Forum Migrationsmedizin, 19.Sept 2019
Kinder- und Jungendgesundheit und Migration

Betreuung von pädiatrischen asylsuchenden Patientinnen und Patienten von der Primärversorgung zur Tertiärmedizin

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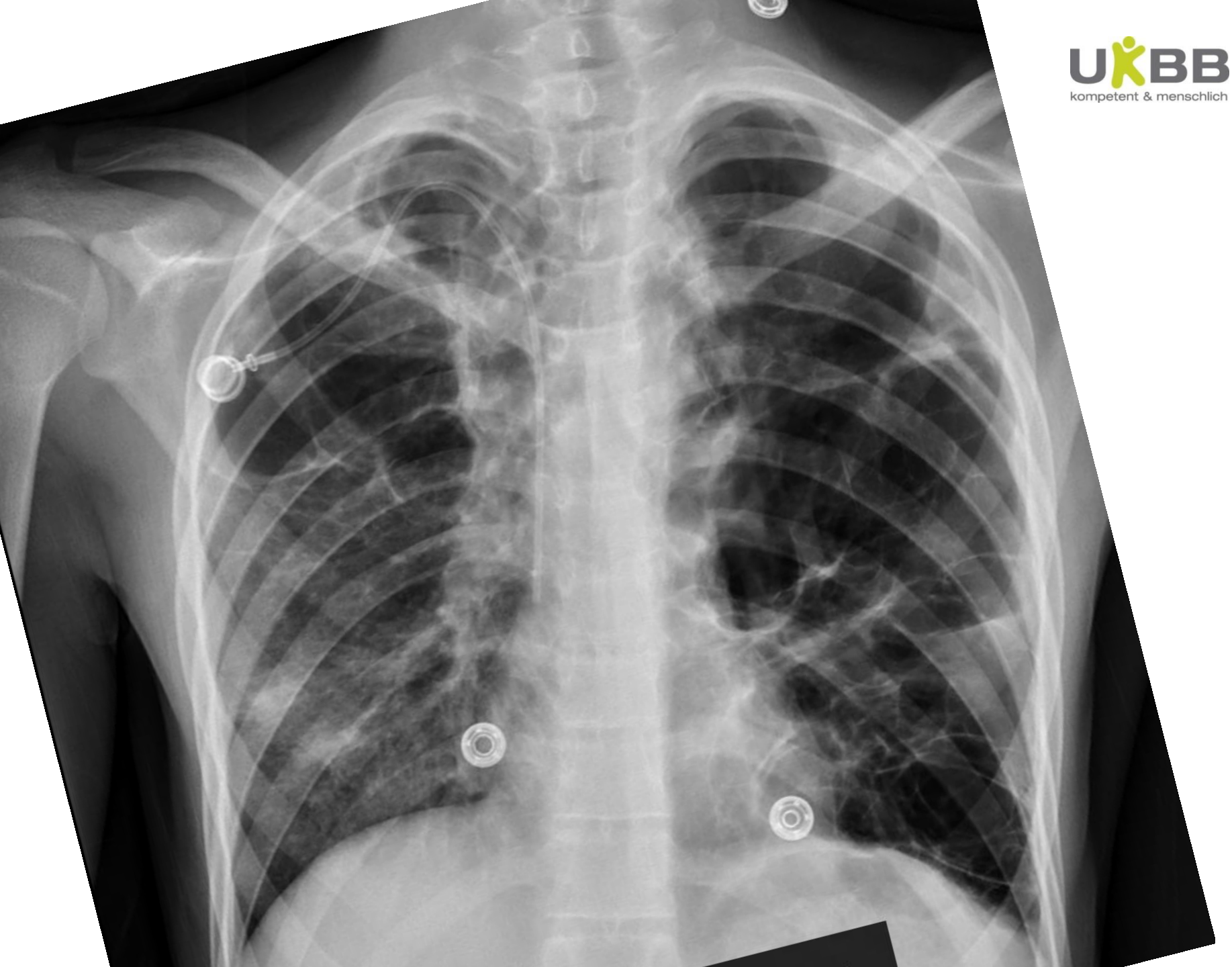
14-jähriger Jugendlicher aus Somalia

- Aufnahme bei Fieber und Erysipel am linken Knöchel

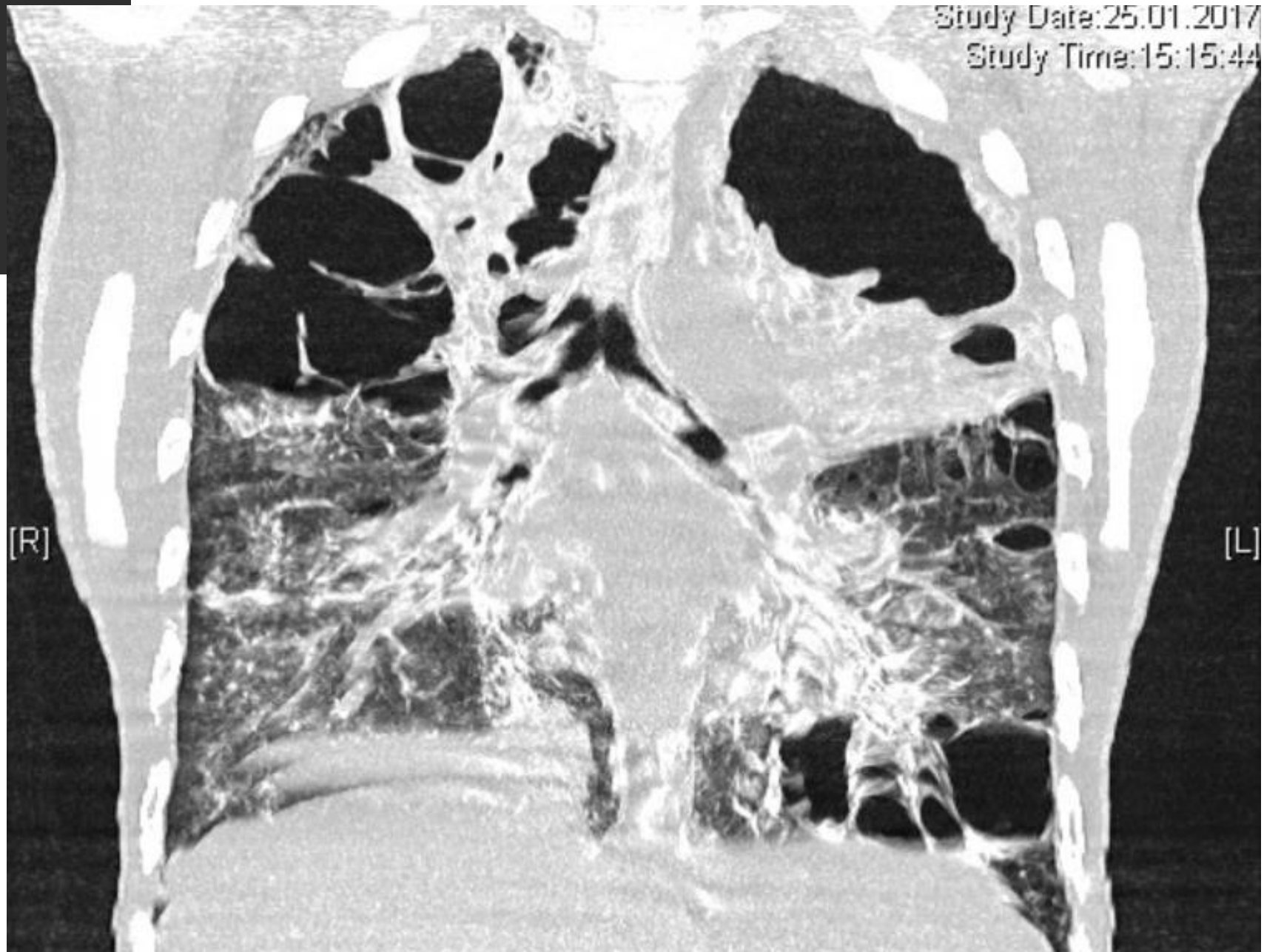
- Untersuchung: 37 kg (BMI 13 kg/m2), afebril
  Erysipel am linken Knöchel und Skabies-artige Läsionen am Fuss
  Atemfrequenz 20/Min, Sättigung unter Raumluft 90%
  Herz und Lungenuntersuchung iunaufällig

- Labor: Hb 112 g/l, Lc 14 G/l, Tc 423 G/l, CRP 42 mg/l, ESR 80/h

- “Übrigens der Patient hat einen seltsamen trockenen Husten”



UKBB
kompetent & menschlich


Study Date:25.01.2017
Study Time:15:15:44
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Übersicht

- Aktuelle Entwicklung für Asylgesuche
- Primärversorgung: akute Probleme
- Primärversorgung: Prävention
- Tertiärmedizin und Migration, kommt das vor
- Nicht medizinische Herausforderungen

Wie sehen die aktuellen Zahlen aus

- 2018 in **Europa**

  > 600’000 Asylgesuche

  1/3 Kinder und Jugendliche

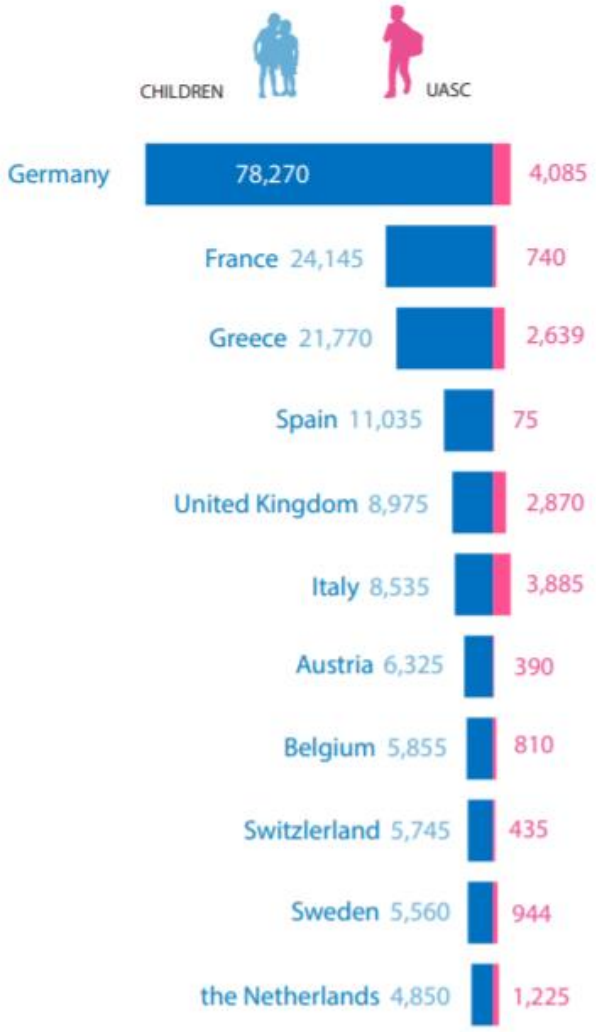
- 2018 in der **Schweiz**

  > 15’000 Asylgesuche

  30% Kinder und Jugendliche

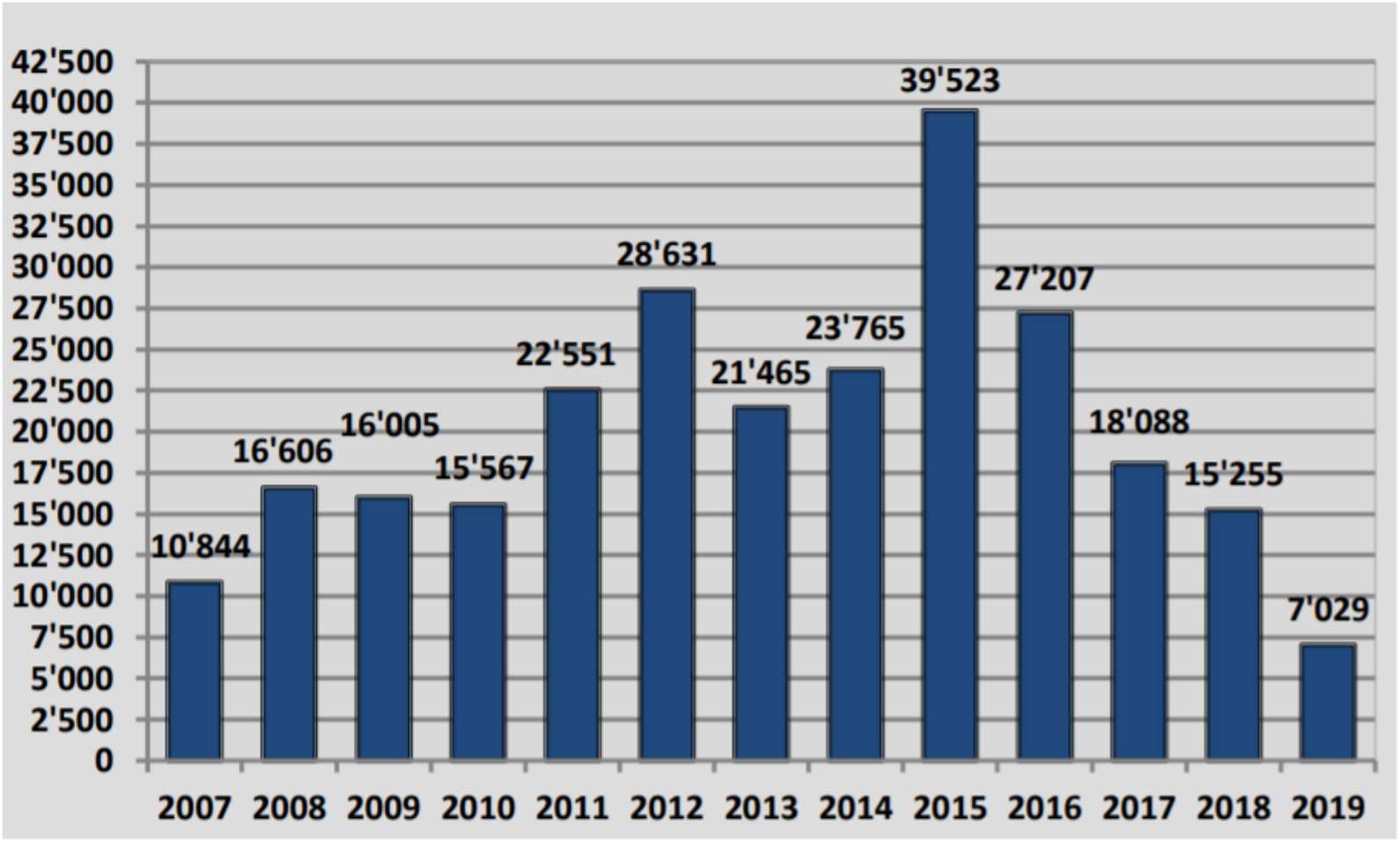
  > 46’000 vorläufig Aufgenommene

  37% Kinder und Jugendliche



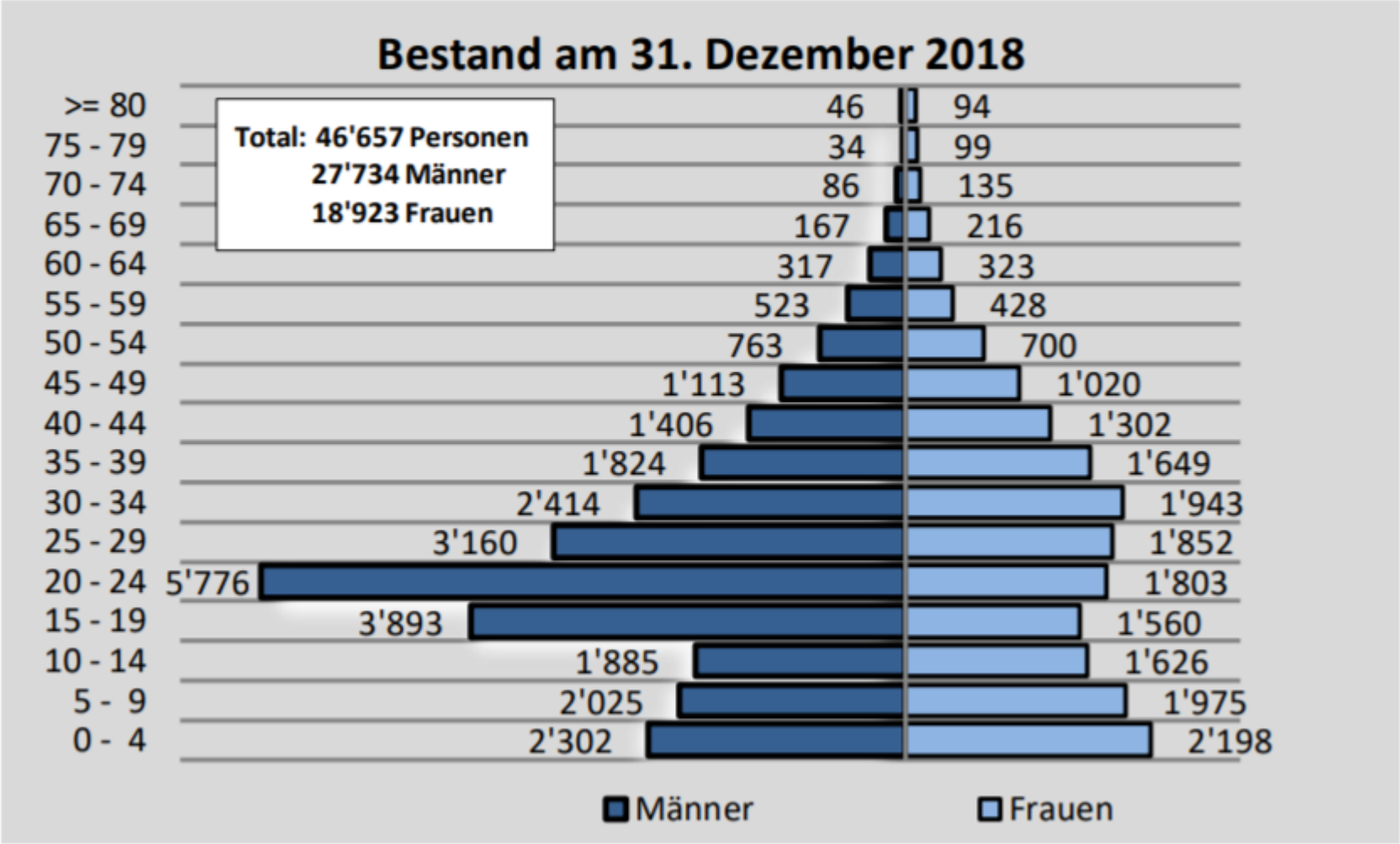
UNICEF report, 2019

Asylgesuche

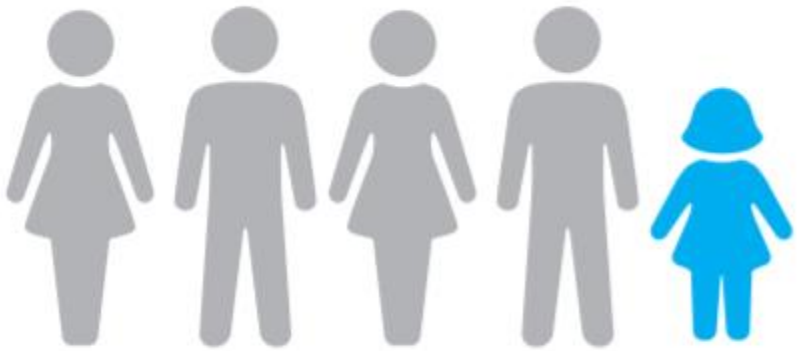


SEM 2.Quartal 2019

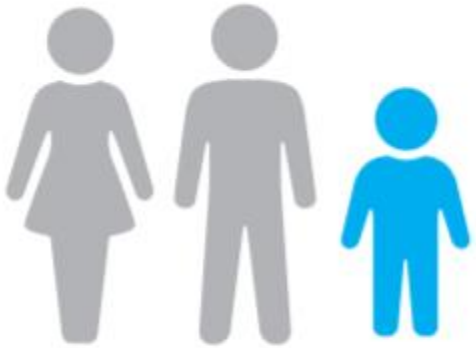
Altersverteilung Asylsuchende



Alter der Asylsuchenden



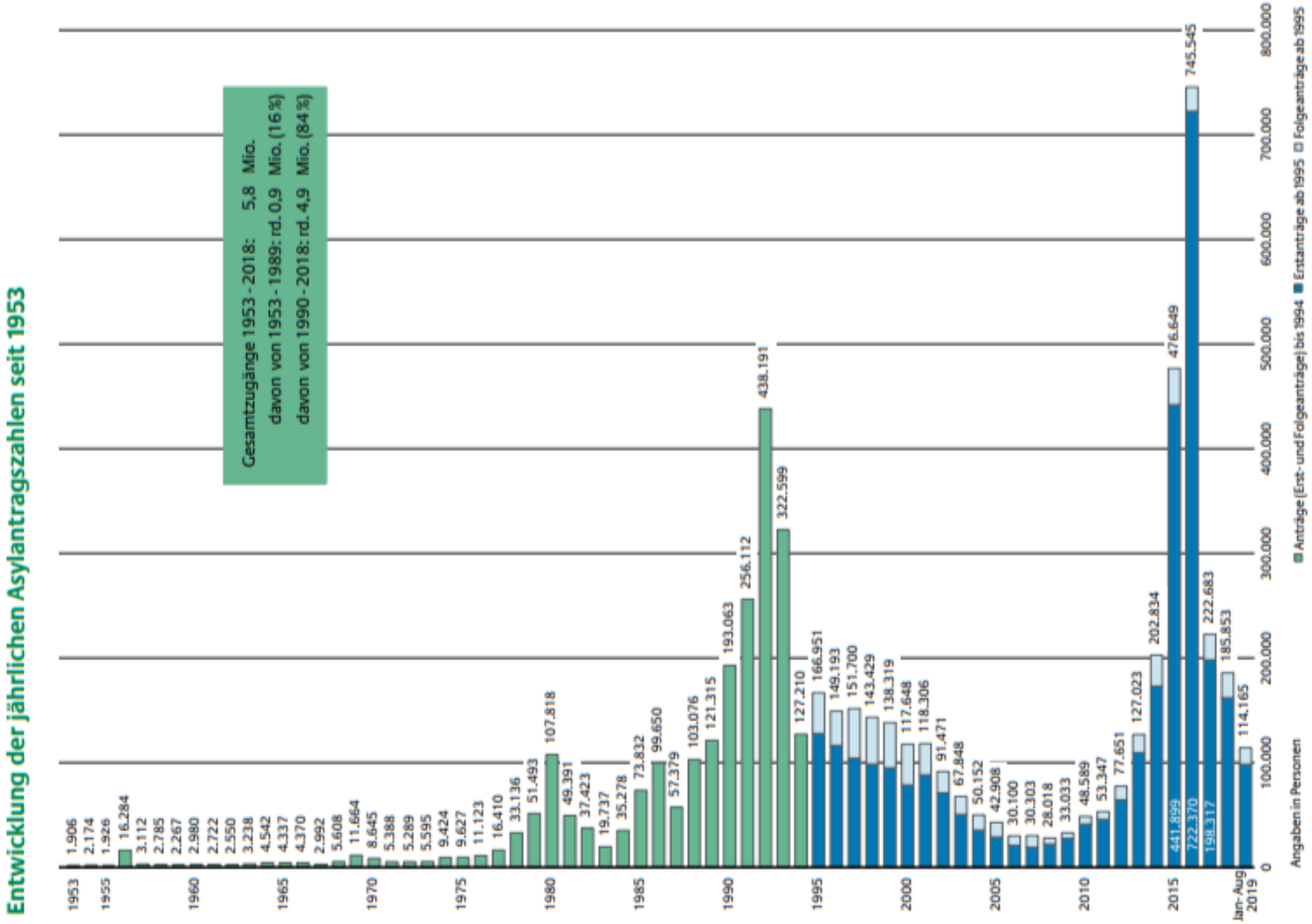
2008



2018

A child is a child”; UNICEF report, May 2017

Langfristige Dimensionen



BAMF, Aktuelle Zahlen Aug 2019

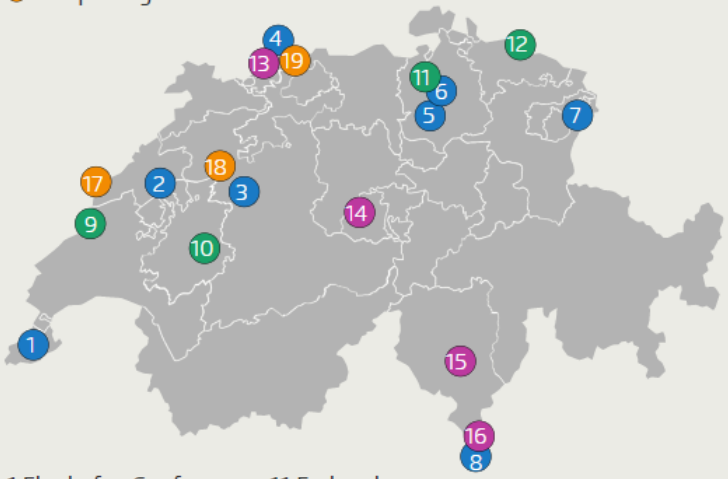
Tiefe Anzahl Asylgesuche

Bund schliesst zwei Asylze wegen weniger Gesuchen

Der Bund schliesst die Asylzentren in Kappelen BE und Muttenz BL bis a Grund: Es sind weniger Asylgesuche eingegangen.

Bundesasylzentren in der Schweiz

- Bundesasylzentrum mit Verfahrensfunktion (BAZmV)
- Bundesasylzentrum ohne Verfahrensfunktion (BAZoV)
- Temporäres Bundesasylzentrum (BAZ)
- Temporär geschlossenes Zentrum



1 Flughafen Genf
2 Boudry
3 Bern
4 Basel
5 Zürich
6 Flughafen Zürich
7 Altstätten
8 Chiasso
9 Vallorbe
10 Giffers
11 Embrach
12 Kreuzlingen
13 Allschwil
14 Glaubenberg
15 Biasca
16 Stabio
17 Les Verrières
18 Kappelen
19 Muttenz

Quelle: Staatssekretariat für Migration SEM, 09.09.19

UNICEF report 2019

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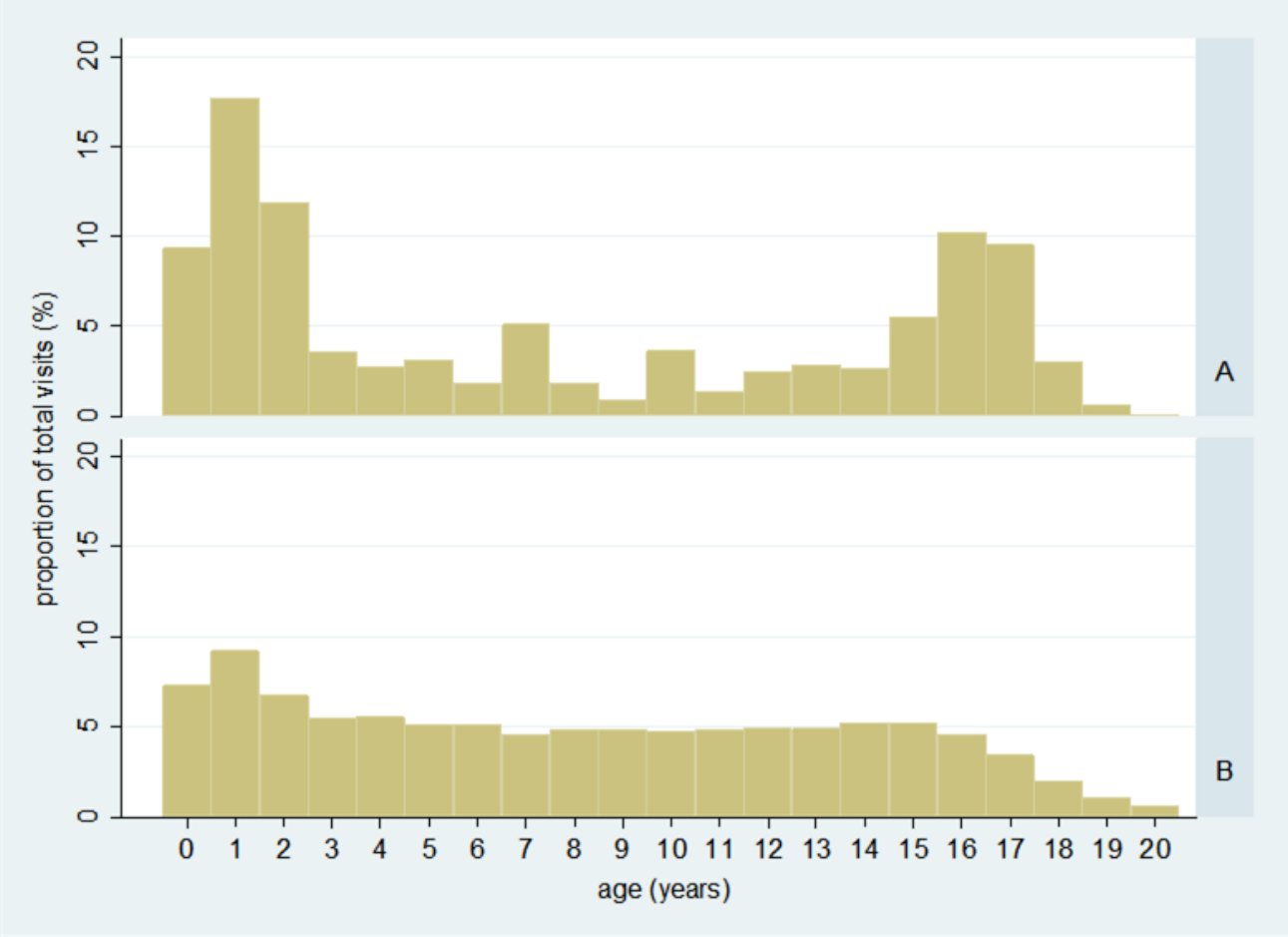
Zahlen am UKBB

2016 und 2017

1674 Besuche von 439 asylsuchenden Patienten

310 Besuche auf der Notfallstation
200 Besuche Physiotherapie
173 Besuche Radiologie

Altersverteilung Asyl Nicht-Asyl



Asylsuchend

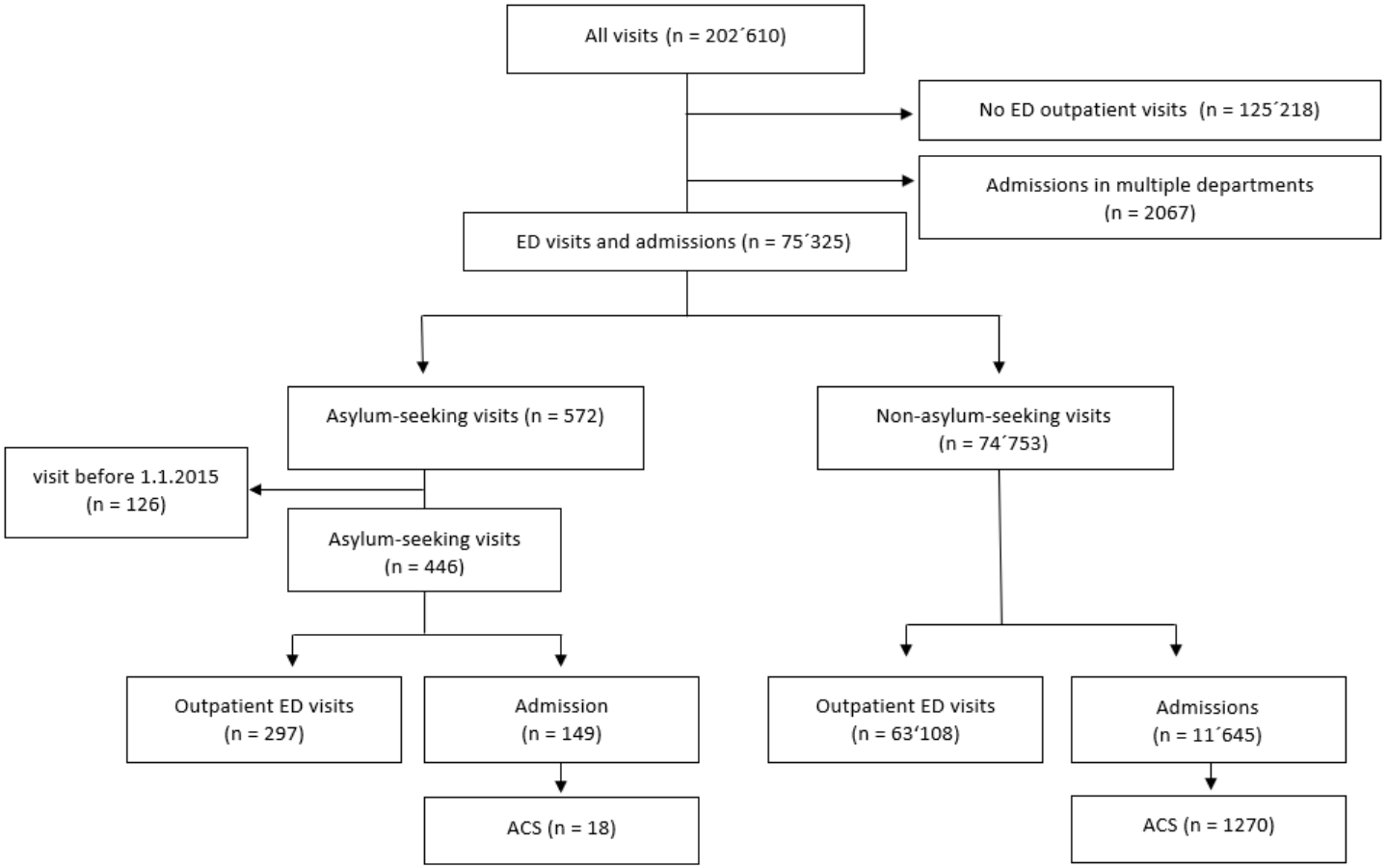
1674 visits
439 patients

Nicht asylsuchend

200’610 visits
55’350 patients

Brandenberger J et al (under review)

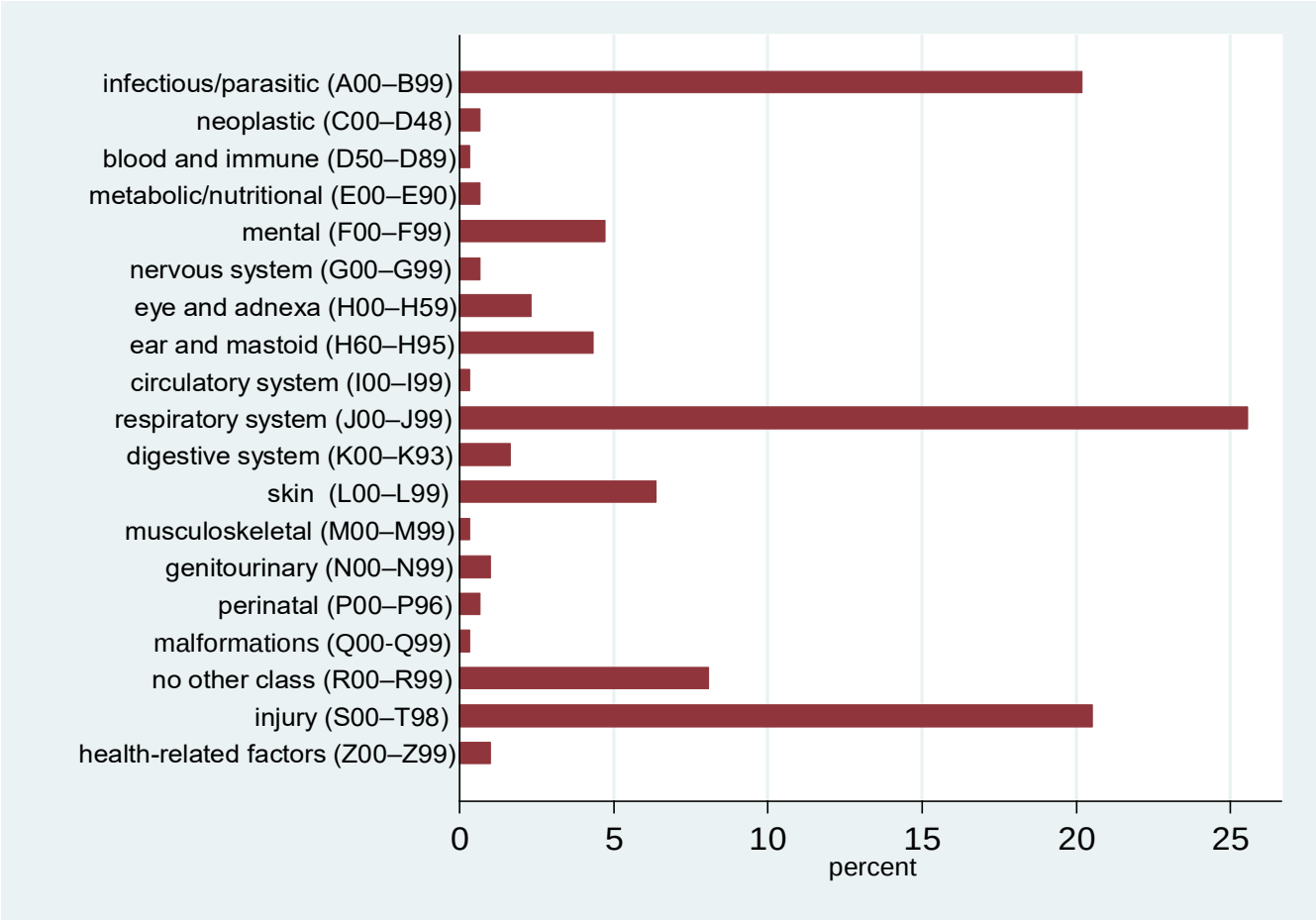
Notfallkonsultationen UKBB



ACS: ambulatory care sensitive conditions; ED: Emergency Department

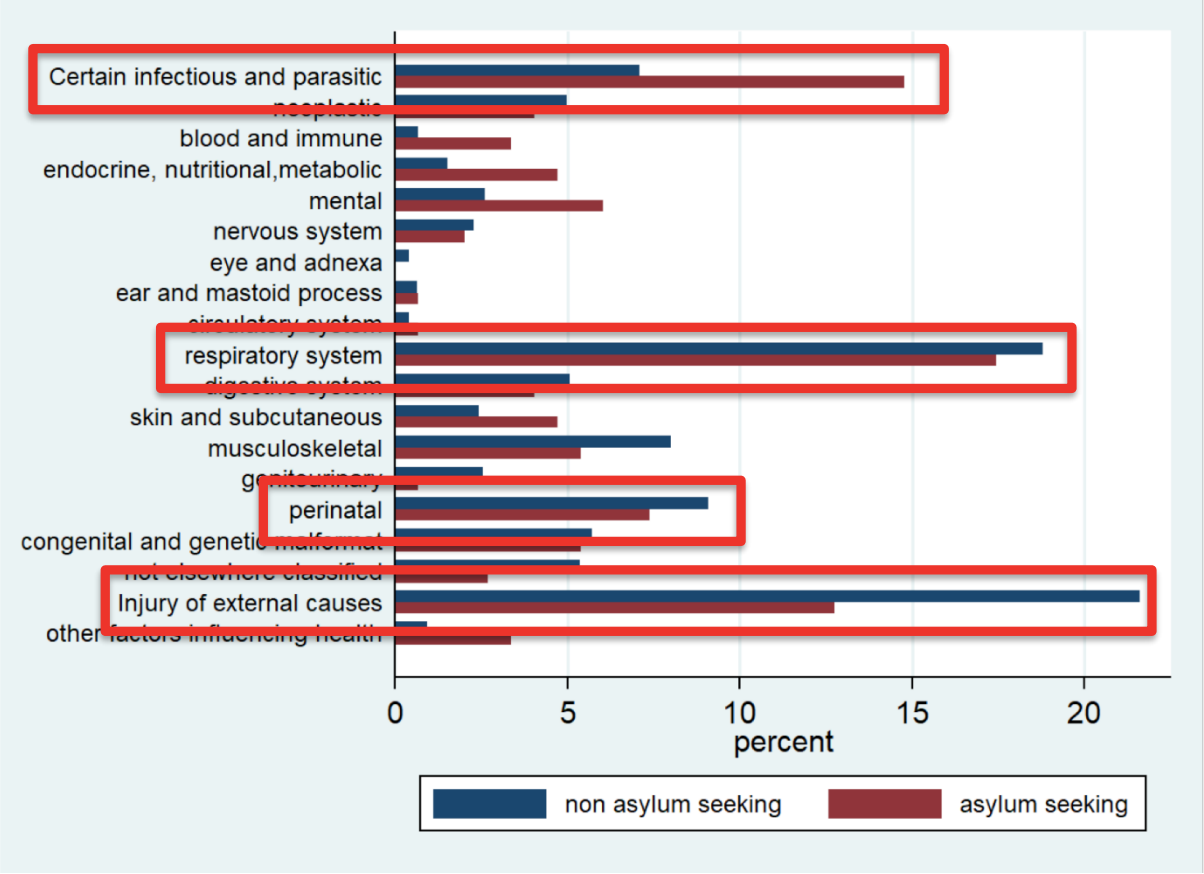
Brandenberger J, (manuscript in preparation)

Notfallkonsultationen UKBB



Brandenberger J, (manuscript in preparation)

Vergleich zu nicht asylsuchenden Patienten (nur stationäre)



Gmünder M, Brandenberger J et al (under review)

Vergleich der Besuche am UKBB

Characteristics	Asylum-seeking				Non-asylum-seeking				
	Visits n = 1674		Patients n = 439		Visits n = 200'642			Patients n = 55'350	
	N	%	N	%		N	%	N	%
Age groups:									
0-2	646	39	96	22		45'478	23	13'297	24
3-14	575	34	152	34		117'546	58	32'819	59
15-17	421	25	171	39		25'736	13	5938	11
> 17	32	2	20	5		11'882	6	3296	6
Total 2016	812	49	243	55		100'842	50	36'560	66
Total 2017	862	51	243	55		99'800	50	36'767	66
Male gender	1172	70	307	70		110'567	55	29'520	53
Most frequent nationalities:									
Syria	442	26	41	9	Switzerland	124'714	62	35'381	64
Eritrea	210	13	60	14	Germany	12'961	6	3853	7
Afghanistan	192	11	58	13	Turkey	9310	5	2080	4
Algeria	182	11	4	1	Italy	7292	4	1984	4
Armenia	157	9	4	1	Kosovo	5368	3	1325	2
Other	371	22	154	35	Other	40'973	20	10'714	19
Missing Data*	120	7	118	27	Missing Data	24	0	13	0
Outpatient visits	1490	89	ns	ns		185'950	93	ns	ns
Office hour visits (7.00 am – 5.59 pm)	1505	90	ns	ns		167'901	84	ns	ns
Most visited outpatient departments:									
Emergency	317	19	ns	ns	Emergency	64'315	32	ns	ns
Exercise therapy	200	12	ns	ns	Surgery	18'507	9	ns	ns
Radiology	173	10	ns	ns	Orthopedics	16'225	8	ns	ns
Occupational therapy	144	9	ns	ns	Ear, nose, throat	15'775	8	ns	ns
Haemato-oncology	141	8	ns	ns	Neurology	10'338	5	ns	ns

Brandenberger J et al (under review)

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Screening ja oder nein

Guidance for testing and preventing infections and updating immunisations in asymptomatic refugee children and adolescents in Switzerland

Sara Bernhard[a)], Michael Büttcher[b)], Ulrich Heininger[c)], Sharon Ratnam[d)], Christa Relly[e)], Johannes Trück[f)], Noémie Wagner[g)], Franziska Zucol[h)], Christoph Berger[e)], Nicole Ritz[i), c)]
on behalf of the Paediatric Infectious Disease Group in Switzerland

Introduction

Worldwide there are an estimated 60 million displaced individuals, of which 50% are chil-

live in crowded dwellings and have to change residence frequently.

After arrival in Switzerland refugees seek asylum and are admitted to one of the the

considered a refugee should receive appropriate protection and humanitarian assistance.

The following recommendations are intended for a health check-up of healthy-looking/asymptomatic children and adolescents ≤ 18 years of age who have recently requested asylum in Switzerland. Implementation of these recommendations should ideally be started at the first visit of a health care provider, preferably within weeks to few months after arrival in Switzerland. Children and adolescents with signs and symptoms of disease are not the focus of this guidance and should be diagnosed and treated according to clinical diagnosis. Recommendations about general health aspects of immigrant children and adolescents are not part of this document and covered in a separate article in this issue. Our

European Journal of Pediatrics
https://doi.org/10.1007/s00431-019-03405-9

EAP STATEMENT

Medical care for migrant children in Europe: a practical recommendation for first and follow-up appointments

Lenneke Schrier[1] · Corinne Wyder[2,3] · Stefano del Torso[4] · Tom Stiris[5,6] · Ulrich von Both[7,8,9] · Julia Brandenberger[10] · Nicole Ritz[10,11,12,13]

Received: 24 March 2019 / Revised: 31 May 2019 / Accepted: 4 June 2019

Abstract

Between 2015 and 2017, an estimated 200,000 to 400,000 children were seeking asylum each year in EU/EEA countries. As access to high-quality health care is important, we collected and compared current recommendations across Europe for a consensus recommendation on medical care for migrant (asylum-seeking and refugee) children. Existing recommenda-

1		Make sure the migrant child is accompanied by at least one parent or a responsible caregiver.
2		Make sure the parent/caregiver can communicate competently; access professional interpreter services if limited language proficiency is suspected.
3		Ask about health problems that the parent/caregiver and the children themselves identify.
4		Ask about growth and development and perform a physical evaluation including of weight-for-age and height-for-age, development and vital parameters. Be alert for signs of congenital anomalies (i.e. heart defects), non-communicable (developmental delay and tumours) and infectious diseases (hepatosplenomegaly and lymphadenopathy).
5		Ask for vision and hearing problems; perform a routine vision and hearing screen.
6		Examine the entire skin and oral cavity and be alert for signs of anaemia, scabies, impetigo, malnutrition, tooth decay and scars.
7		Check immunisation status and - if unknown or incomplete - start catch-up immunisations according to national recommendations as soon as possible.
8		Take a blood sample to measure a) haemoglobin to check for anaemia and treat iron deficiency if present b) HBV-antibodies (Hbs-Ag, anti-Hbs and anti-HBc)

		ADD a) if risk factors or signs for nutritional rickets: Vitamin D b) if from sub-Saharan Africa: Schistosomiasis* serology and CCA urine test c) if from sub-Saharan Africa or known risk: HIV serology or PCR d) if febrile: Malaria screen e) if immunosuppression known or foreseen: Strongyloides serology f) if sexually active or abused: Syphilis serology **OPTIONAL** g) HCV-antibodies
9		Perform a tuberculosis screening for latent infection (tuberculin skin test/ interferon-gamma release assays) followed by chest x-ray if either test is positive in: a) all migrant children < 5 years of age b) migrant children from a high-endemic country including but not limited to sub-Saharan-African region, Afghanistan, Somalia/Eritrea
10		Treat empirically for intestinal parasites with albendazole in children > 2 years and > 10 kg.
11		Schedule a follow-up appointment for catch-up immunisations, screen for mental health risk factors and symptoms, female genital mutilation and coordinate ongoing care needs the child may have.
12		Provide the parent/caregiver with a document of the health assessment and interventions and store a copy of this in your records. If available and compliant with data protection law of your country, also store health care related information in encrypted digital form enabling both migrants and healthcare institutions to have fast and secure access.

Schrier L et al , EJPE 2019

Evidenz für die häufige Probleme

Table 3 Estimated prevalences (%) and 95% CI (%) of selected conditions among refugee children 0–18 years from all regions on entry in reception countries

	Prevalence estimates, %	95% CI	Studies, n	Participants, n
Anaemia and genetic disorders of the red blood cells				
Anaemia	13.7	(8.7 to 19.7)	14	14632
Haemoglobinopathy	3.7	(0.2 to 10.5)	4	5400
Infectious diseases				
Hepatitis B	2.6	(1.6 to 3.7)	16	19196
Hepatitis C	0.2	(0.0 to 1.2)	5	1415
HIV	0.03	(0.00 to 0.25)	4	2165
Active TB	0.2	(0.0 to 0.5)	19	162100
LTBI (IGRA)	11.3	(9.4 to 13.3)	4	3291
LTBI (Mantoux)	19.3	(11.0 to 29.3)	8	33317
Schistosomiasis	3.5	(5.6 to 14.4)	10	3393
Strongyloidiasis	10.4	(4.3 to 17.7)	3	3733
Intestinal infections	31.0	(22.1 to 40.6)	15	12723
Malaria	2.58	(0.7 to 5.4)	6	2408
Growth, nutrition and micronutrient deficiencies and lead poisoning				
Vitamin D deficiency	3.3	(0.1 to 7.5)	3	732
Vitamin D deficiency	44.6	(27.7 to 62.2)	7	3715
Wasting	8.8	(6.5 to 11.4)	15	9167
Stunting	17.2	(9.4 to 26.5)	7	2293
Overweight	10.8	(7.6 to 14.3)	6	7838
Obesity	5.7	(1.9 to 11.4)	4	8538
Elevated blood lead level	6.1	(2.4 to 11.0)	8	5898
Vaccine coverage				
Immunity for rubella	72.4	(45.3 to 92.9)	2	256
Immunity for measles	70.2	(30.7 to 97.2)	2	402
Immunity for hepatitis B	63.0	(51.1 to 74.2)	3	1802

Baauw A et al, BMJ pediatrics open 2019

Impfungen Nachholen

Region	All regions	Africa All	North Africa	Sub-Saharan Africa	Asia	Middle East
Immunity for vaccine preventable diseases						
Immunity for rubella	72.4%				84.6%	
95 CI	(45.3 to 92.9)					
256	2	0	0	0	1	0
N	256				59	
Immunity measles	70.2%				86.8%	
95% CI	(30.7 to 97.2)					
Studies	2	0	0	0	1	0
N	402				228	
Immunity hepatitis B	63.0%				50.2%	
95% CI	(51.1 to 74.2)					
Studies	3	0	0	0	1	0
N	1802				241	

Baauw A et al, BMJ pediatrics open 2019

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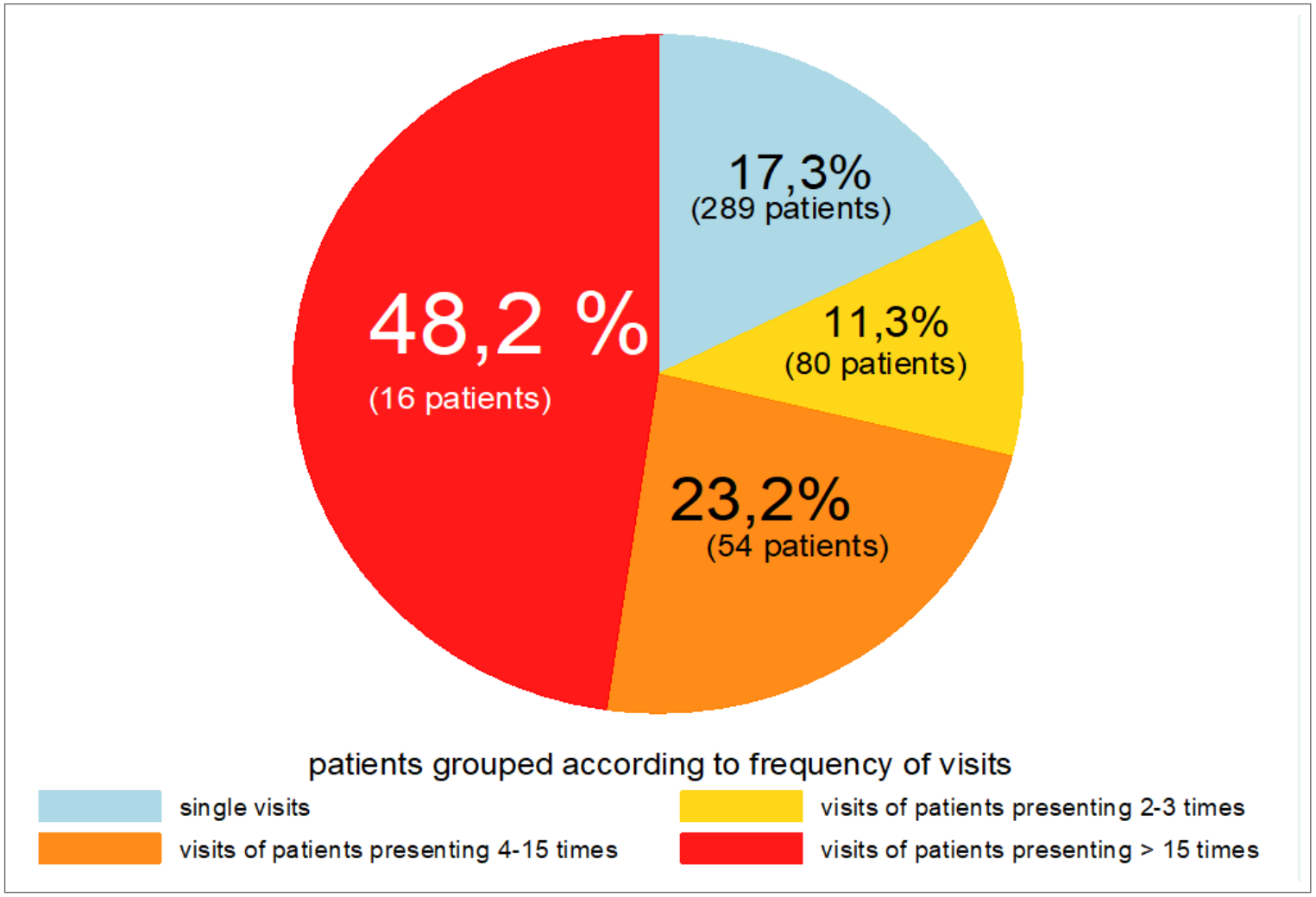
Wenige Patienten mussten häufig betreut werden



Buser S, Brandenberger J et al (under review)

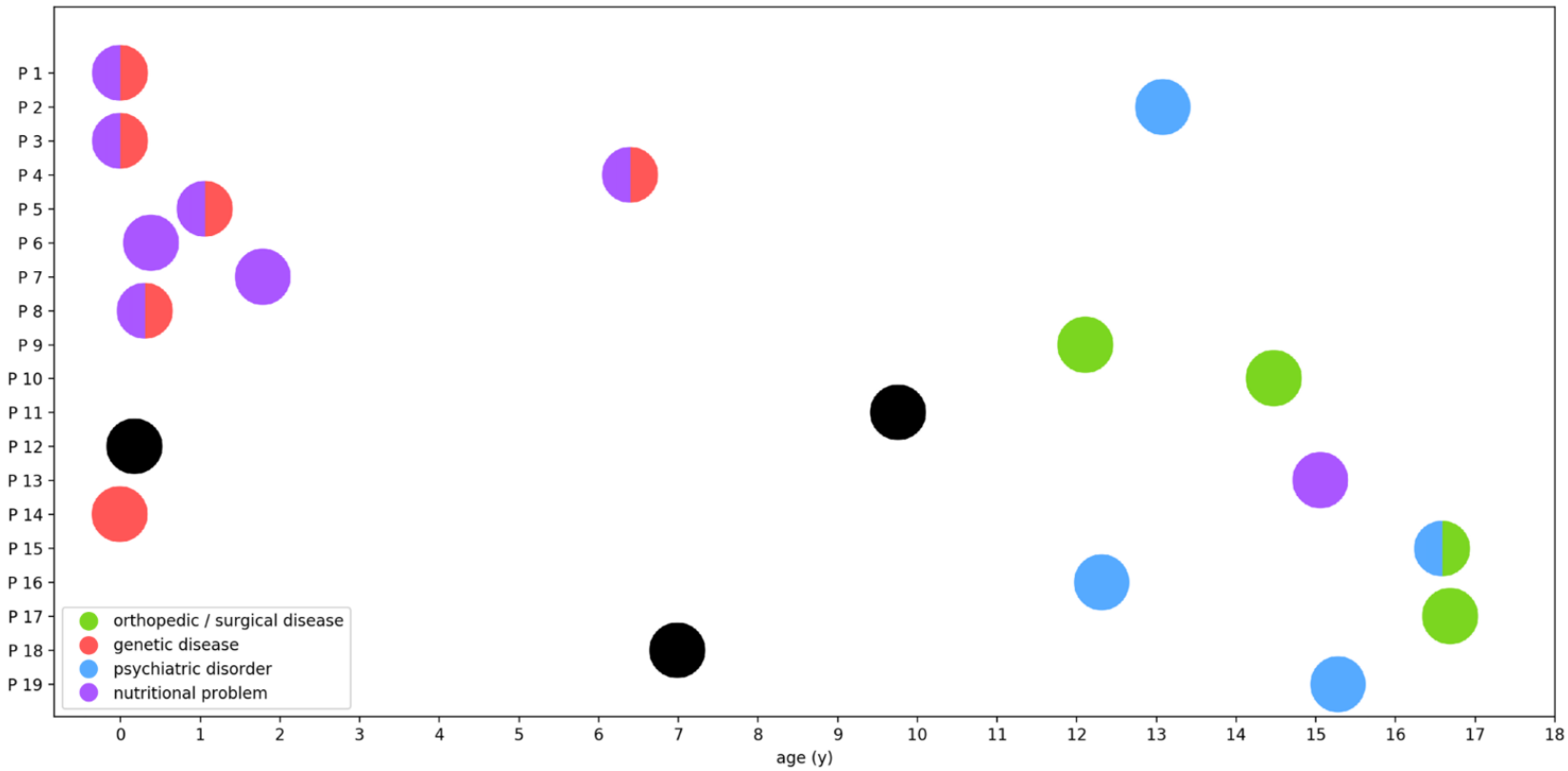
Asylsuchende haben auch seltene Erkrankungen

	P1	P2	P3	P4	P5	P6	P7	P8	P9	P10	P11	P12	P13	P14	P15	P16	P17	P18	P19
Gender	f	f	m	m	f	m	m	f	m	m	m	m	m	f	m	m	m	f	m
Time between arrival and first visit (days)	0	153	0	0	1	1	89	0	3	178	3	61	0	0	13	22	366	1	5
Humanitarian visa	-	no	-	yes	yes	yes	ns	yes	ns	no	ns	ns	no	-	no	no	no	no	no
Child accompanied by	-	op	-	bp	bp	bp	bp	bp	-	bp	bp	bp	UMR	-	UMR	op	UMR	bp	bp
Distance from last documented address to hospital (km)	1.5	64	16	1.7	1.7	3.7	5.5	1.5	3.7	15	4	18	2.3	0.8	2.4	34	67	4.4	3.5
Total n. of addresses documented	1	1	1	4	4	2	1	3	2	1	1	2	2	2	2	2	2	3	3
Family present in host country	bp	bp	bp	bp	bp	bp	bp	bp	ns	bp	bp	bp	UMR	bp	UMR	bp	UMR	bp	bp
Number of siblings	1	1	3	2	2	1	2	0	ns	2	1	ns	>5	1	3	>5	ns	ns	1
Siblings in treatment	yes	no	yes	yes	yes	no	yes	no	no	yes	no	no	no	yes	no	no	no	no	yes
Primary care physician	Ped	GP	Ped	Ped	Ped	Ped	Ped	Ped	Ped	Ped	none	Ped	GP	Ped	GP	GP	GP	Ped	none
Hospital social worker documented	yes	yes	yes	yes	yes	yes	no	yes	no	no	yes	no	yes	yes	yes	yes	no	yes	yes
Main diagnosis	Noonan-like syndrome	Depression with attempted suicide	Laron-Sydrome	Mitochondriopathy	Mitochondriopathy	Marasmus	Failure to thrive of unknown origin	Turner syndrome	Chronic wound infection	Osteochondrosis with chronic pain	Ependymoma	Scalding	Cystic pneumpopathy of uknown origin	Arthrogryposis	Osteomyelitis foot with superinfection	Type 1 diabetes	Severe scoliosis	Complex congenital heart disease	B-cell ALL
ICD-10 of main diagnosis	Q87.1	F32	E34.3	G31.81	G31.81	E41	R62.8	Q96.1	T79.3	M92.5	C72	X19.9	J98.4	Q74.3	M86	E10.1	M41.15	Q21.8	C91.01
Country of first main diagnose	CH	CH	CH	CH	CH	CH	CH	CH	CH	CH	CH	CH	IT	CH	CH	SA	CH	RU	AM

ns = not specified; op = one parent; bp = both parents; UMR= unaccompanied minor refugee; PED= paediatrician; GP= general practitioner;
CH= Switzerland; IT= Italy; SA=Saudi Arabia; RU= Russia; AM= Armenia

Buser S, Brandenberger J et al (under review)

Genetische Erkrankung und schwere Ernährungsstörungen



Buser S, Brandenberger J et al (under review)

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Wo liegen die Herausforderungen

- **Medizinisch**
- **Nicht-medizinisch**

Brandenberger et al. BMC Public Health (2019) 19:755
https://doi.org/10.1186/s12889-019-7049-x

BMC Public Health

RESEARCH ARTICLE Open Access

A systematic literature review of reported challenges in health care delivery to migrants and refugees in high-income countries - the 3C model

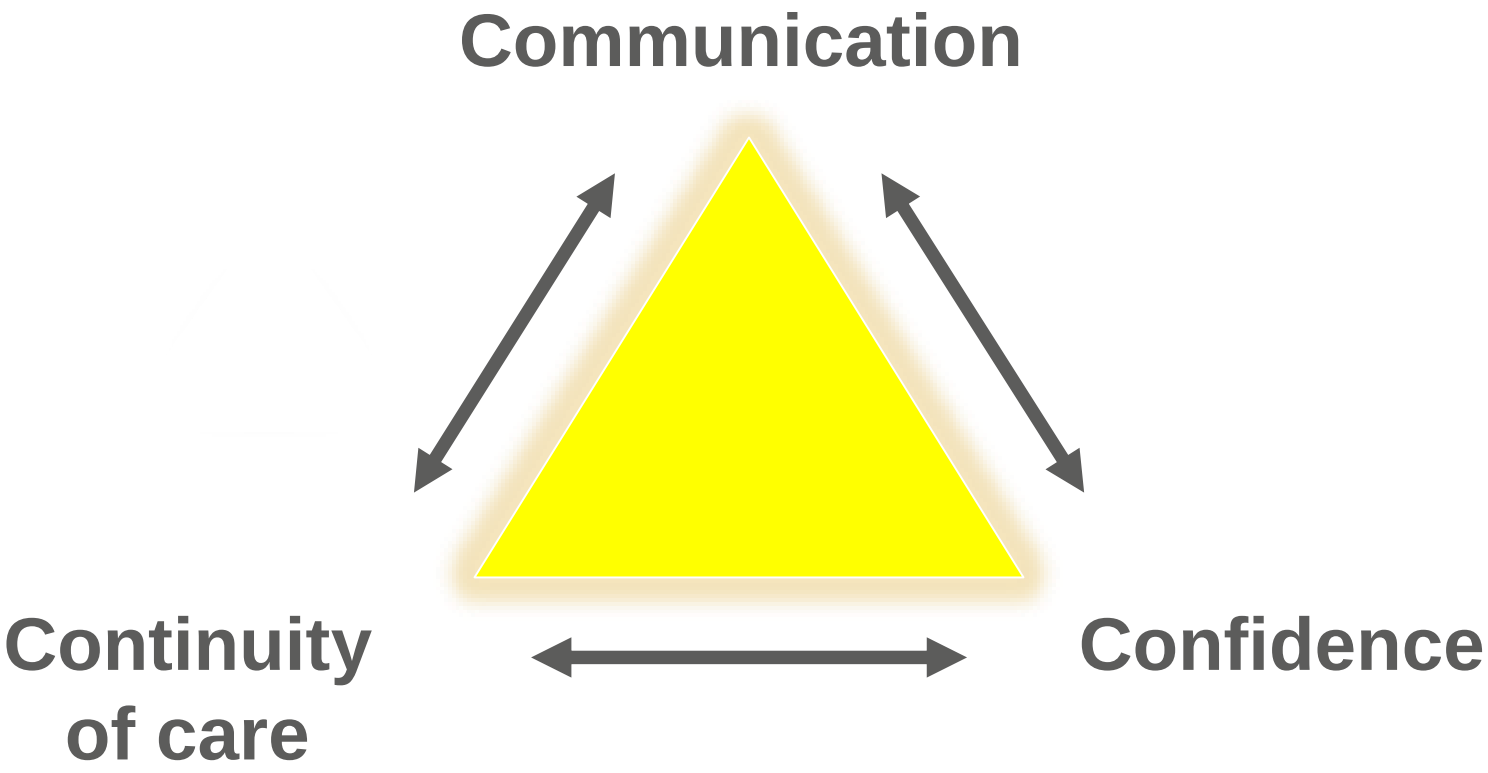
Julia Brandenberger[1,2,3,4*], Thorkild Tylleskär[5], Katrin Sontag[3,6], Bernadette Peterhans[2,3] and Nicole Ritz[1,3,7,8]

Abstract

Background: Migrants and refugees have important health needs and face inequalities in their health status. Health care delivery to this patient group has become a challenging public health focus in high income countries. This paper summarizes current knowledge on health care delivery to migrants and refugees in high-income countries from multiple perspectives.

Methods: We performed a systematic literature review including primary source qualitative and quantitative studies between 2000 and 2017. Articles were excluded if the study setting was in low- or middle-income countries or focused on skilled migration. Quality assessment was done for qualitative and quantitative studies separately. Predefined variables were extracted in a standardized form. Authors were approached to provide missing information.

Nicht medizinische Herausforderung



Brandenberger J et al, BMC Public Health (2019)

Kommunikation

Bedarf für Dolmetschende erkennen

Wann werden professionelle Dolmetschende eingesetzt?
- Wenn eine Fachperson oder die Patientin/der Patient dies als notwendig erachtet
- Wenn die Verständigung eingeschränkt oder nicht möglich ist

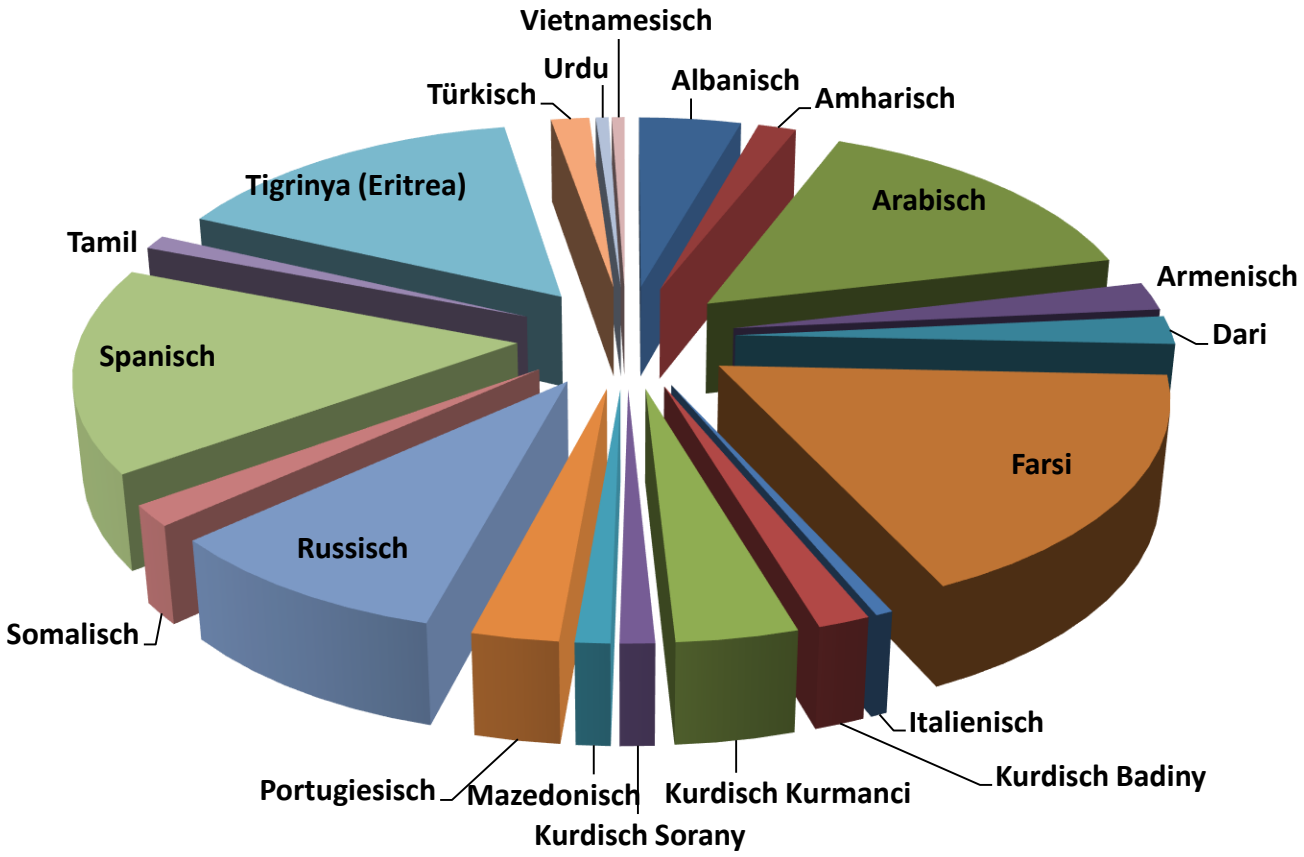
und bei
- Anamnese, Assessment
- komplexen diagnostischen Massnahmen und bei Einverständniserklärungen
- Besprechung der Diagnose und Therapie
- Patientenedukation, Beratung, Austrittsplanung

Art des Dolmetschenden entscheiden

Wann werden Dolmetschende eingesetzt [1] ?

Professionelle Dolmetschende vor Ort				Professionelle Dolmetschende telefonisch	Ad-hoc Dolmetschende
gering	← Dringlichkeit →	hoch			
Dringlichkeit ist wichtigstes Kriterium, andere sind nachrangig!					
gut	← Planbarkeit →	schlecht			
lang	← Dauer →	kurz			
hoch, abstrakt	← Komplexität →	tief, konkret			
hoch	←Tragweite/Konsequenz für den Patienten →	gering			

Dolmetscherdienst UKBB Telefon 2016



Sprache	Gesprächs-dauer in Min.
Albanisch	99
Amharisch	36
Arabisch	381
Armenisch	40
Dari	57
Farsi	411
Italienisch	12
Kurdisch Badiny	36
Kurd. Kurmanci	75
Kurdisch Sorany	20
Mazedonisch	20
Portugiesisch	67
Russisch	308
Somalisch	38
Spanisch	14
Tamil	37
Tigrinya (Eritrea)	374
Türkisch	32
Urdu	38
Vietnamesisch	10
Total	**2105**

Wie sieht Vertrauen aus?

“ In all of my work, I seek the moments when ordinary people are at their most extraordinary, their most special, and most purely themselves - to distill the essence of who they are in a single image. “

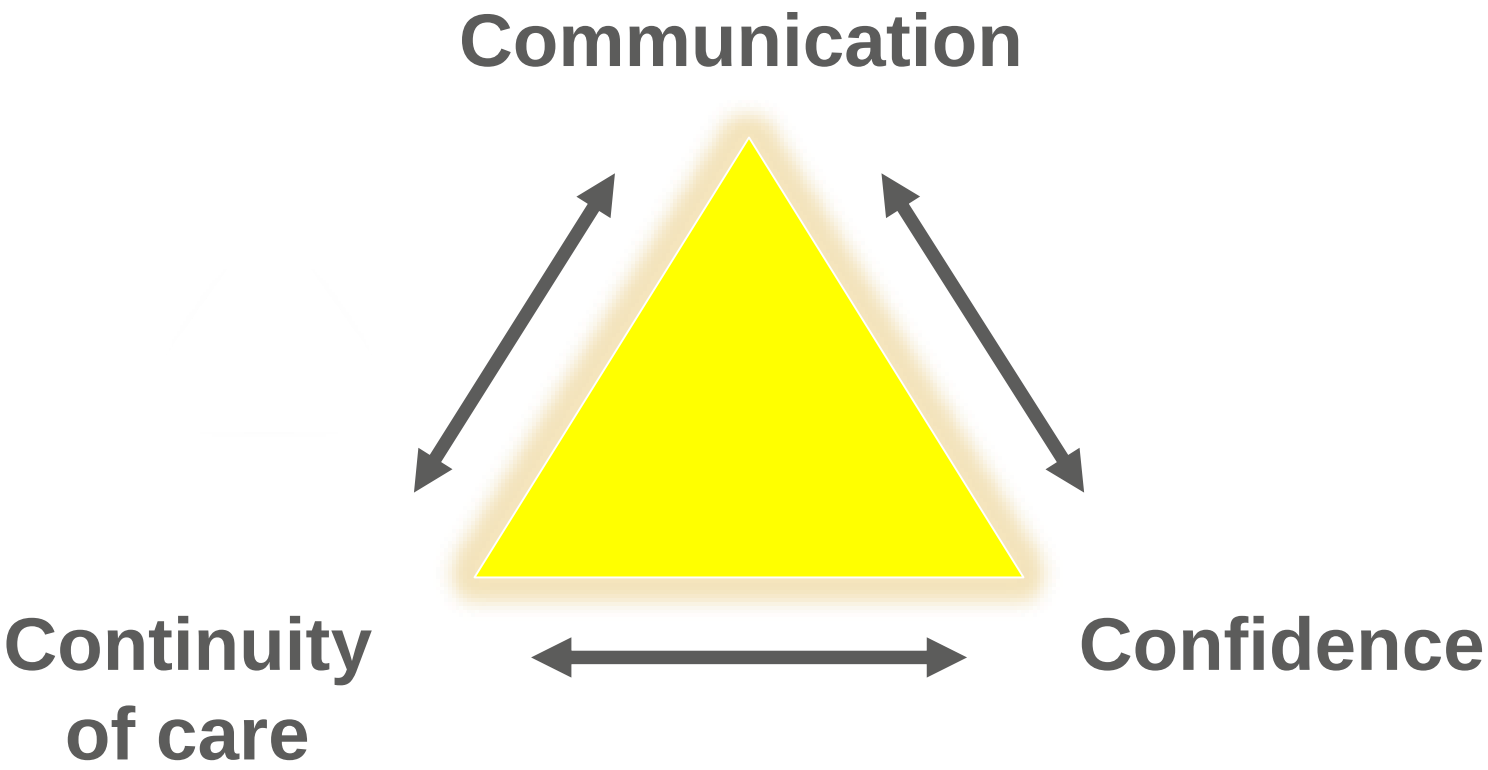
https://www.heatherperryphoto.com/bio

Faces of conficence

Heather Perry

Und im Spital?

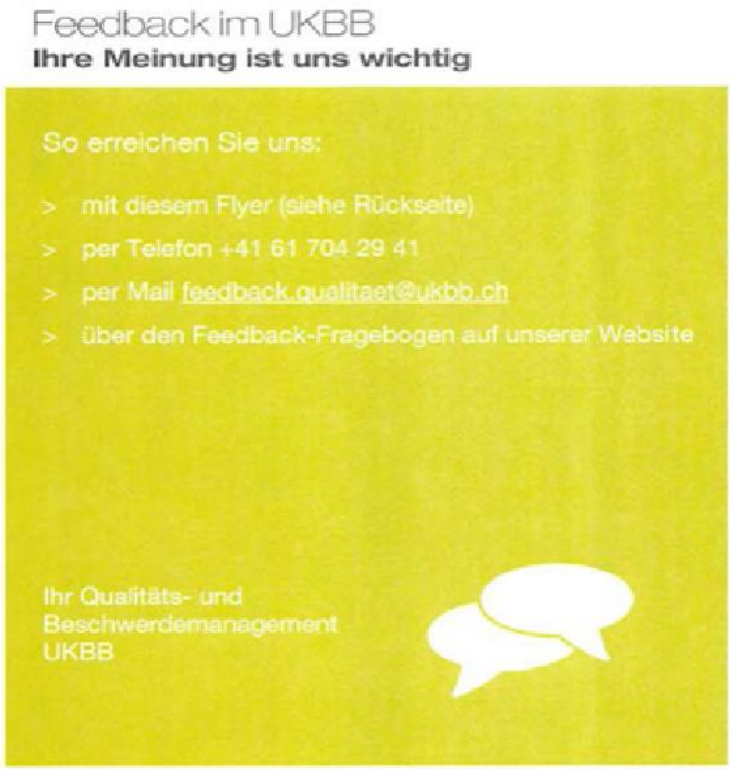
Nicht medizinische Herausforderung



Brandenberger J et al, BMC Public Health (2019) 19:755

Was denken die Eltern von asylusuchenden Kindern von uns

- Eltern von Asylsuchenden Patienten
- Semi-strukturierte Interviews, Dauer 1h
- Mit Präsenzdolmetscher Transkription ins Englische
- Auswertung nach Standards für qualtitative Forschung



Bandenberger J et al, BMJ open 2019

Continuity of care

“I thought she would get a lot of medication, as she had fever. But no: they only gave this suppository to her. […] They said: don’t be frightened, your daughter will be fine. She just needs time to recover. And that was the right way. I went back, and that was right. So that is an ideal doctor to me: Who knows exactly what happens, without giving too many drugs. “

Bandenberger J et al, BMJ open (2919) *in press*

Schlusswort

In der Migrationsmedizin gibt es viel zu tun

UKBB Kommunikation, 17.09.2019

Während der Bund derzeit Asylzentren in der Schweiz schliesst, kehrt in der Migrationsmedizin vorerst keine Ruhe ein. Es gilt die geflüchteten und in der Schweiz aufgenommenen Kinder und Jugendliche aus anderen Ländern zu betreuen und in unser Gesundheitssystem zu integrieren. Dr. Julia Brandenberger trägt mit ihrer Forschung im Team von PD Dr. Nicole Ritz am UKBB dazu bei, dass dies immer besser gelingt.

von Aline Eberle und Martin Bruni

https://www.ukbb.ch/de/blog/