them" [9].

As well as needing food, clothing, shelter and security, the migrant community could present with a range of medical needs, including stress related illness and mental health problems such as Post-Traumatic Stress Disorder [1,10]. Furthermore, health problems could be acute, chronic, or acute and chronic, whether for newly arrived asylum seekers or for those living in settlements for longer periods of time [11]. While international agencies give recognition and support to the health care needs of refugees [12], no agency has it within its power to ensure that UN Convention goals are fully met, and inevitably, such goals are partly aspirational [7]. Acknowledging these difficulties, refugees who go without adequate health care may experience significant human suffering, and in responding to this situation, there is an ethical and human rights case for trying to assist, for example, by ensuring an adequate supply of trained HCPs.

The health needs of refugees do not stop when they are accepted into a host country, even if refugees are successful in finding a new home and accessing local services. Therefore, HCPs do not have to volunteer to go and work in a refugee camp in order to encounter problems associated with refugee health. A nurse working in the East End of London, an internist working in the Paris suburbs, or an obstetrician working at a public hospital in Kolkata could each and severally find themselves treating refugees [13]. Because the need for education in refugee health is not restricted to HCPs working in the field, the ability to respond to health problems among long and short-term refugees could be required of practitioners working anywhere in the world. In spite of this, refugee health is not universally taught in global health education [14]. This situation needs to change, and to help address these problems, I offer a set of indicative learning outcomes, which can be incorporated into programs offered by global health educators. Having an adequately trained workforce requires educational objectives that are fit for purpose, covering the necessary skills to enable HCPs to perform important roles, perhaps in difficult circumstances. While refugee health can be included in undergraduate modules on global health, the subject could assume greater relevance after someone has made career choices and gained life and clinical experience, making it a more natural fit for post-qualification training and education [15,16].

Intended Leaning Outcomes

After appropriate training, HCPs should be able to:

i. Understand public health risks associated with migration.

ii. Demonstrate awareness of the type and scope of health problems encountered by refugees and be willing to advocate on their behalf.

iii. Demonstrate relevant skills for treating health problems associated with migration, working with whatever local resources are available.

iv. Demonstrate leadership when trying to affect change and address health problems faced by refugees.

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v. Show resilience when dealing with social stigma and political pressure that could be associated with helping refugees.

vi. Demonstrate mindfulness of links between mental and physical health problems affecting refugees.

vii. Teach core global health skills to health care professionals with less experience than yourself.

viii. Explain the relevance of refugee health in urban primary care settings, not just in the field.

ix. Identify vulnerabilities within refugee communities and know what actions to take.

x. Demonstrate an appropriate response when medical emergencies are encountered by refugees.

xi. Acquire relevant language and cultural competency skills when working with refugees.

xii. Demonstrate sensitivity to social customs without necessarily acceding to unlawful or unethical practices.

Conclusion

Education providers and health care leaders should be mindful of ethical imperatives that underlie the need for service provision for this large and growing body of people. While each objective could be the subject of more detailed discussion, enumerating them in this way could help to provide a trigger for that discussion. In terms of limitations, it is acknowledged that,

a) political and social barriers could impede the ability of HCPs to provide care for refugees and displaced persons,

b) further research may be needed to fully ascertain what is being currently taught, especially in low and middle-income countries [LMICs], and

c) additional barriers to providing global health training and education could include the ability of health systems (e.g., in LMICs) to design, manage and accredit programs for continuing professional development (i.e., if countries lack the resources and infrastructure needed to offer accredited training).

A potential solution could come from building collaborations between established institutions in wealthier, developed countries and institutions in less resourced, less developed countries. This idea is not new, and joint programs potentially bring mutual benefits through exchange of skills, opportunities to learn, and the ability to help refugees. However, there may be arguments (especially in the longer term) for encouraging LMICs to be independent. Either way, providing educational tools to help facilitate further discussion is hopefully a step in the right direction towards addressing some of these issues. If objectives such as the ones listed above are built into programs for continuing professional development, it could make a practical difference to the scope and quality of care received by at least some refugees.

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