‘May I get asylum for my diabetes?’

A fter stabilising his diabetic ketoacidosis and switching to subcutaneous insulin therapy, a 15-year-old Hispanic male was started on learning about type 1 diabetes mellitus with the help of the hospital diabetes educator and a certified Spanish language interpreter. The patient had been transferred from a refugee special campus while waiting for his deportation from the United States. He had no parents or family members with him in the country and was found to be illiterate. The patient not only could not speak English, but also could not write or read Spanish. This created a major challenge since he could not read medication labels or count his insulin units.

The patient stayed in the hospital for 10 days post-stabilisation while social service staff worked extensively with the immigration authorities to arrange for his diabetes care. An employee at the immigration campus, where the patient used to stay, volunteered to help, acknowledging that she has type 2 diabetes herself. She came to hospital to learn about his diabetic care. The patient was discharged back to the campus.

A detailed discharge summary was provided to the immigration authorities explaining the diagnosis and management plan for type 1 diabetes in this patient. A temporary protection status was given to the patient to allow him to remain in the United States and he was seen for follow-up visit one month after discharge.

Discussion

Illegal immigration remains not only a political, economic and social problem, but also a major medical one.1 A comparative study of country policies in the European Union (EU) noticed that medical screening was provided to asylum seekers in all European countries except in Greece.2 The same study concluded that health policies towards asylum seekers differed significantly between EU countries and may cause deficiencies in meeting the health needs of asylum seekers.2 Priorities are usually given for the prevalence of any infectious disease. A detailed British study on the health needs of asylum seekers and refugees highlighted the need for trained interpreters, support from community organisations and the high importance of providing support and protection for children, especially unaccompanied minors.3 Another British study called on the UK National Health Service to provide equal access to health care to asylum seekers and refugees rather than using health policy as a means of enforcing immigration policy.4 There are few studies specific to diabetes and asylum seekers. An American study from Massachusetts analysed chronic disease and its risk factors among refugees and asylees in that State. The study found that almost half of the sample (46.8%) was obese or overweight and 12.8% had diabetes.5

A study from The Netherlands evaluated specifically the diabetes prevalence in asylum seekers. The study found that the prevalence rate of diabetes was higher in asylum seekers compared with the reference population.6 Post-traumatic stress disorder was suggested as a risk factor for developing type 2 diabetes among asylum seekers in another Dutch study.7 This public health issue has led to the need for increased diabetes resources in hosting countries.6,7 The recent death of a Syrian refugee child with type 1 diabetes during sea crossing after her traffickers destroyed her insulin has alerted the public to the importance of understanding type 1 diabetes and insulin therapy.8 The attitude of health care providers remains of great importance in dealing with the medical problems of illegal immigrants and asylum seekers. Language barriers are a major obstacle in addressing health care.9 Many health care providers understand the social, economic and language barriers that they may face while treating illegal immigrants but they feel that medical care should not be discriminatory against them. A British study argued that physicians should not allow the denial of health care to be used as a tool of immigration policy.10 The ethical and moral aspects of medicine have always been called for by British physicians.4

There are no global studies about the outcome of health asylum related to diabetes, specific diagnoses or specific age groups. A French study conducted a survey of French public health medical officers and found some subjectivity of health asylum outcome based on health causes.11 A study about the asylum grant rate among US asylum alleged maltreatment, and sometimes torture in the country of origin, found that asylum seekers who received medical evaluations from physicians for human rights (PHRs) had a much higher grant rate of 89% compared to the national average of 37.5% among asylum seekers who did not receive such evaluation.12 This may argue for the need of a complete physical assessment for health asylum seekers from an independent medical source.

Conclusion

The increased prevalence of type 1 and type 2 diabetes globally has created an increased burden on countries targeted by illegal immigration. This leads to the need for a greater understanding of diabetes management and therapies, and allocating enough resources to prevent diabetes-related complications and deaths.

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References

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