Nobody left behind - Improving access to healthcare for underserved people

Organised by MSD
Nobody Left Behind

Improving Access to Healthcare for Underserved People

#EHFG2017
#healthinequalities
#EUhealth
#healthsystems
Migration and Health

The Facts

• The right to health is a fundamental human right

• EU Member States are signatories to the 1966 ICESCR treaty which upholds the right to mental and physical health of all residents, regardless of their immigration status

• Migrants are not an economic pressure on healthcare systems and are less likely to use the system than regular residents

• Barring access or charging for access deters migrants from seeking preventative/early stage care until it becomes a medical emergency

• Obstacles and legal constraints built into the health system often blocks access to care or has a negative impact on the quality of care

The Issues

• Economics
• Public Health
• Human Rights
• Racism
• Healthcare systems
HIV Testing and Access To Care for Migrants Across Europe

• Despite universal access being key to achieving 90-90-90 goals, only 10 countries out of 49 countries in WHO European Region report free access (OptTEST 2017)

• Nearly 4 out of 10 people with HIV are migrants in the EU country of diagnosis. In 2015, of the 25,785 new diagnosed cases, 37% were migrants

• Most HIV-positive migrants in Europe acquired HIV post-migration: 45% among sub-Saharan African, 72% migrant MSM, 58% heterosexual men and 51% women.

Barriers:
• Restrictive practises- complex health systems, eligibility criteria, fees
• Legal barriers – 13 of 49 countries do not provide treatment to migrants
• Stigma, discrimination and racism
• Cultural, faith and language barriers
• Criminalisation of PLWH - non-disclosure, potential/perceived exposure
• Confidentiality - fear information will be shared with immigration depts
• Limited interventions to empower migrants to access healthcare
• Poverty, destitution, poor living conditions
• Partner violence, trafficking, modern slavery

Fola, 28 from Nigeria
Anastacia Ryan

International Committee on the Rights of Sex Workers in Europe
Sex workers - who, what, why, where?

• “Female, male and transgender adults and young people...money or goods in exchange for sexual services, either regularly or occasionally...”

• Sex work varies ...in the degree to which it is more or less formal or organised

• Brothels to roadsides, markets, petrol stations, truck stops, parks, hotels, bars, restaurants and private homes” ...

• Cater to local communities (transient, migrant and mobile populations of both sex workers and clients)

• Economic Activity: full-time occupation, part-time, or occasionally to meet specific economic needs

“Defining sex work as violence against women is dangerous, as it obscures the root causes and different forms of violence sex workers are subjected to.

Sex work must be recognised, treated and regulated as work, with labour rights afforded to sex workers in all circumstances.”
The Key Components of Sex Worker Health Programming: Sex Worker Implementation Tool, 2012 (Link)

1. Community Empowerment
2. Addressing Violence against Sex Workers
3. Community-led Services
4. Condom and Lubricant Programming
5. Clinical and Support Services
6. Programme Management and Organizational Capacity-building

Starting, managing, monitoring and scaling up a programme—from both a centralized and community perspective.

[Link to document]
Community Empowerment

“Community empowerment includes working towards the decriminalisation of sex work and the elimination of the unjust application of the non-criminal laws and regulations against sex workers, and recognising and respecting sex work as legitimate occupation or livelihood.” (WHO, 2013)

- Assuring **meaningful participation** of sex workers in the design, implementation, monitoring and evaluation of HIV programming
- **Sustaining** sex workers’ movement
- Shaping **policy and creating enabling environments**
- Struggling for the **recognition of sex workers’ human and labour rights**
- Advocating for **decriminalisation of sex work** and other legal reforms
George Kalamitsis
Prometheus, Hellenic Liver Patient Association
Είσαι για ένα γρήγορο; Είναι δωρεάν...

ΚΛΕΙΣΕ ΡΑΝΤΕΒΟΥ ΣΤΟ 210 33 10 400
ΔΕΥΤΕΡΑ - ΣΑΒΒΑΤΟ 12:00 - 20:00

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Είσαι για ένα γρήγορο; Δε θα το μάθει κανείς...

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Freek Spinnewijn

European Federation of National Organisations
Working with the Homeless
**Mortality**

Chronic homeless people have a life expectancy of only mid-40s. Women die earlier than men.

- **UK:** Homeless people average age of death is 30 years below the national average.
- **Denmark:** People who live on the street die an average of 20 years before the general population.
- **Netherlands:** Homeless population dies sooner - 11yrs for men and 16yrs for women than average age in general population.

**Suicide**

1 in 10 homeless person with mental health conditions in social services will attempt suicide.

Homeless people are over *9 times more likely to commit suicide* than the general population.

**Mental health**

Half of homeless people suffer from mental health problems in most countries.

Dual diagnosis very common.
**Traumatic Brain Injury**
Homeless people are twice more likely to have suffered from traumatic brain injury than the general population - 90 percent before becoming homeless.

**Disability**
Dutch research showed that 35% of homeless adults have a cognitive impairment.

**Tuberculosis**
UK studies show homeless are 30x more likely to suffer from TB compared to the general population.

**Hospital costs**
Are approximately 4x higher for homeless people and the inpatient costs are 8 times higher than the average population.
Causes of death: general population

- Cardiovascular (36.5%)
- Cancer (27.3%)
- Other diseases and disorders (16.7%)
- Respiratory (13.8%)
- Infections (1.2%)
- Due to alcohol (1.3%)
- Due to drugs (0.3%)
- Suicide/undetermined intent (0.9%)
- Falls (0.6%)
- Traffic accidents (0.4%)
- Other external causes (1.0%)
Causes of death: homeless people
Alyna Smith
Platform for International Cooperation on Undocumented Migrants
The damaging effects of systematically limiting access to health systems for people who are undocumented begin with the individual, and ripple outward to the broader community.

Restricted access to health care means people are unable to get assistance to adequately treat and manage existing conditions, to the further detriment of their mental and physical health.
Exclusion from health systems means:

• Exclusion from basic information about risk factors, disease prevention and health promotion

• Exclusion from access to routine testing in pregnancy, for communicable infections, and chronic conditions

• Absence of pre- or post-natal care, and vaccines or routine paediatric follow-up during childhood

• No diagnosis or support for mental health conditions until they reach crisis point.
Eberhard Schatz

Correlation Network
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<th>Surveyed</th>
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<td><strong>58</strong></td>
<td><strong>39</strong></td>
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Why?

High Prevalence

• Injecting drug use is a major route of transmission of Hepatitis C with over 10 million PWID infected globally

• In European Region, the burden of the Hepatitis C is concentrated amongst PWID

• Hepatitis C prevalence among this population varies from approximately 21% in Finland to over 90% in Estonia
Barriers to accessing healthcare for PWID

• Unstable housing
• Criminalisation
• Stigma & discrimination

• Multiple obstacles and layers of barriers within the health care settings
Enablers to accessing healthcare for PWID

Recommendations

- Eligibility criteria should ensure access for all (drug use is no reason to preclude access to healthcare)
- Stigma reducing interventions
- Decriminalisation
- Welcoming, not judgemental environment
- Peer involvement, personal interaction
- Assistance with practical problems (housing, flexible appointments etc)
- Monitor stigma and discrimination and establish procedures
Rachel Halford
Hepatitis C Trust, UK
Globally, over 10 million people are held in prisons and other places of detention at any given time.

A majority of these people are socially disadvantaged and come from the lower socio-economic levels within our societies. There is a high prevalence of substance misuse, mental health, domestic violence, homelessness, low levels of health literacy.
In the EU, it is estimated that about half of the prison population have used illicit drugs at some time in their lives.

Up to 48% of men and 60% of women were dependent on or used illicit drugs in the month before entering prison.

A majority of sentences are for drug related crimes.
Prison offers a window of opportunity - the first opportunity for many - to access health care

Testing and treatment for blood-borne viruses (BBVs)

Mental health assessments

Physical health screening

Harm minimisation messages

Drug treatment

Dental care
Accessing Health Care in Prison – What’s the Problem?

- Stigma
- Shut downs
- Prison Regime
- Funding
Claire 45 yrs old – 30yr history of drug and alcohol use and offending

Offence: Grievous bodily harm

Sentence: 5 years

Health Issues
Mental health issues
Hepatitis C
A mouth full of rotten teeth

“When I think about prison today, I think that prison probably saved my life.”

“It was the first time I had ever taken any care of my health, doing the Hep C treatment made me realise I can do anything. I think the medication for my depression have helped too but I have only relapsed once, when I first got out – and I have not re-offended. I am volunteering for a community café and I even have my own flat with a little garden – I didn’t know life could be like this”
Access to physical and mental health is a fundamental human right – people in prison should have the same standard of medical care as people living in the community.

**Health Care in Prisons must be funded by Health Departments focused on Health**

**NOT**

**Justice Departments focused on Justice**
Dr Andrej Kastelic
National Centre for the Treatment of Drug Addiction, Slovenia
Addiction treatment
Providing care to people who use drugs

• Understand what their daily life entails
• Dignity and humane, person-centric approach
• De-stigmatisation built into the care plan
• Interventions should not lead to marginalisation
• Robust care planning
• Realistic & individualised goals
Care plans & care planning in addiction treatment

- Most important and useful tools in drug work
- Setting and development realistic goals
- Detail the desired outcomes: interventions, support, care
- Should be accepted by the client as well as the service providers
- Realistic and achievable
- Different providers: professionals, self help, family, friends, peers,…
- Individualised and consistent with goals, values and life situation
Discrimination & Stigma study in PWID in Slovenia

- All experienced stigma and discrimination:
  - Half within their family
  - 66% within their neighborhood
  - All with friends
  - 33% at their job
  - 50% when seeking social support
  - 82% at mental health services
  - 82% had to hide drug use and/or mental health problems
Prof Jeffrey Lazarus

Barcelona Institute for Global Health (ISGlobal), Hospital Clínic, University of Barcelona
“A health system consists of all organisations, people and actions whose primary intent is to promote, restore or maintain health”

A paradigm change:
The central role of people and communication

Source: Lazarus and France. A new era for the WHO health system building blocks? 2014
People-centred health systems

See: http://www.who.int/servicedeliverysafety/areas/people-centred-care/en/
A people-centred health system leaves no one behind

- Effective surveillance/monitoring of loss to follow up?
- Strategies for engaging key populations?
- Packaging language, tools to support key pops?
- National strategy/plan incl stakeholder input from eg key populations, patients
- Workforce needed to address key populations?
- Budget for referral and adherence support?
SACC: “Borgernær” shared care

Source: http://www.chip.dk/Collaborations/SACC
Putting it all together ...
A people-centred health systems approach to leaving no one behind
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16:00-16:20 Round 1
What are the main challenges and common needs in accessing healthcare for key populations?

• Stigma and discrimination
• Logistical or legal barriers to access,
• Awareness of right to health, etc.
• Accessibility of services
• Etc...
16:30-16:50  Round 2

What could be the policy response at each level of policy-making?

Are there practical solutions to help create a more inclusive, more effective health service design?

What do we want each actor to do?

- Community
- Health care professionals
- National health systems
- EU Institutions
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