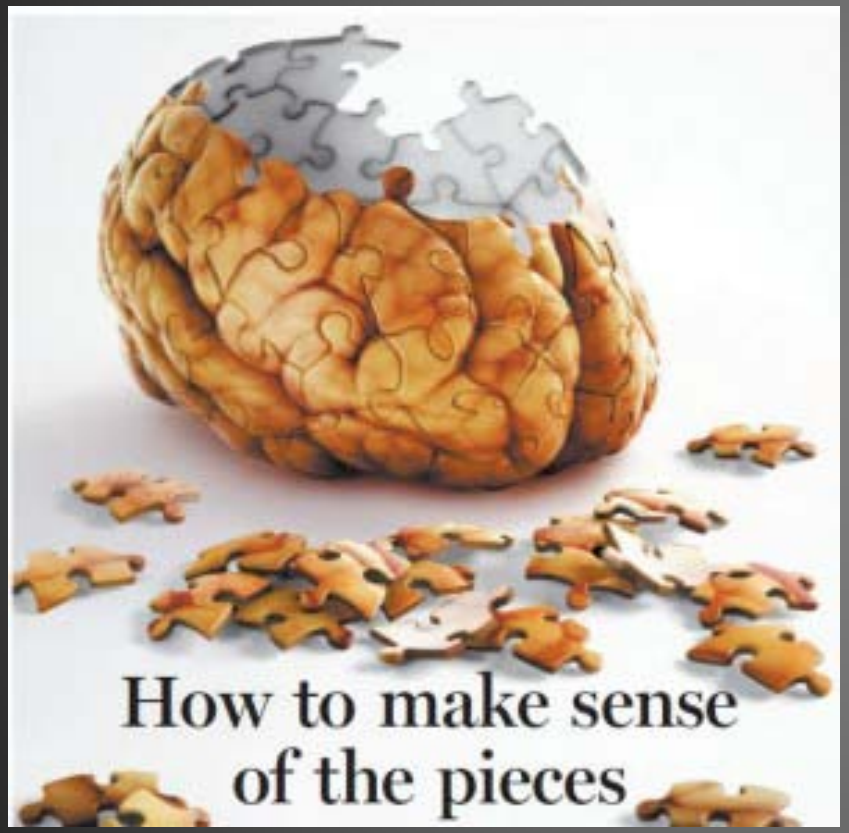
Global and refugee health

Inaugural seminar

18 March 2011

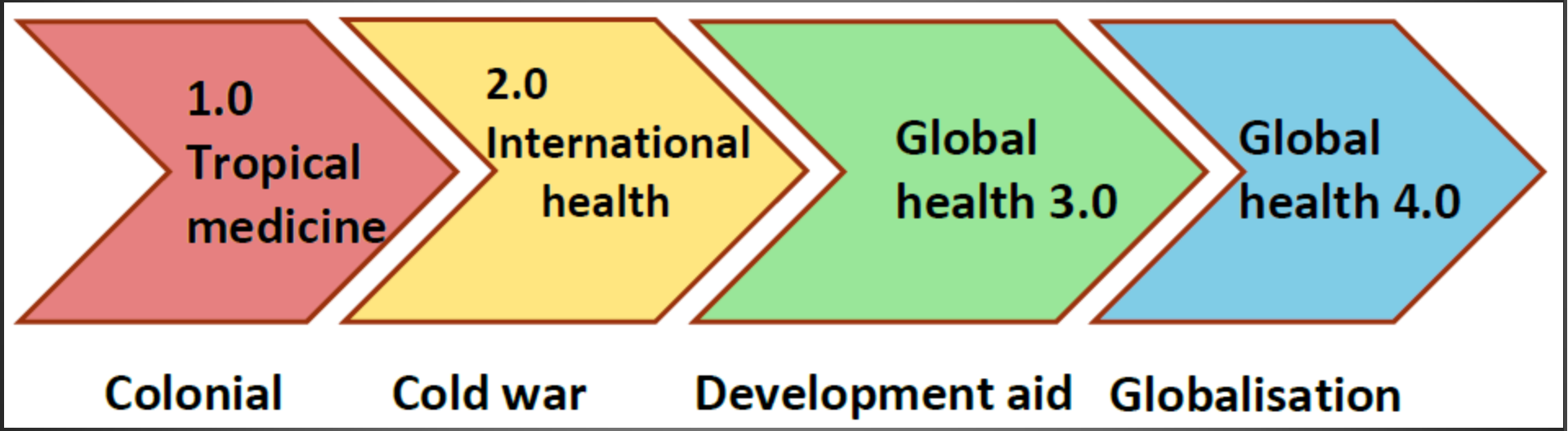
- 14.00-14.05 Welcome by **Ole Skøtt**, Dean, Professor, the Faculty of Health Sciences, University of Southern Denmark
-
- **Cancelled** "Global and refugee health in a post conflict area of Northern Uganda" by **Emilio Ovuga**, Ph.D., Dean, Faculty of Health Sciences, Gulu University, Uganda
-
- 14.05-15.00. "There is no brain in the system: The anthropology of international health" by **Peter Aaby**, professor, The Bandim health Project, Guinea-Bissau and The State Serum Institute, Denmark
-
- 15.00-15.50 "Maybe life is worth living after all: human security and human health in a global context" by professor **Morten Sodemann**

Making sense of global health



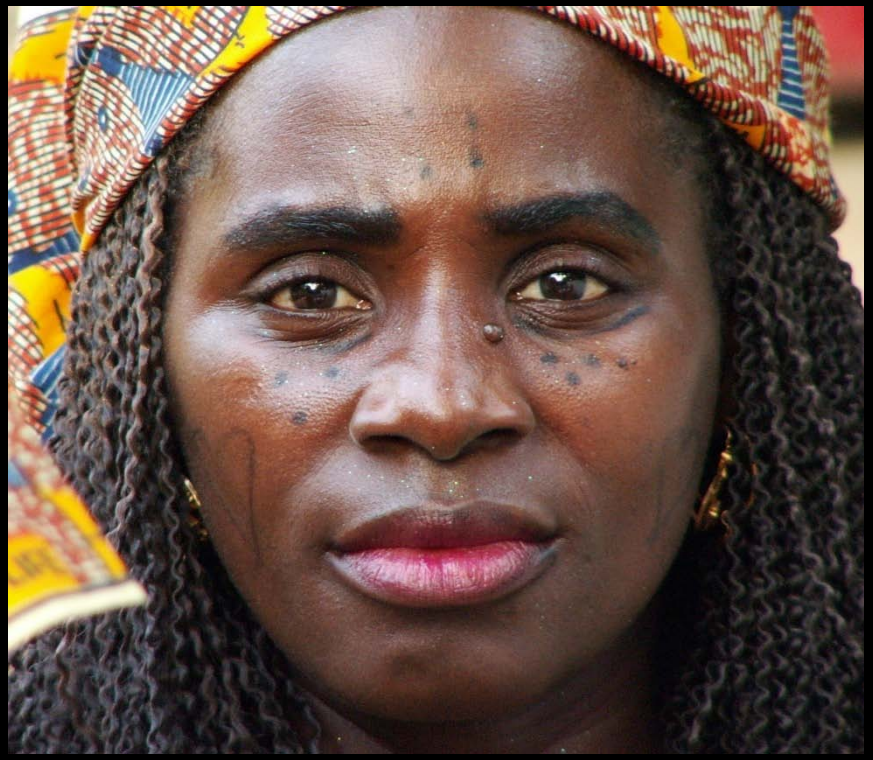
- Has medical science passed away?
- Or does it just smell funny because Trojan social scientists like Peter Aaby and other have created anxiety and confusion in biomedical research?

Global health 4.0

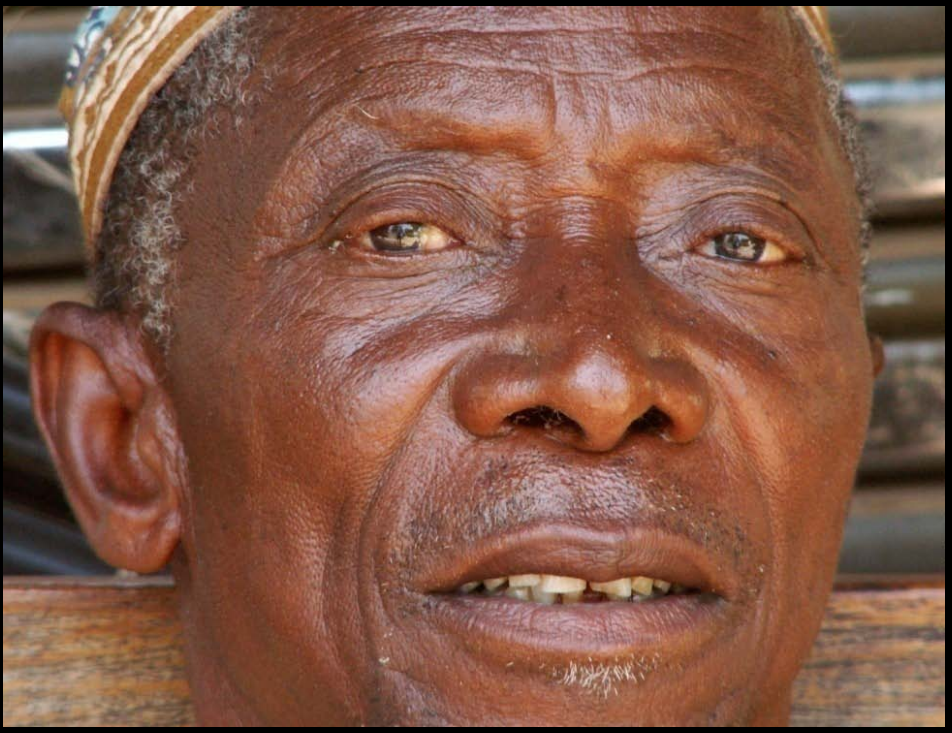


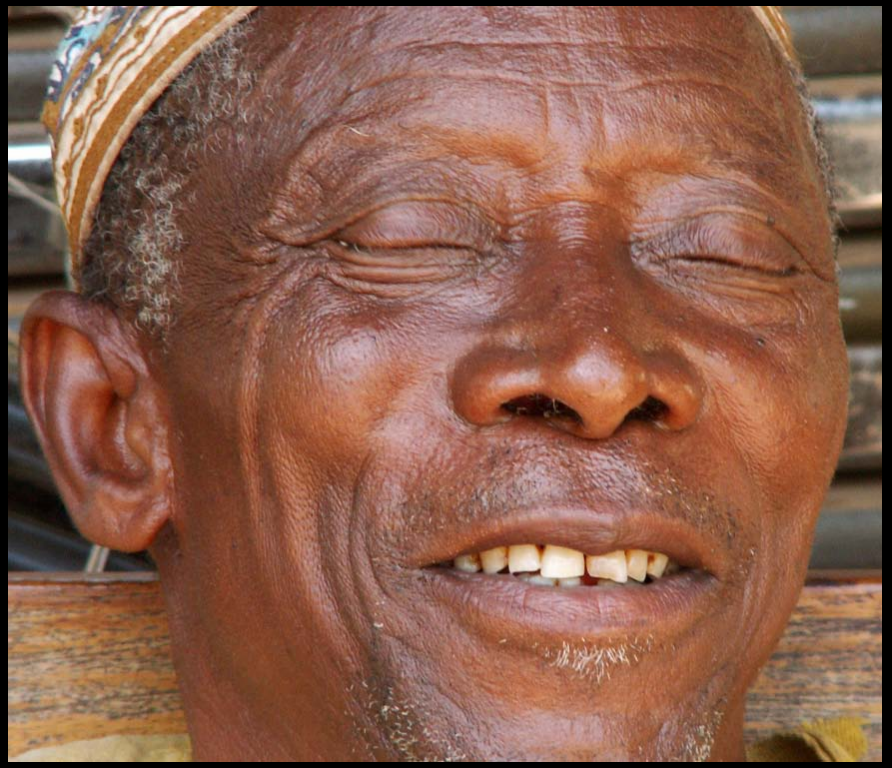
Free mental first aid

”Maybe life is……..



”..... worth living





After all?”

Quote from patient after first visit to the migrant health clinic

Why are we here today?

It’s all about early exposure:

Counting rats that keep disappearing in dark cellars

OR

Picking up and analysing experience real time in real life

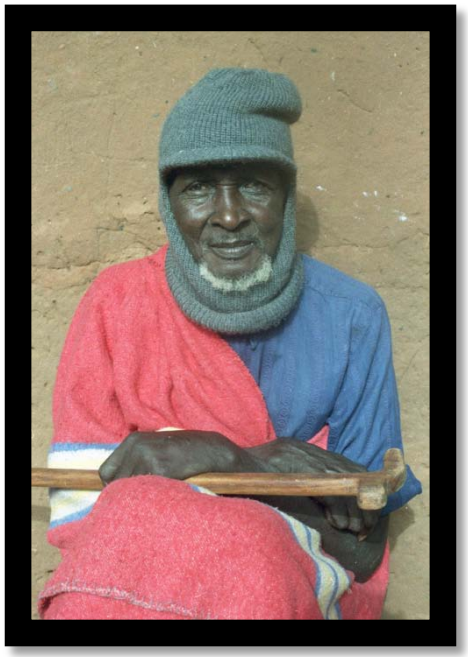
Foto: Eskestad Mik

Why do patients contract and risk dying from preventable and treatable diseases?

- Early exposure to an ”Out of The Box Experience”
- Early exposure to programme fashions and failures
  - Immunizing children, household interviews
  - Care seeking in severe diarrhoeal disease & fatal illness (450 interviews)
- The role of donors, decision makers and doctors
- Social capital and locus of control and fatal illness
- Health systems research
  - Armed conflict: where there is no doctor there is help, post war vacuum
  - Favouritism
  - Gulu, Uganda: post conflict health, the war after the war
- Bringing it home
  - Infectious diseases: no organ, lots of problem patients
  - Denmark: You have been to Africa – you look after them!
  - ENRECA health & MESU & Platform for Human Health
- ***Ethnic minority patients: Global health issue, Same clinical problems, same questions, same answers, same experience, same solutions – so***
- The Migrant Health Clinic & Global Health

Human security from cradle to grave:

Doctor: my patient doesn't understand me



- What is the role of governments, donors and health sectors in creating and sustainin health problems?
- What are patients actually trying to tell us and why don't they understand us?
- How do we carry out inclusive counting when we do research?

Some problems are just the same as ever…….

The fiction in common wisdom

”It is not the facts that have changed peoples attitudes and practices.

- on the contrary attitudes and practices have detached themselves completely from the facts”

Ilvo Diamanti, Italian sociologist, Information 2008

Humans detached from the system

”After all, we have to remind ourselves

that we should make room for
individual human beings

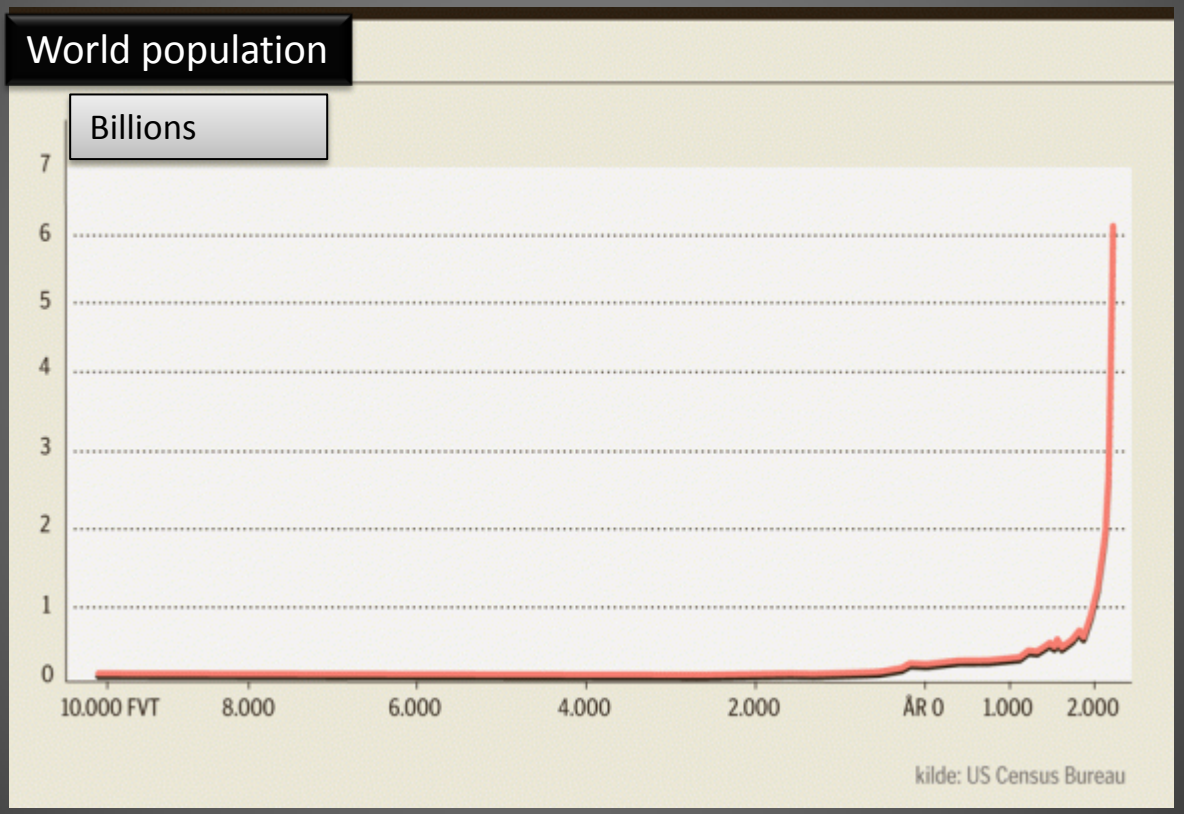
in the (wellfare) system”

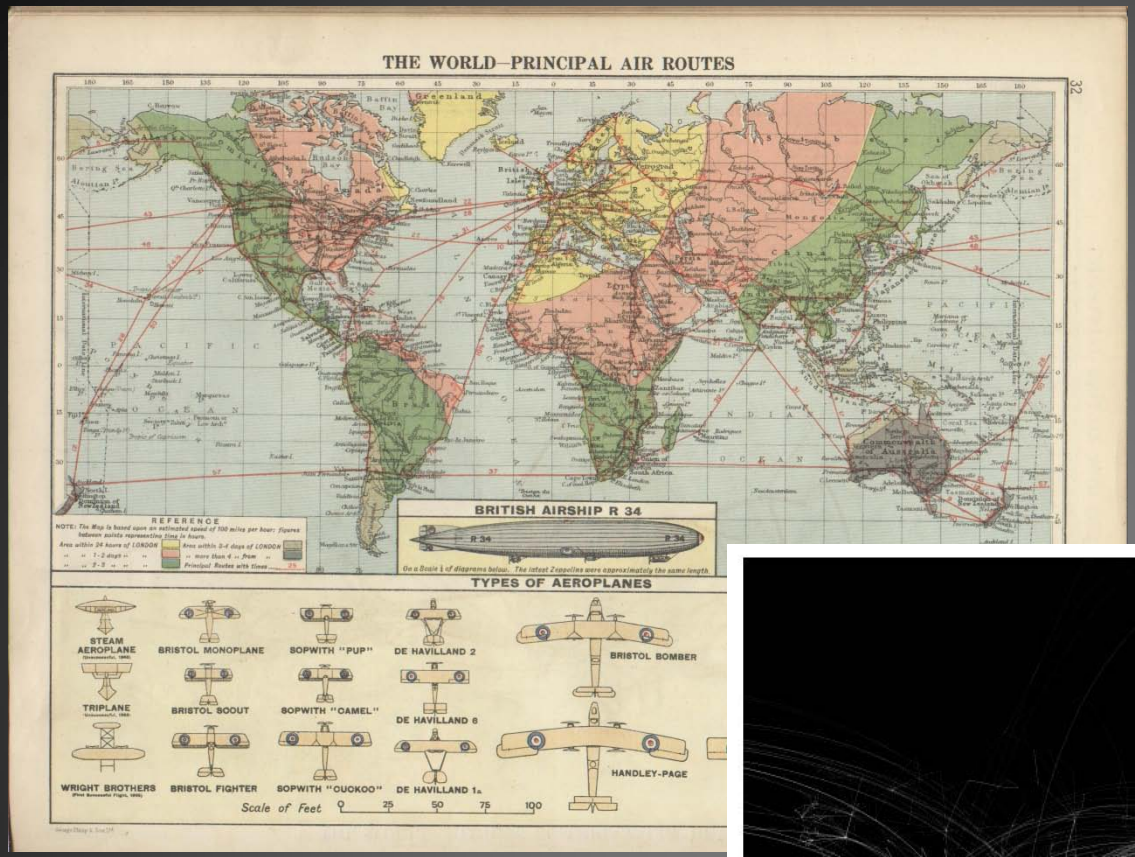
Minister of social welfare, Denmark, Danish national television, 26.4.2010

Granny dumping

Human beings mean trouble – where can I dump this patient?

0 to 1 billion took a thousand years
6 to 7 billion only took 12 years……





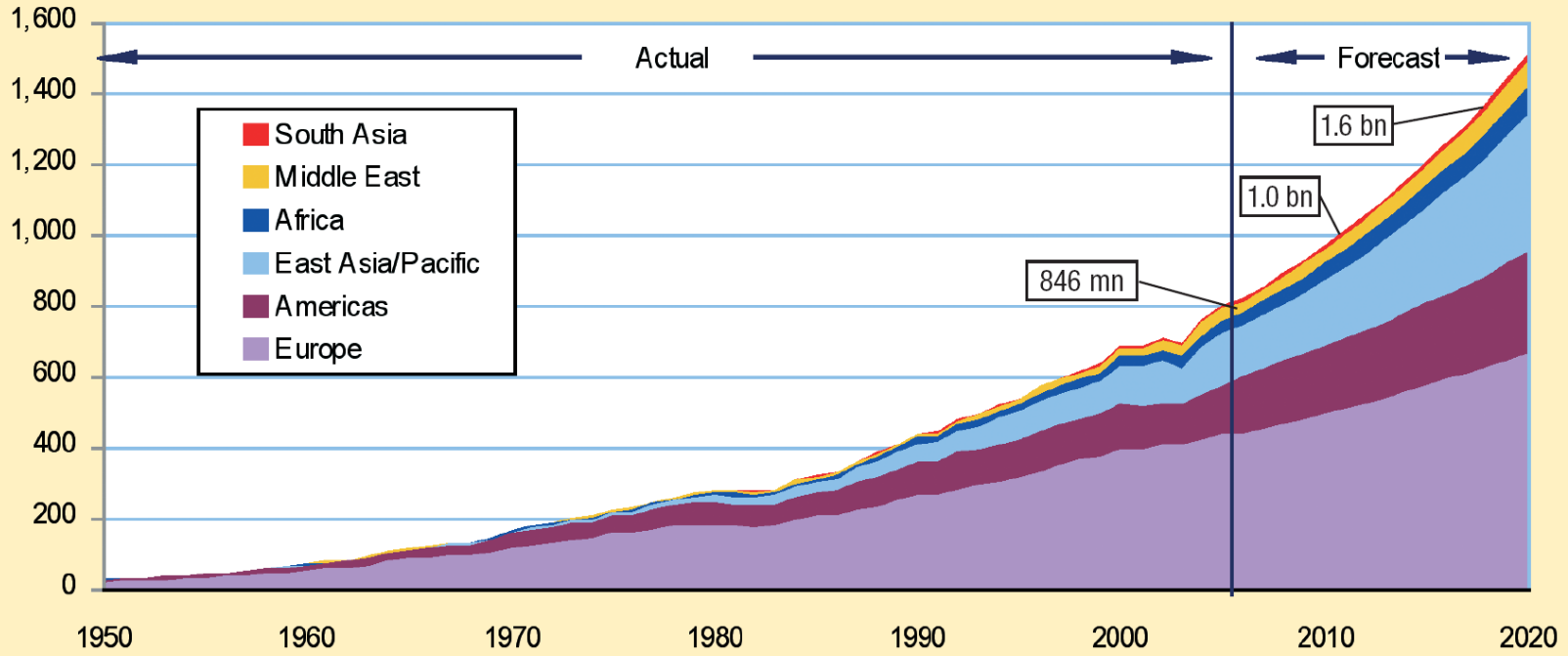
London geographical institute,
The peoples atlas, 1920

Mario Freese, ”Airlines”

Anywhere < 24 hours

And there is more to come

International Tourist Arrivals, 1950-2020

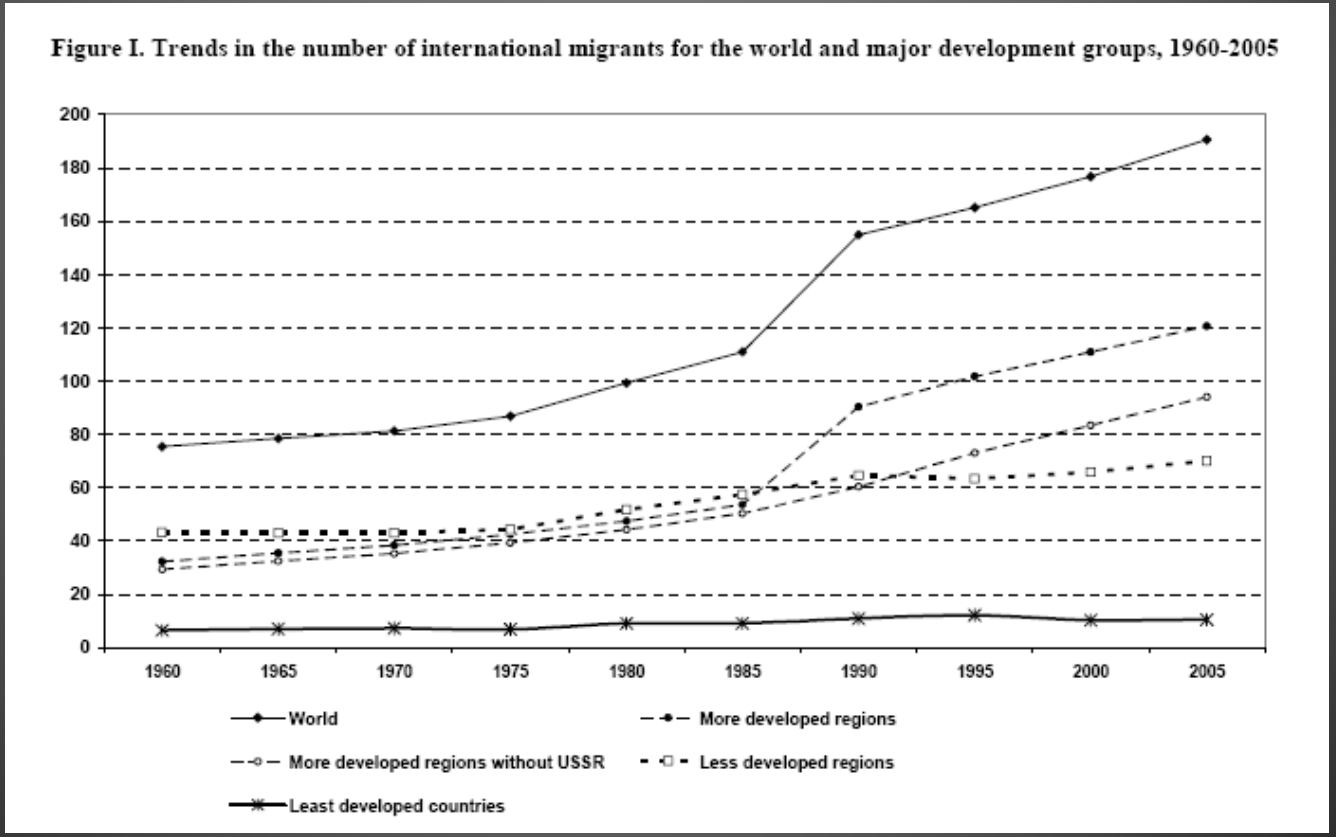


Source: World Tourism Organization (UNWTO) ©

Changing volumes of migration:

191 million migrants (3 %!) worldwide =

5th largest country



Trends in Total Migrant Stock: the 2005 Revision. Department of economic and social affairs, population division. POP/DB/MIG/Rev.2005/Doc February 2006. http://www.un.org/esa/population/publications/migration/UN_Migrant_Stock_Documentation_2005.pdf

Why is migrant health the sexiest way to explain global health?

It has everything a scientist could ask for:

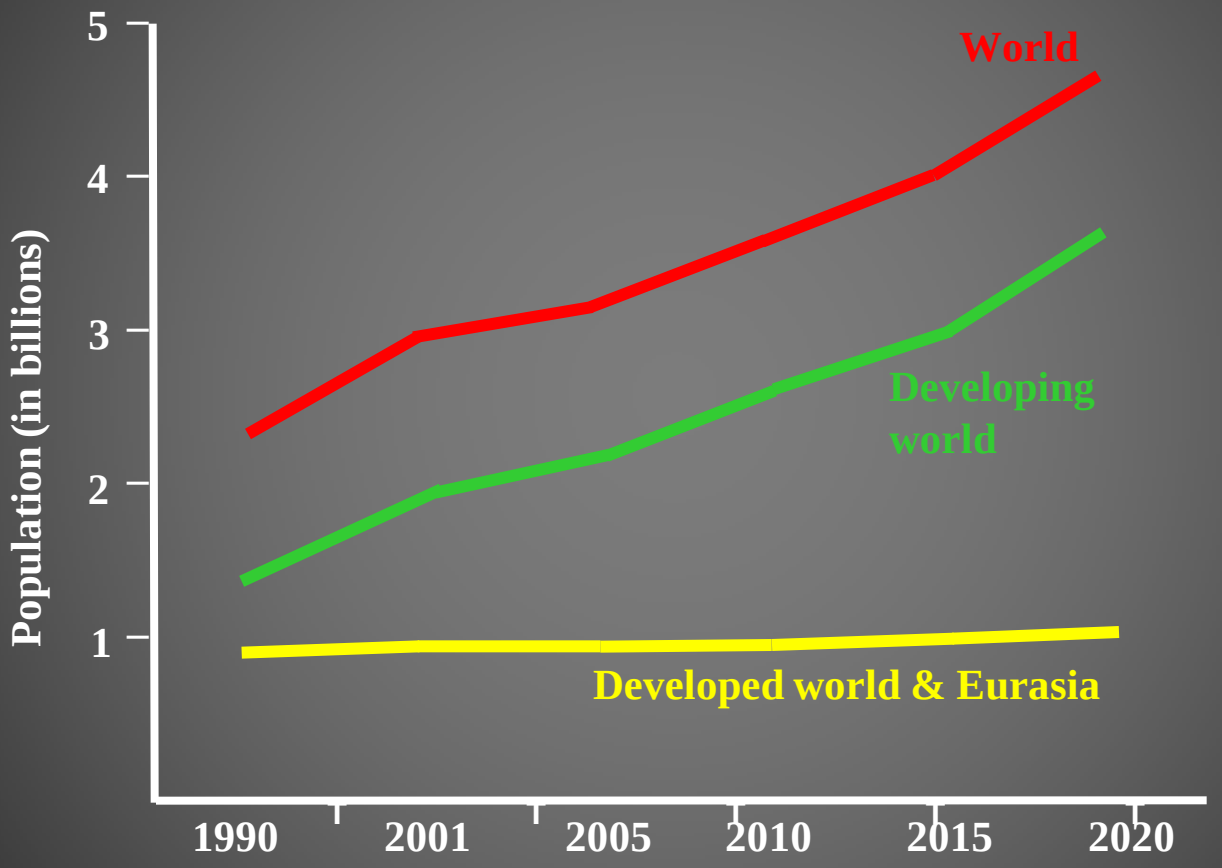
Migrant health is about human security: a global health model

- Climate
- Nutrition
- Education
- Gender
- Moral
- Religion
- Stigma
- Minority
- Prevention
- Treatment
- Health outcomes
- Rape as a weapon
- Hunters, war, apes, colonial power and sexworkers
- Knowledge into action
- Inequity
- Brain drain
- Fragile states
- Post conflict vacuum
- Health literacy and empowerment
- Catastrophic expenditures
- Food security

- Convenient presumptions
- Common wisdom
- Literacy vs. Illiteracy
- Unwarranted differences in quality of care
- Tuberculosis (SA & China)
- Diabetes and living conditions
- Double disease burdens
- Human rights
- Reproductive health
- Sex trafficing
- Brain drain
- Poverty
- Social determinants
- Decoding and translating values and concepts of health
- Health behaviour
- Never part of research
- Corruption
- Social torture
- Demographic and nutritional transition
- Transgenerational issues
- The global village idea

The global village….yes, but are we talking about the same village?

SLUM POPULATIONS



("Ideas on the Future of the World's Cities", P. Witcher, The World Urban Forum, UN Chronicle Online Edition. http://www.un.org/Pubs/chronicle/2006/issue2/0206p30.htm)

The right to count

- -and to BE counted
- - and to be counted RIGHT

Data or gut feeling

”You have the right to your own opinion but not to your own data”

Connie Hedegaard, former Danish minister for environmental affairs on global warming

The language of sterility

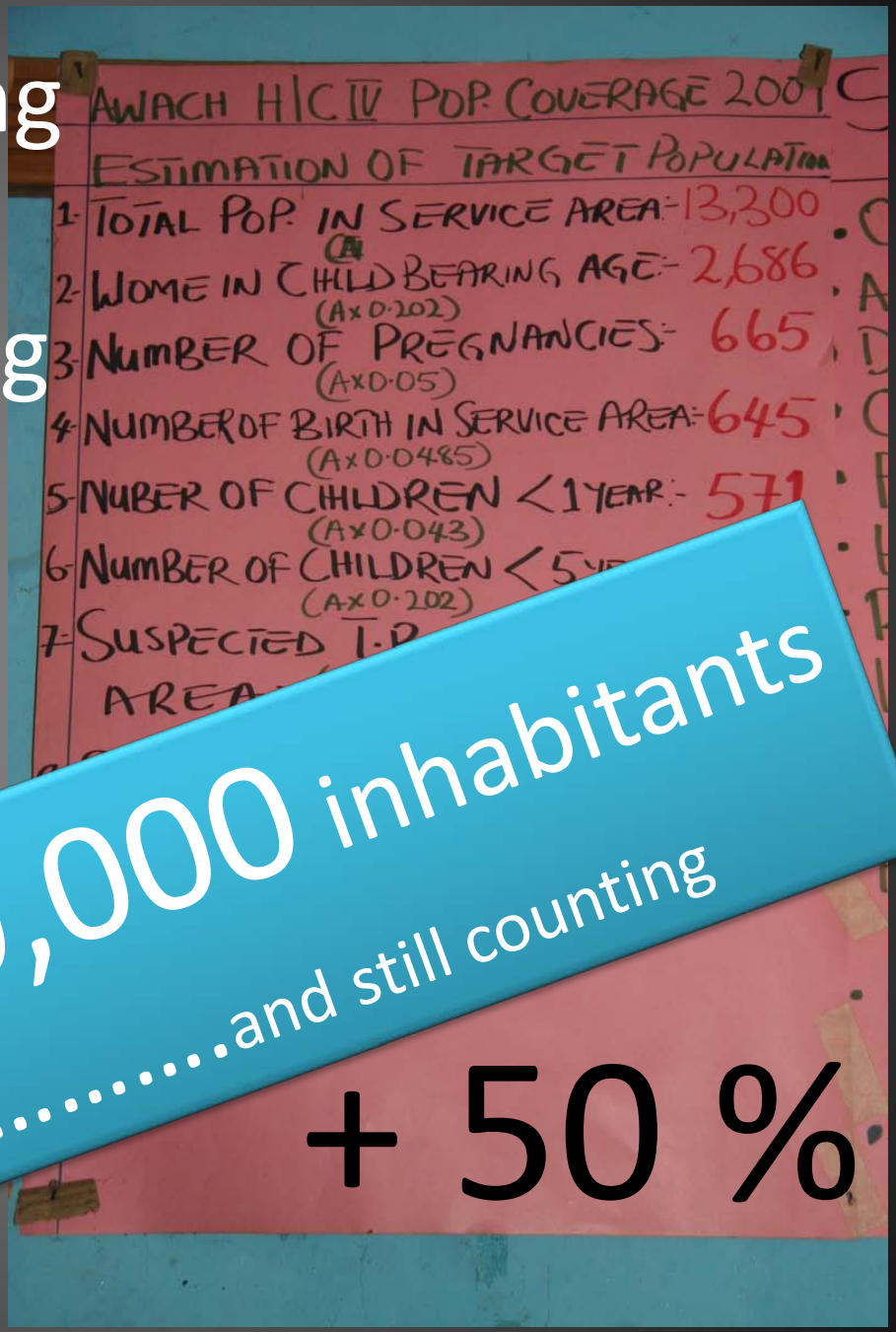
Think how casually we treat casualties of war:

victims, refugees and rapes

are just large numbers

Zainab Zaldi, ted.com, July 2010

Counting for planning
Or
Planning for counting



OK, we counted: then what?

Global fund – donor countries

- Routine health information systems are poorer than anticipated…….
- ART has diverted funds from other diseases, such as malnutrition and eroding health systems
- There is a lack of mortality data
  - Zambia: child mortality fell but data does not distinguish between effect of bednets, breastfeeding, vitamin A….
  - Ethiopia: Health information systems are weak, mortality data lacking, the data we need is simply not there
  - Burkina Faso: we need support for Long term M&E

- Ethiopian representative: ***You made us do health research – so what to do about the results?***

(3 year reports Burkina Faso, Ethiopia, Malawi and Zambia)
Research for health Conference, Bamako 2008:

How to ruin good data

Tanzania health information system:

- Number of deaths switched with total population at health centers – *error in official tally form and data clerks changed data*

- Deaths counted twice for certain notifiable infectious diseases (measles) – *reported in to separate forms*

Sodemann, et al, unpublished


BEHAVIORAL AND BRAIN SCIENCES (2010) 33, 61–135
doi:10.1017/S0140525X0999152X

The weirdest people in the world?

Joseph Henrich
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http://www.psych.ubc.ca/~henrich/home.html

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Ara Norenzayan
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Weird but true

Counting weirdos or human beings?

Review of 800 papers on behavioural psychology with global conclusions:

Study participants are almost entirely drawn from **Western, Educated, Industrialised, Rich, and Democratic** societies (WEIRD)

It is assumed they are standard objects and representative for the global population

Looked at: fairness, cooperation, reasoning, categorization, moral, self concepts, IQ

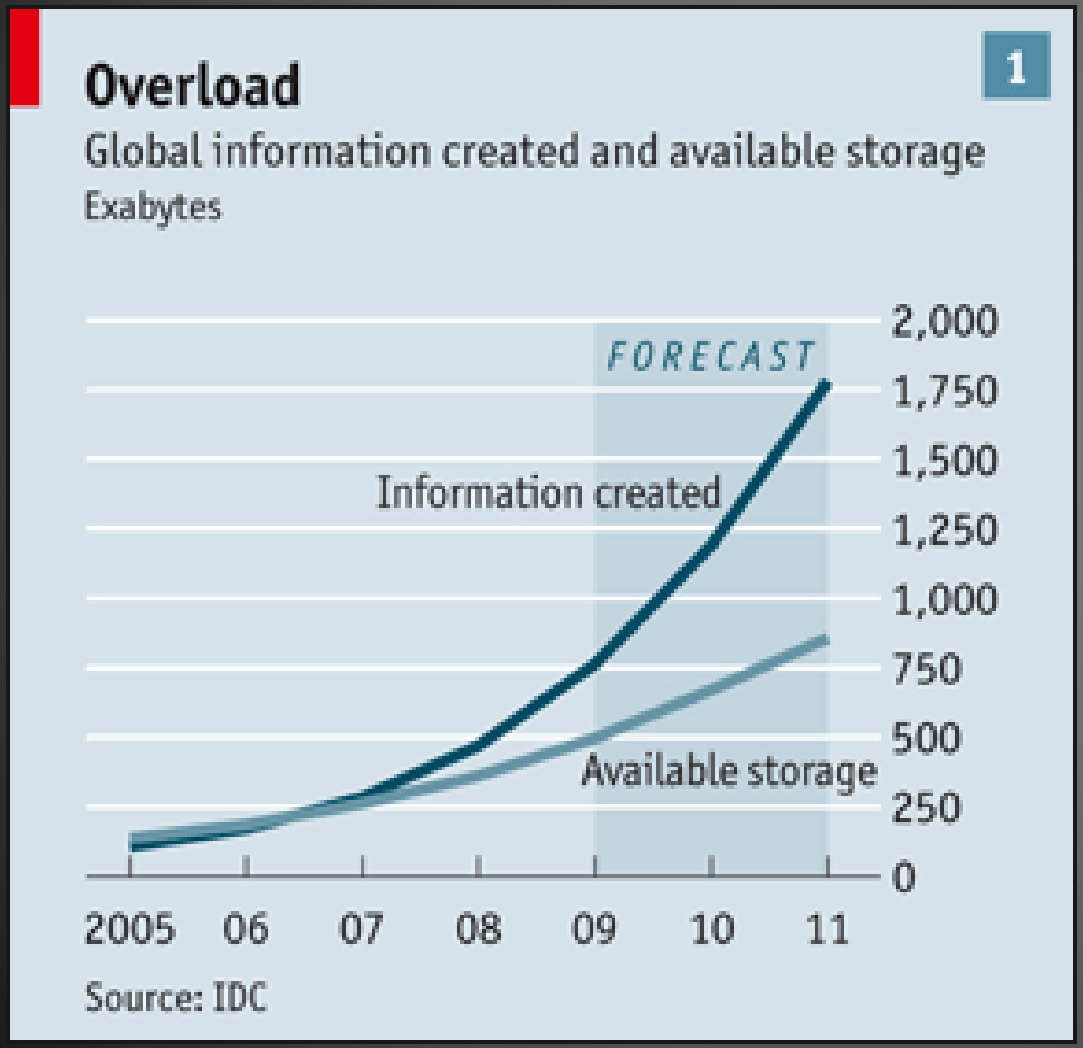
Conclusion:
WEIRD people are particularly different from the rest, frequent outliers
They are among the least representative populations one could find

Getting the proportions right

- 8 weeks oil spill in Mexican gulf = 1 day oil spill in the Nigerian river delta
- Earthquake in Haiti 2009 = 150.000 deaths
  - 2010: 50 % of NGO funds still in banks, 80 mill. USD in interest, 300.000 still homeless, cholera brought in by UN troops
- Child mortality per week in Africa = one Tsunami hitting Africa per week

http://www.scribd.com/doc/46320380/OneYear-Followup-Report-Transparency-of-Relief-Organizations-Responding-to-2010-Haiti-Earthquake
Denmarks radio P1, environment and health, 12th December 2010
http://www.washingtonpost.com/wp-dyn/content/article/2010/01/20/AR2010012004621.html

Global Information
From scarce to superabundant



Too much:

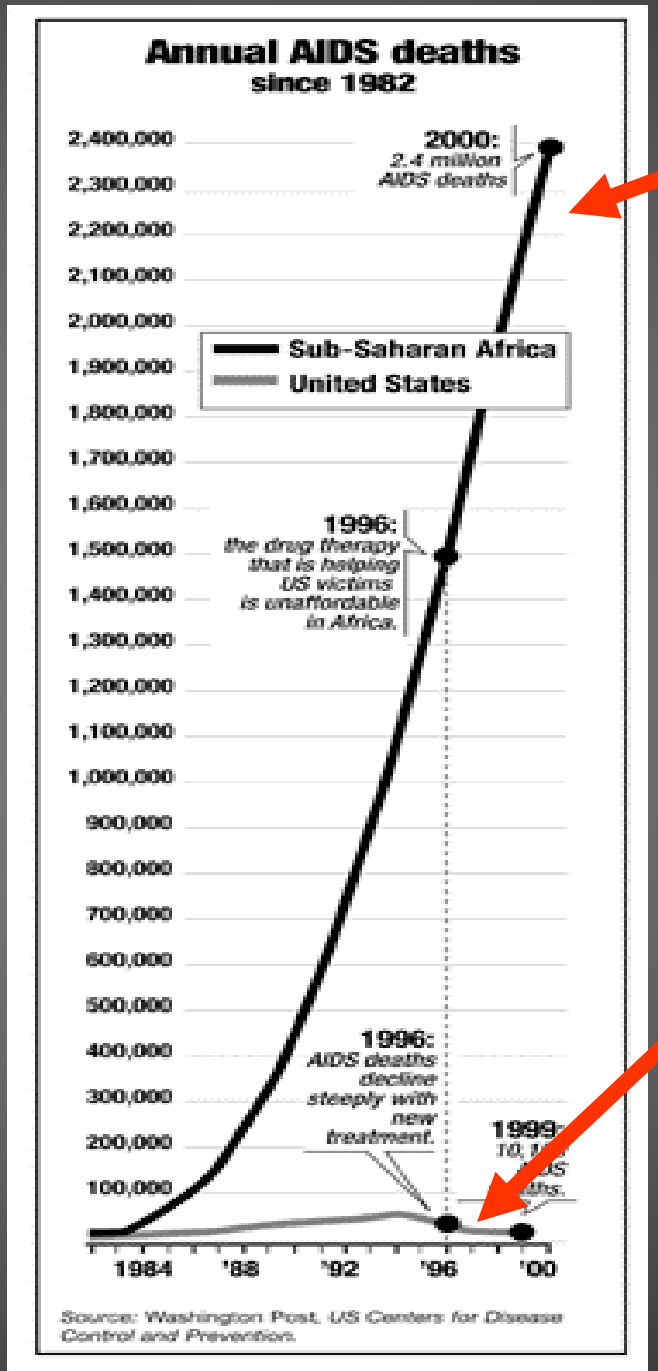
We can't store it

Too little:

low income countries
have no acces

”We spend more time digging graves than ploughing the fields”

South African farmer, 2000



Africa

USA and Europa....

The Cost Gap of Fighting AIDS

At today's market prices, treating AIDS patients with antiretroviral medicines would cost more than the health care budgets of many developing countries. For some, including Uganda and Zimbabwe, the cost would dwarf the size of their national economies.

	Switzerland	Ivory Coast	Uganda	Zimbabwe
Population	7 million	14 million	21 million	12 million
People with HIV	12,000	700,000	930,000	1.5 million
Potential cost if all infected people were to be treated with antiretroviral drugs*	$144 million	8.4 billion	11.2 billion	18 billion
Potential treatment cost as percent of GNP	0.06%	84%	172%	265%
Average total health care spending, 1996-98, as percentage of GNP	7.1%	1.4%	1.8%	3.1%

*Three-drug combination therapy, at a mean cost of $12,000 a year

SOURCES: Bernard Hirschel, World Health Organization

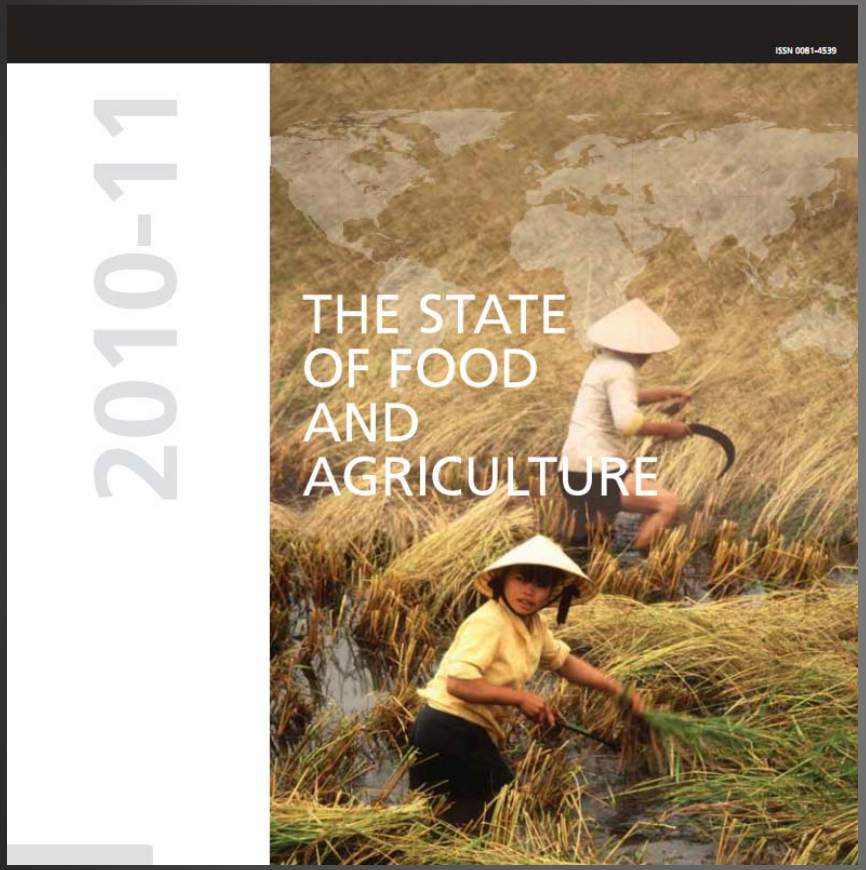
THE WASHINGTON POST

Hiv and maize

- Reduction in crop production if one adult member of a farming family is Hiv-positive:
  - Maize 61 %
  - Cotton 47 %
  - Vegetables 49 %
  - Cocoa 37 %

Stover and Bollinger 1999

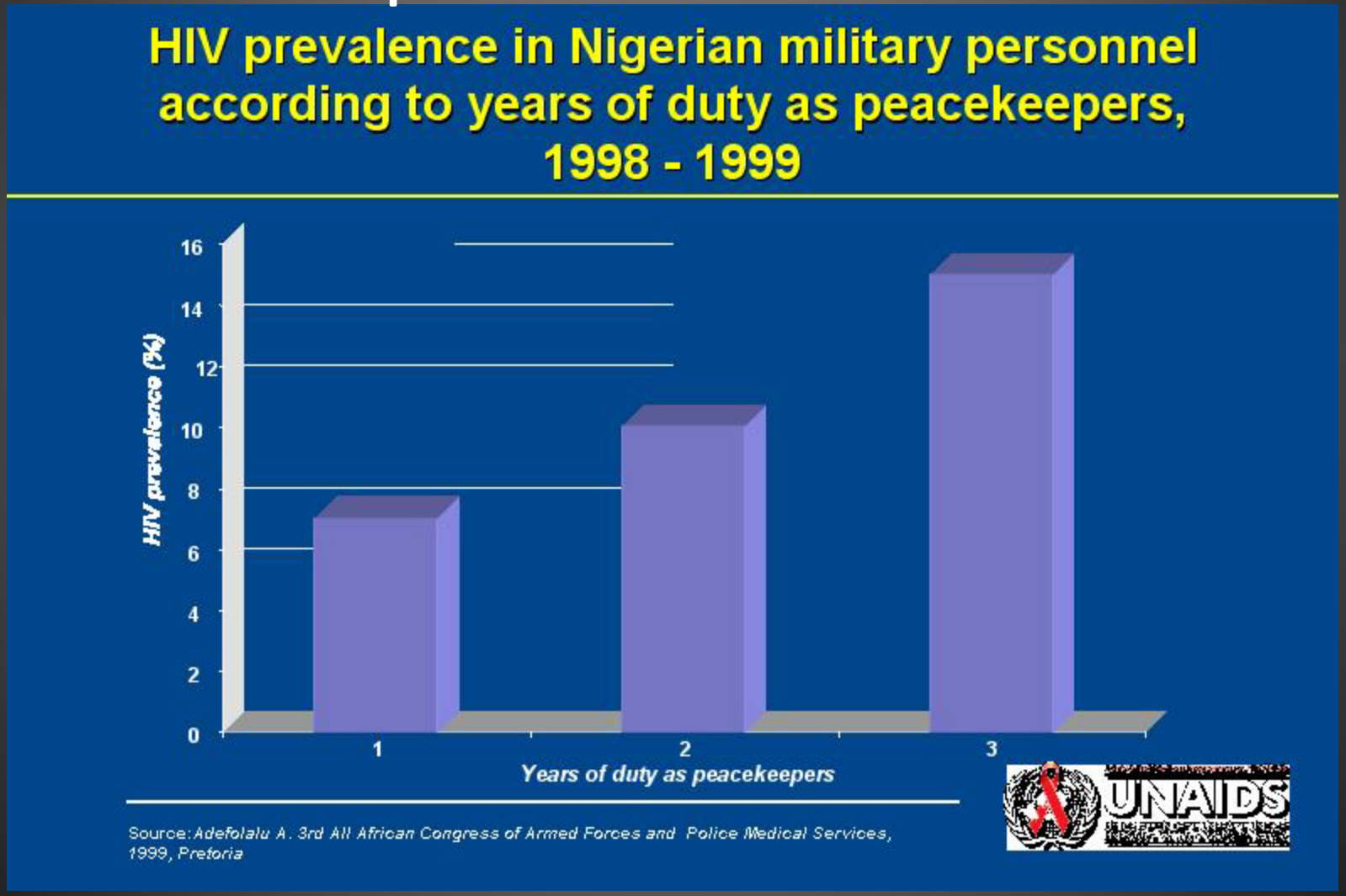
Mind the gender gap



- Women = 43 % of the agricultural labour force in developing countries
- Giving women same access as men to agricultural resources increases total agricultural production in developing countries by 2.5 to 4 %
- Could reduce the number of hungry people in the world by 17 %, or 150 million people.

www.FAO.org, March 2011

Conflict, peace…..
and new problem we didn't ask for



Human security and human health

in a global context

UN commission for Human Security:

"…to protect the vital core of all human lives in ways that enhance human freedoms and human fulfillment"

Moved from national security to individual human security

- Protecting fundamental freedoms
- Protecting people from critical (severe) and pervasive (widespread) threats and situations.
- Creating political, social, environmental, economic, military and cultural systems that together give people the building blocks of survival, livelihood and dignity.

(CHS, final report: 2003: 4)

….but that is not how human beings assess risk

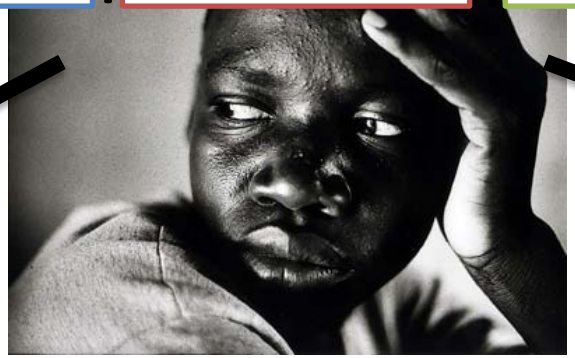
The human security equation

Do I feel...

Safe+free+secure+I have a clear future+I belong here+I can choose+I can educate myself+I can bring up family and children+I can get a job+my opinion matters+crop yields are high+My friends can help me+generally well+a sense of belonging+a sense of citizenship+i can move freely+not stimatised+no ethnic+clashing+ respect+public+ condidence+healthy+service+good school+understood+love+caring+I count family+not too poor+feed back+ overall satisfaction+no shooting+no police trouble+no social pressure+many friends+large family+functional language+stupid neighbours+politicians are liars+too many road accidents+too much malaria+crowding+housing is expensive=

\+ Choice making experience

Locus of control + Risk behaviour type + Previous experience + Social network + Access to knowledge/ information about options



Yes, I will stay and invest here

No, I will migrate somewhere else and start all over again

”Nothing but security in Denmark – but I dont feel safe here

Nothing but insecurity in Iraq – but there I feel safer”

Iraqi male

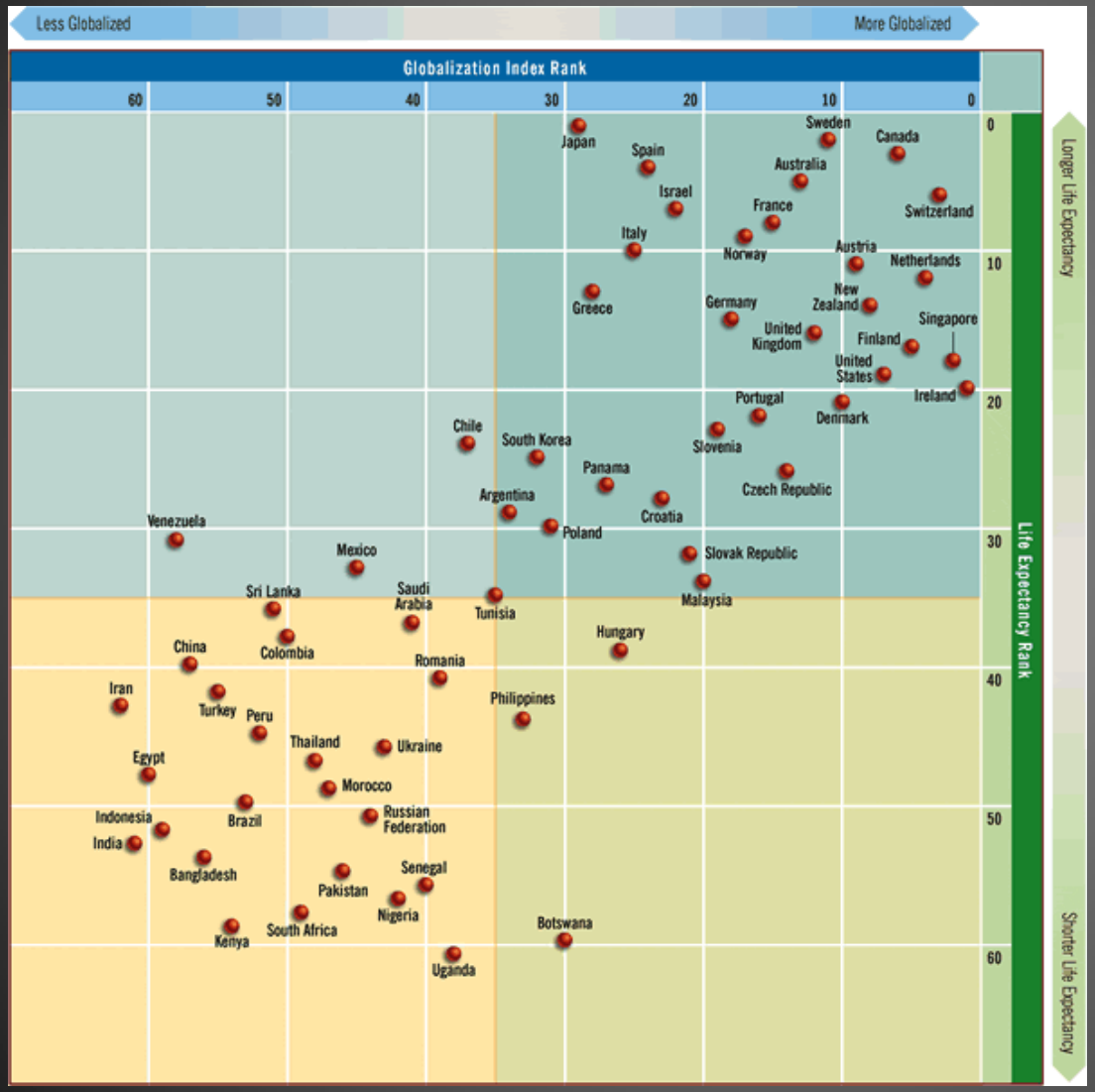
Tjernobyl

Survival, hope and security

Is globalization

healthy?

Life Expectancy



Levels of globalization vs. life expectancies at birth

Finding: people in the more global countries tend to live the longest. The same holds true when only developing countries are examined.

Globalization & health

- At a statistical level increasing globalization increases life expectancy

- …but there are many ”outliers”

de Kluyver - Oxford MBA 2005
Maartens, Atkin et al, Globalization & Health, 2010

The outliers - examples

- **High globalization & high mortality: Egypt**
- Average globalization & very high mortality: **Uganda**
- Low globalization & average mortality: **Brazil**
- **Low globalization index & very low mortality: Japan**

Large expanding import-export compagny

Multiresistent TB
Food insecurity
HIV
Chikungunya
Malaria
birdflu
SARS
Difteria
Polio?
Measles?

Cancer
Cardiovascular
Traffic acidents
Diabetes
Obesity
Hypertension
Depression, anxiety
Stress
Expensive drugs
Privatised health care

But who is head of the compagny?

Assimilation or death?

POINT–COUNTERPOINT

Is modern Western culture a health hazard?

Richard Eckersley

Please assimilate to: No drinks, driving or drugs

International Journal of Epidemiology 2006;**35**:252–258
doi:10.1093/ije/dyi235

Global health case 1: snapshots from Gulu, Uganda

National

Get a yellow fever card for only Shs25,000

Daily Monitor Reporter
Kampala

It is 3.25pm I walk towards Kampala City Council (KCC) clinic for yellow fever vaccination.

On this sunny afternoon, I arrive at the KCC gate opposite the Ministry of Finance Planning and Economic Development, clearing beads of sweat off my face.

A private guard asks me what I want and I tell her I was proceeding to the clinic for a medical checkup.

"What kind of checkup? Tell me, maybe I can help you," she insists. I tell her it is about my personal health and I can only discuss it with a doctor.

"You are becoming stubborn. I would have helped and opened for you but I will not.

This gate is only used by police and prisons officials. Go through the lower gate," she orders.

Without hesitation, I proceed to the 'civilian' gate opposite dfcu bank Impala branch.

In the parking yard is a group of three ladies and a gentleman the guard asks whether they want to be vaccinated or they want yellow fever cards. I later see exchange of paper and money.

At this moment, I have no idea of who to deal with and I spend some 40 minutes watching the situation. Later I target one man whom I engage in Lusamia.

He tells me if I want the vaccine it will cost Shs45,000 but if I want the card, I can only pay Shs25,000.

I try to negotiate but he tells me that the money is shared by many people. I later accept and he replies, "Deal, give me a few minutes".

Thirty minutes later, the man has not yet returned. I develop second thoughts and fear that I could fall in a trap and be arrested for allegedly bribing public officers.

But I steady my nerves, consoling my self that the investigation was in public interest to save lives and public resources.

Reassuring though is the fact that I had not paid the agent for the card.

As I debate whether to leave or not, the man arrives with the card complete with KCC stamps but my details, including name, passport number, among others were not filled. He takes me through how to fill the blank spaces.

I pay him and leave with my vaccination card although I have not received the vaccine just like those who applied while I were. I later clarify me the 'stubbo I ca about proce

'What kind of check up? Maybe i can help you'

Private guard
KCC clinic

BLANK BUSINESS: A blank card complete KCC stamps which the writer bought. PHOTO BY ISMAIL KEZAALA

About the card

An Aedes mosquito

The rot in fight against an old deadly dis

CONTINUED FROM PAGE

circumstances, vaccination and a card for proof costs Shs46,000 at this facility—but if you bargain with these

have been bounced at the embassy for showing fake cards.

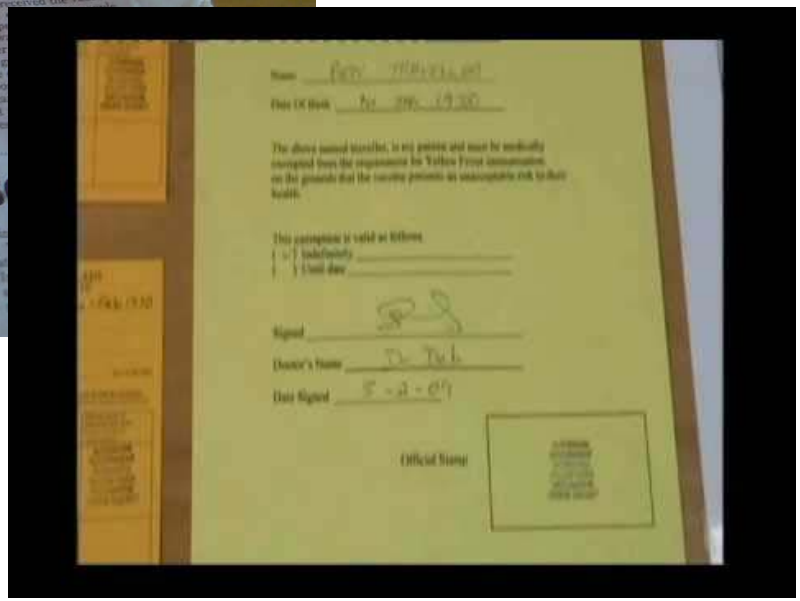
"I definitely will not be complementary to Uganda on this," Mr Qweizane said. "We can have as many as five to six

having been about three years ago.

He says the practice of selling fake cards initially came up because of a shortage of the vaccine but added that the

Control estimates that a traveller's risk of acquiring yellow fever is determined by various factors, including one's immunisation status, location of travel, season, duration of

an outbreak of the disease in northern Uganda. The funds will facilitate mass vaccination in 26 districts, although the disease is still confined in the 10; Abim, Agago, Lamwo, Pader, Kitgum, Gulu, Arua,



Index case: a wild life hunter


THE New Vision
JOBS JOBS JOBS!
15 pages of great opportunities inside
EBOLA
How to avoid the killer virus
EBOLA UNIT ATTACKED
Museveni blames West for hot climate
Mugabe: Archbishop Sentamu cuts collar
Kiwanuka residents vandalise isolation centre
BY VISION REPORTERS
Turn To Page 2

UGANDA: Displaced first by war, now by elephants

Photo: Charles Akena/IRIN

Elephants have strayed into the village of Laminator in Koch Goma, Amuru district

AMURU, 24 October 2008 (IRIN) - Marauding elephants in northern Uganda have added to the challenges faced by civilians trying to rebuild their lives in the wake of 20 years of civil war, destroying their crops and prompting some to return to displaced people's (IDP) camps they had only recently left.

"The villagers are scared of the elephants; some of them have sought refuge in huts they had left in the [IDP] camps," John Bosco Okullo, a local leader in Amuru District told IRIN.

Most affected are hund
Purongo, Ongako, Cor
have also been eaten
and pasture.

Some of the returnees
competing for the sam

Jackson Lukwiya, 78, from Koch village, said his 10 hectares of banan

"A few days ago a man was thrashed beyond recognition by a charging
worried," Lukwiya said.

He said some families were now commuting from IDP camps to cultiv

Earlier this year, a group of people were attacked by elephants crossin
village. The elephants also trampled on a bicycle belonging to one of t

Local leaders have vowed to kill the elephants marauding in the area.

Okullo said: "We shall organise the community to send back the eleph

Another resident said if one elephant were killed, the rest would autom

Human-wildlife conflict

Okullu said the elephants had destroyed the crops of up to 800 people

"Crops like bananas, millet, sweet potatoes, beans, cassava, maize, y

Area residents accused the government of prioritising wildlife over the
of returning IDPs - in reference to the government's failure to revise the
wild protected animals.

Between May and July, an estimated 100 elephants from the park roam
villages in Gulu and Amuru, ravaging crops and interrupting the reinteg
IDPs.

Uganda's wildlife senior conservation officer, Stonewall Kato, told IRIN
that in recent years there has been an explosion in the number of eleph
the park, forcing some to stray out in search of water and food.

"It's a problem, but the law prohibits the killing of wild life. We have dispatched

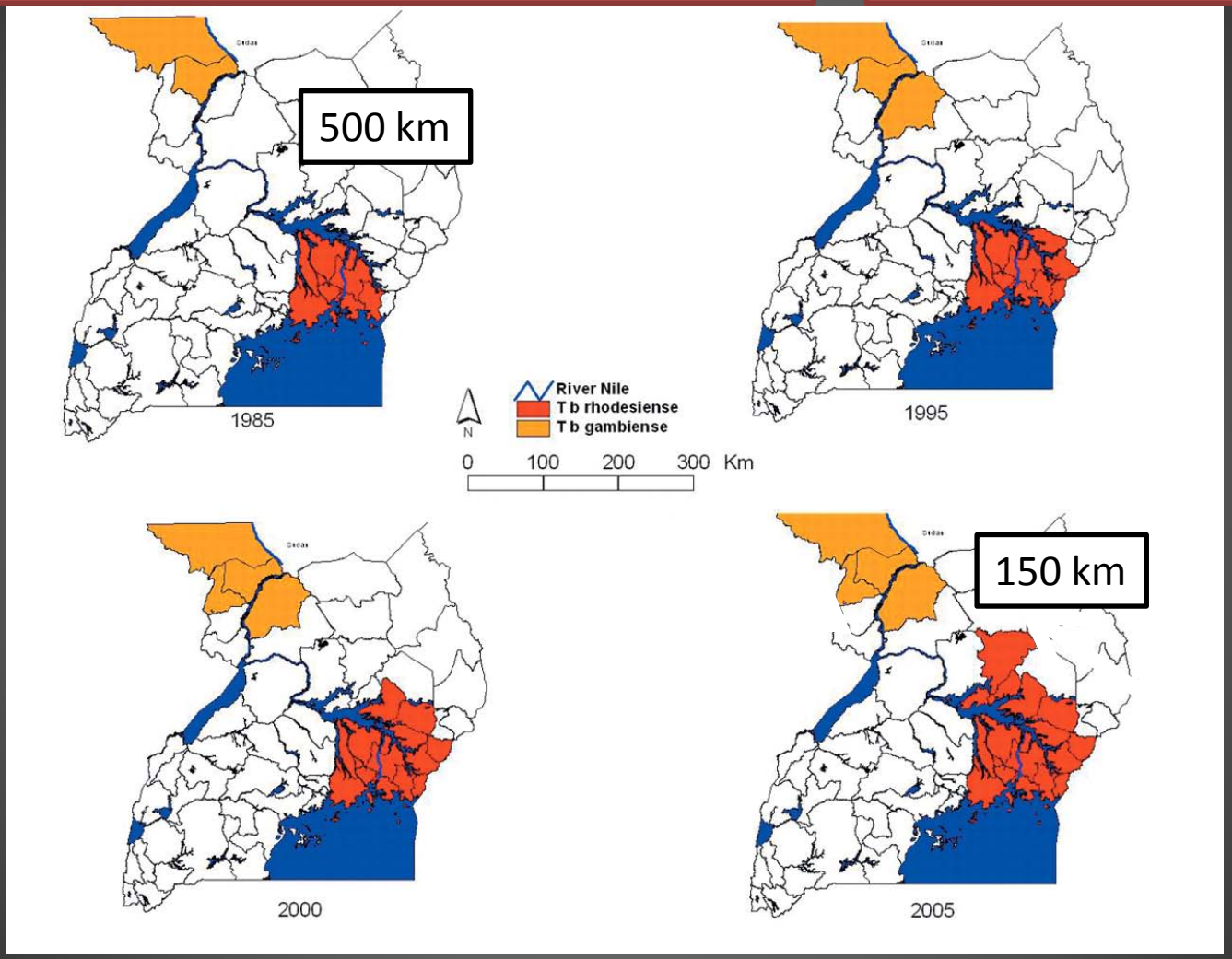
Countries
- Select a country -

Photo | Film & TV

Sequential maps of areas of Uganda affected by sleeping sickness.

Civil instability in the north: spread with displacement

Cattle sent from south to north



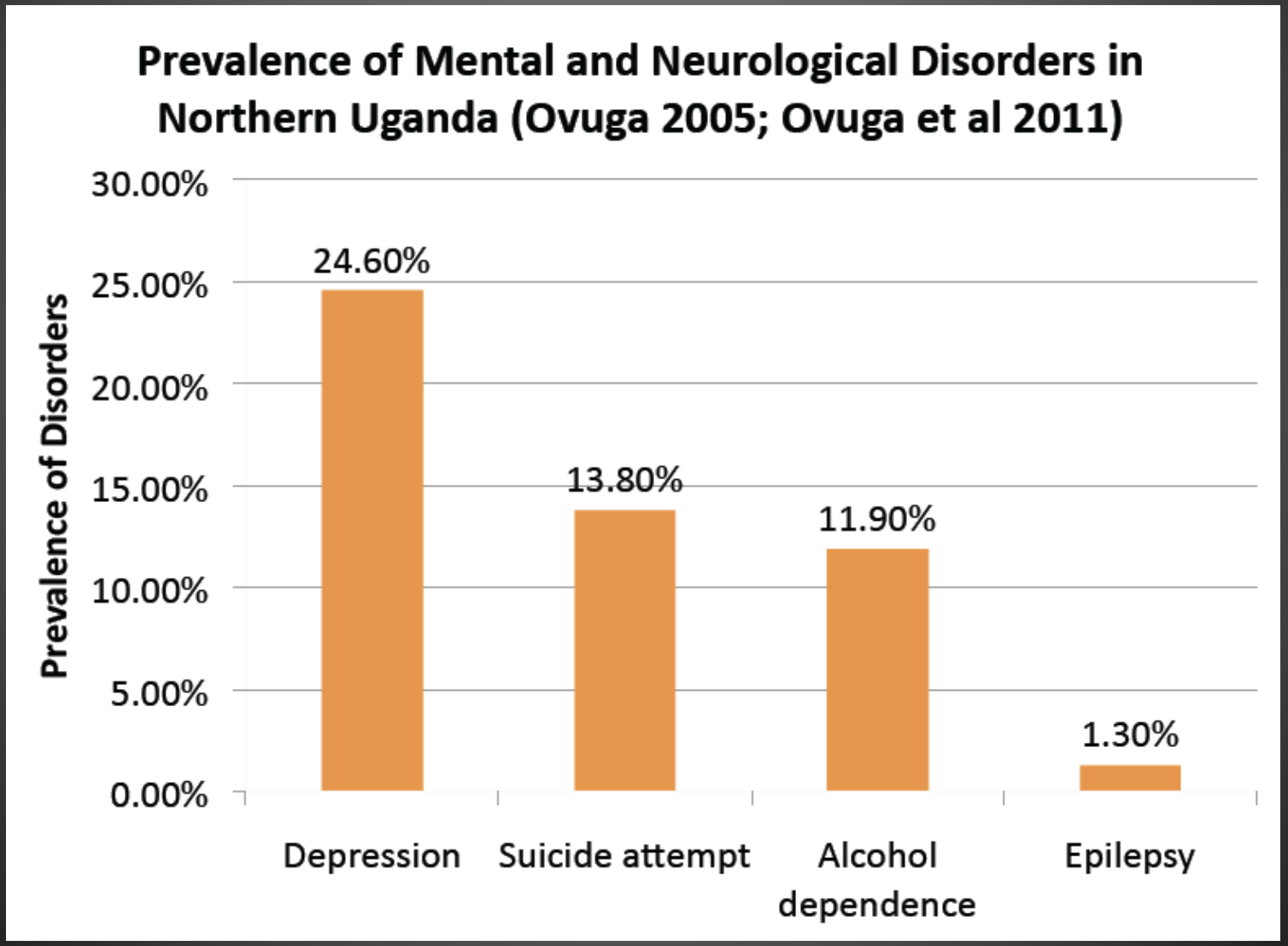
Picozzi K et al. BMJ 2005;331:1238-1241

Visceral leishmaniasis and the Sudanese independence referendum

- Returnees from North Sudan to Southern Sudan:
  - low immunity
- From Southern Sudan to Gulu in Uganda
  - Very low immunity

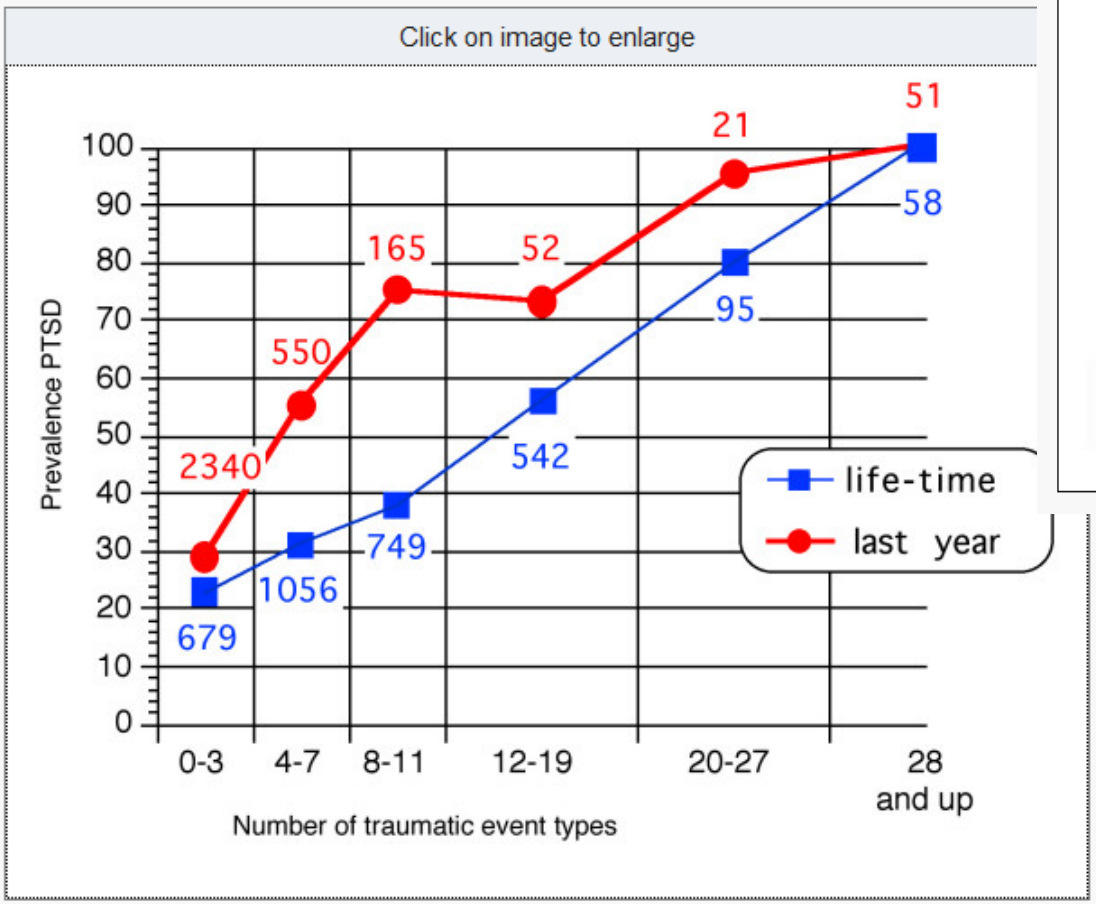
Other post conflict epidemics

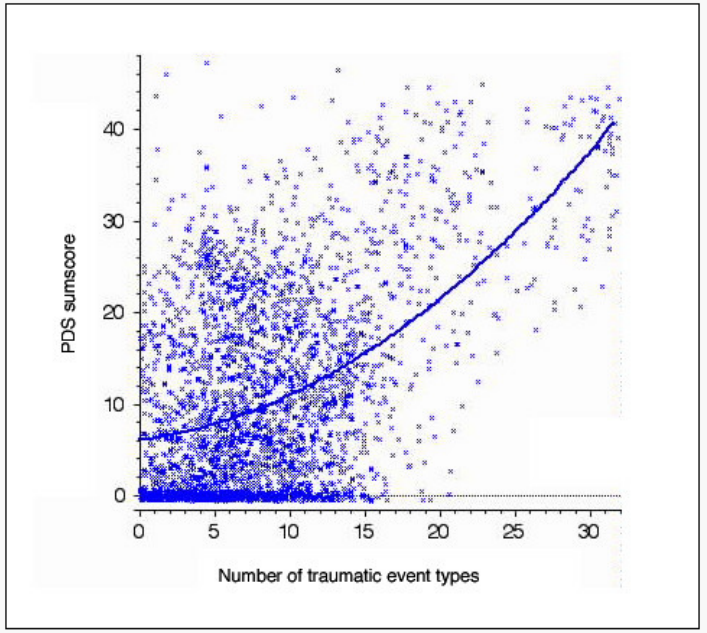
Gulu, Uganda:



More trauma = higher risk of PTSD

3339 adults in th e West Nile Region, Uganda





Neuner, Karuna et al BMC,2004

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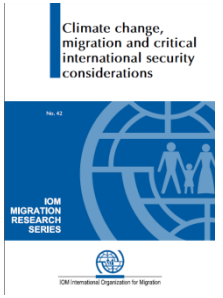
African Health Sciences
Makerere Medical School
rnal List > Afr Health Sci > v.8(3); Sep 2008
Afr Health Sci. 2008 September; 8(3): 136–141. PMCID: PMC2583264
Copyright © Makerere Medical School, Uganda 2008
Post traumatic stress disorder among former child soldiers attending a rehabilitative service and primary school education in northern Uganda
Emilio Ovuga,[1] Thomas O Oyok,[2] and EB Moro[3]

- 12 children hospitalised with mass psychosis
  - Same rehab school for former child soldiers
  - => evaluation of all 112 child soldiers at the school
- **87.3% experienced ten or more war-related traumatic psychological events**
- 55.9% had symptoms of post-traumatic stress disorder
- 88.2% had symptoms of depressed mood

Global health case 2:

Climate change and forced migration

- Anthropogenic (!) climate change causes:
- 200 million – 1 billion to be displaced by 2050
- But: no statistical or empirical data
- And: migration is closely linked to ***armed conflict and social, health, economic, cultural, institutional factors and GLOBAL FACTORS***
  - shaping the ***vulnerability*** and ***adaptive capacity*** of exposed populations and the decision to migrate or not.



Meyers N, 2003, *Philosophical Transactions of the Royal Society London: Biological Sciences: Series B*, 357(1420): 609–613.

Global health case 3:

Hiv, migration and food security

Low in science and technology

High in global content

Clear local impacts:
Global health is local health

Bandim 1987, 1992 and 2008: Care seeking in fatal childhood illness

- 85-90 % seen at a health facility before death
- Nearly 50 % discharged before death to die at home
- 8-13 % died while waiting in the hospital before receiving treatment

Mølbak et al 1992
Sodemann et al 1997
Tofthøj et al, 2011

Who neglects who?

A review of verbal autopsy studies

with information on care-seeking during fatal childhood illness 1968 to 2011

Sodemann & Tofthøj Under prep

Identified studies

- Kenya: 6
- Tanzania: 5
- South Africa: 1
- Guinea-Bissau: 4
- Malawi: 2
- Nigeria: 1
- Ethiopia: 3
- The Gambia: 5
- Cote d'Ivoire: 1
- Burkina Faso: 1
- Uganda: 1
- Egypt: 2

- Mexico: 5
- Brazil: 11
- Chile: 1
- Guatemala: 1
- New Mexico: 1
- Java: 1
- West Jawa: 1
- Sri Lanka: 1
- India: 10
- Indonesia: 1
- Papua New Guinea: 1
- Pakistan: 1
- Bangladesh: 1

Summary

- More than 50% of fatally sick children seen by a health worker before death
- 50-70% hospitalised
- 30-45% discharged before death
- 10-15% die on the way to hospital
- No real improvements over time

To know or not to know a medical doctor

Sodemann et al TMIH 2006

To know or not to know a medical doctor

		Mortality risk Odds ratio (95% C.I.)	
	Deaths/children in group (%)	Crude	Adjusted**
Maternal acquaintance or familiarity with:			
Medical doctor			
Yes	27/531 (5.08)	0.49 (0.31-0.77)	0.54 (0.33-0.89)
No	82/836 (9.81)	1	1
Nurse			
Yes	33/372 (8.87)	1.36 (0.74-1.73)	1.18 (0.73-1.91)
No	76/977 (7.76)	1	1
Other health worker*			
Yes	11/102 (10.8)	1.39 (0.73-2.68)	1.15 (0.72-1.84)
No	119/1491 (7.98)	1	1
Field assistant			
Yes	8/131 (6.11)	0.73 (0.35-1.53)	1.25 (0.57-2.74)
No	100/1217 (8.22)	1	1

Soudemann et al TMIH 2006

To know or not to know a medical doctor

Clinical team on duty (period 1)			
1	11/178 (6.18)	0.56 (0.25-1.23)	0.74 (0.32-1.72)
2	14/171 (8.19)	0.75 (0.36-1.57)	0.84 (0.38-1.88)
3	18/170 (10.6)	1	1
4	7/166 (4.22)	0.37 (0.15-0.92)	0.30 (0.11-0.83)
5	12/153 (7.84)	0.72 (0.33-1.54)	0.61 (0.26-1.41)
Clinical team on duty (period 2)			
1	19/225 (8.44)	1.63 (0.63-4.20)	1.75 (0.59-5.13)
2	20/133 (15.0)	3.13 (1.21-8.09)	3.17 (1.06-9.50)
3	13/145 (8.97)	1.74 (0.64-4.73)	2.36 (0.75-7.47)
4	10/140 (7.14)	1.36 (0.48-3.86)	1.28 (0.39-4.21)
5	6/112 (5.36)	1	1

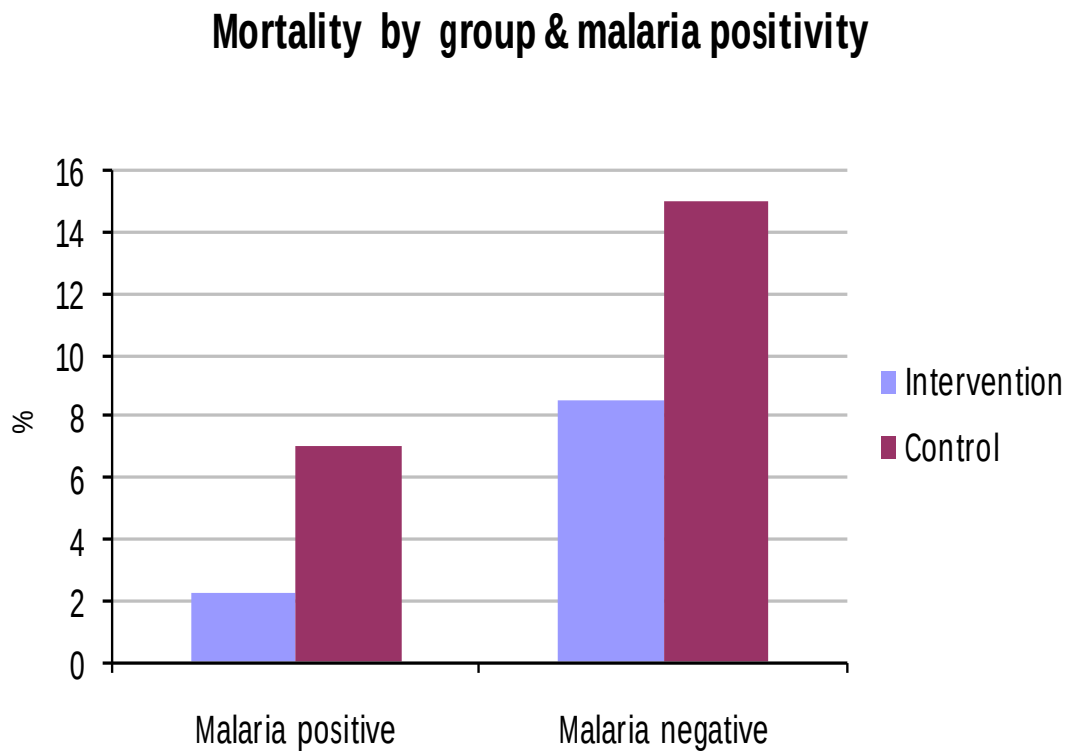
Sodemann et al TMIH 2006

To know or not to know a medical doctor

		Mortality risk Odds ratio (95% C.I.)	
	Deaths/children in group (%)	Crude	Adjusted**
Consultation at day of week			
Monday	21/264 (7.95)	0.64 (0.35-1.17)	0.74 (0.38-1.45)
Tuesday	24/266 (9.02)	0.74 (0.41-1.32)	0.66 (0.34-1.28)
Wednesday	12/277 (4.33)	0.34 (0.17-0.68)	0.35 (0.16-0.77)
Thursday	21/241 (8.71)	0.71 (0.39-1.30)	0.76 (0.39-1.49)
Friday	27/228 (11.8)	1	1
Saturday	12/175 (6.86)	0.55 (0.27-1.12)	0.39 (0.17-0.89)
Sunday	13/142 (9.15)	0.75 (0.37-1.51)	0.81 (0.36-1.80)

Sodemann et al TMIH 2006

Results



RR =0.36 (0.16–0.80) RR =0.59 (0.31–1.12)

Biai S et al, BMJ 2007

Doctors and patients don’t attend the same classes:

Who is illiterate?

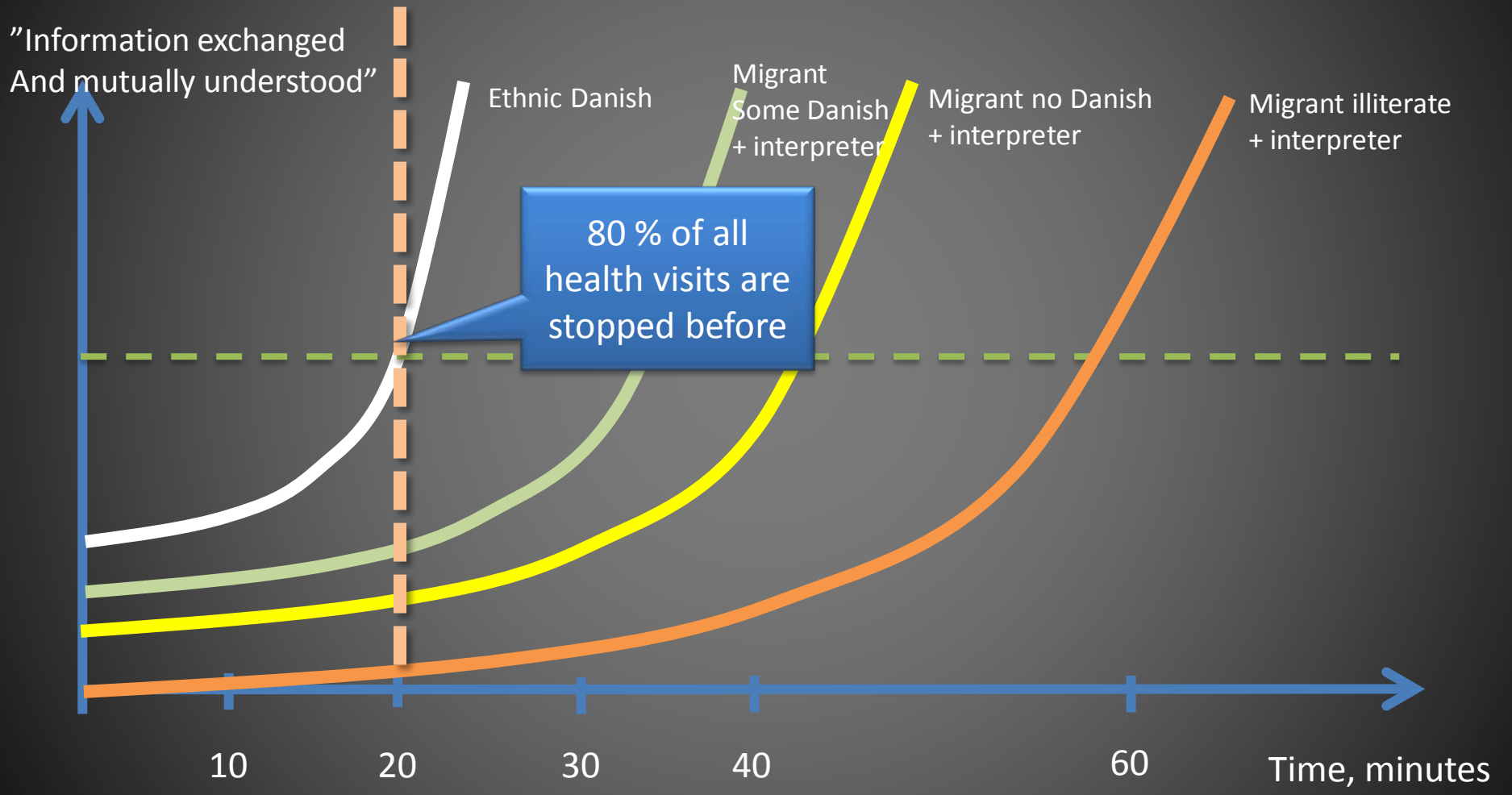
?

You have to understand what it is like not be understood

To be able to understand it

38 year old refugee from Rwanda

Time for trust, confidence and information



The migrant health clinic, Odense University hospital

Empowerment and self efficacy

From family to individual human being

The strategy starts and ***stops*** with the escape from the warzone

- …..but then what?

”I feel like human being no. 2”

40 year old refugee

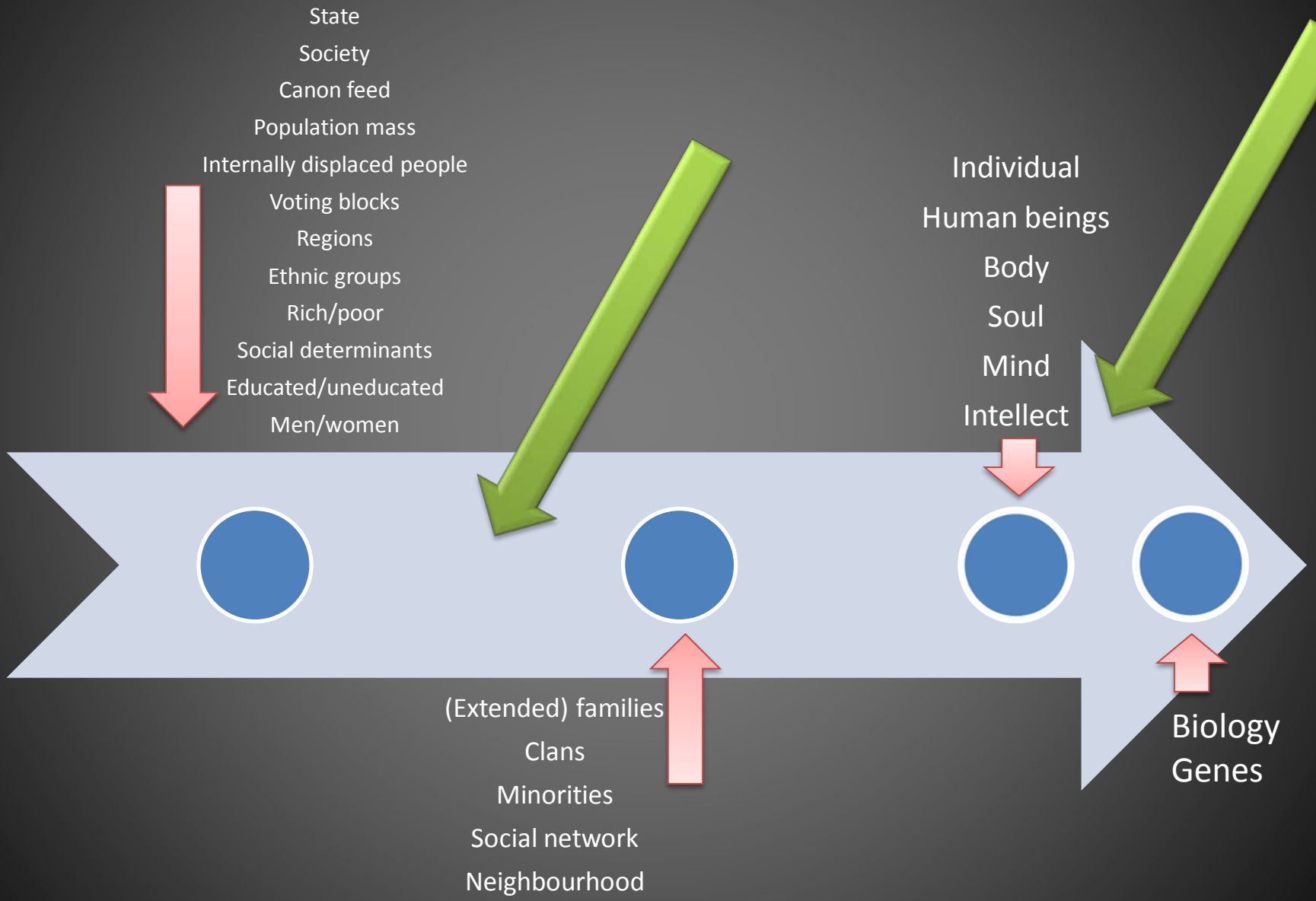
”In Denmark I learned that

human beings have value.

I honestly didn’t know before I came here and I never thought about it that way”

34 year old mother to 3 children

Empowerment



Who are the first to leave? Women and children?

Brain drain = ”Sick system syndrome” or brain sucking?

- The brains leaving low income countries are not just brains:
  - PhDs and masters are over represented

- =>who will be teaching the teachers and supervising research talent?

Dodani S et al. J R Soc Med. 2005 November; 98(11): 487–491.
Oommen TK, International Migration, 27(3)
411–425, Sept 1989
Pang T. *BMJ* 2002; 324 : 499

Premature ageing among ethnic minorities

Ethnic Danes: feel 20 % younger (> 40 years)

Ethnic minority patients: 20 % older

Ongoing study

Communication speaks louder than words

- Doctor and patient of same ethnicity
- = higher compliance

- High education = high level information

A. Baggrundsoplysninger

Dette afsnit skal bruges til at undersøge, om de, der deltager i denne undersøgelse, er repræsentative for alle hiv-smittede i Danmark.

A.1 Hvornår er du født? Måned _____ år _____

A.2 Jeg er 1 ☐ Mand 2 ☐ Kvinde

A.3 Hvor er du født? *(sæt et kryds)*

1 ☐ Danmark
2 ☐ Andet europæisk land
3 ☐ Afrika
4 ☐ Asien
5 ☐ Nordamerika
6 ☐ Sydamerika/Mellemamerika
7 ☐ Australien/New Zealand

A.4 Hvor bor du nu?

1 ☐ Danmark Postnr._____
2 ☐ Udlandet
3 ☐ Uoplyst

A.5 Hvilken af følgende muligheder passer bedst på din nuværende situation? *(sæt et kryds)*

1 ☐ Fuldtidsarbejde
2 ☐ Deltidsarbejde
3 ☐ Flexjob ordning
4 ☐ Anden ansættelse/job
5 ☐ Ingen af delene

A.6 Hvilken af følgende muligheder passer bedst på din nuværende situation? *(sæt et kryds)*

1 ☐ Indtægtsgivende arbejde (gælder også hvis du er syge- eller fraværsmeldt)
2 ☐ Arbejdsledig med dagpenge
3 ☐ Revalidering
4 ☐ Kontanthjælp
5 ☐ Førtidspension
6 ☐ Under uddannelse (studerende, lærling, elev)
7 ☐ Folkepension
8 ☐ Pension + deltidsarbejde
9 ☐ Andet, skriv:_____

A.7 Hvis du har fået tilkendt pension, er det så på grund af: *(sæt et kryds)*

1 ☐ HIV
2 ☐ HIV og andet, skriv:_____
3 ☐ Andet, skriv:_____
4 ☐ Ved ikke

Mange tak fordi du ville svare på spørgsmålene. Hvis du efterfølgende har spørgsmål, eller har brug for at drøfte nogle af de omtalte emner med os, er du velkommen til at ringe eller maile til en af os.

Ville du have svaret væsentligt anderledes på spørgeskemaet, hvis du havde besvaret skemaet anonymt?

1 ☐ Ja 2 ☐ Nej

Venlig hilsen og mange tak for hjælpen!

Morten Sodemann
Klinisk lektor
Overlæge, Ph.D.

Odense Universitetshospital

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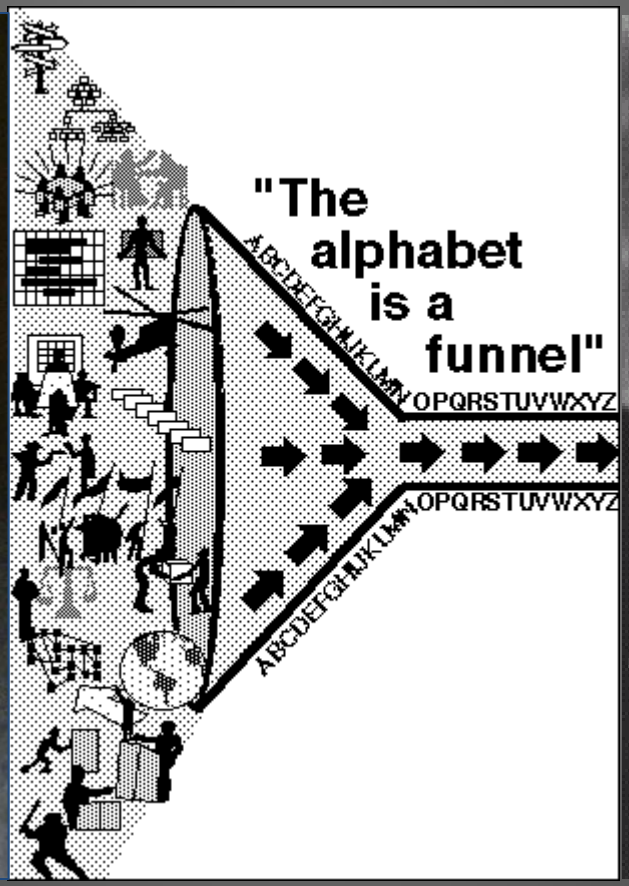
HELP

Language barriers are associated with:

- Less awareness of health care access and rights
- Longer consultations
- Less frequent health visits
- More visits to emergency departments
- Less understanding of health information given by doctor
- More and more expensive tests, x-rays and scans
- Less follow-up
- Less patient satisfaction
- Less likehood of hiv test
- Less uptake of preventive measures
- Same exam or treatment takes longer time
- More complications, medical errors, side-effects, and more severe outcome

(Feinberg et al., 2002), Kravitz et al., 2000, Derose & Baker, 2000, David & Rhee, 1998; Gerrish, 2001, David & Rhee, 1998; Gerrish, 2001 Hampers et al., 1999, Meredith et al., 2001; Morales, Cunningham, Brown, Liu, & Hays, 1999, Levy et al, 2005, Jacobs et al 2004, Bischoff et al, 2010, Australian council for safety and quality in health care (2005)

Everything has to be channeled to the doctor through the language funnel



Immigrants and refugees

- Less access to dis… …vention and screening
  - *Smear, mamm… …egnancy, D… …ome, smoking cessatio… …ssure, clinic…*
- More ris… …haviour
  - *High BMI, low physi… …gher blood pressure*
- More t… …ed infections
  - *Hepatitis, …enza, hiv, tuberculosis, typhoid fever*
- Longer on wait… …t for surgery
  - Rehos… …n, die on waiting lists
- Die more frequ… …y after hospitalization
  - *Acute myocar… …, inkompensated heart disease*
- More a… …re complex psychiatric illnesses
  - *PTSD, anxiety, torture survivors, more frequent overtreatment, fixation*

Prevention

Treatment/quality of care

Follow-up

Outcome

Ethnic minorities live longer than other Danes

- Lower mortality from: certain cancers and cardio-vacular diseases
- Because ethnic minorities:
  - Drink less alcohol
  - Take less drugs
  - Smoke less (and from a higher age)
  - Less likely to own a car
  - Rarely commit suicide
  - Haven't got a job
- But if they did they would have a **higher mortality** because of preventable infectious diseases and their consequences:

Danish statistical bureau, 2011, The state of Ethnic minorities

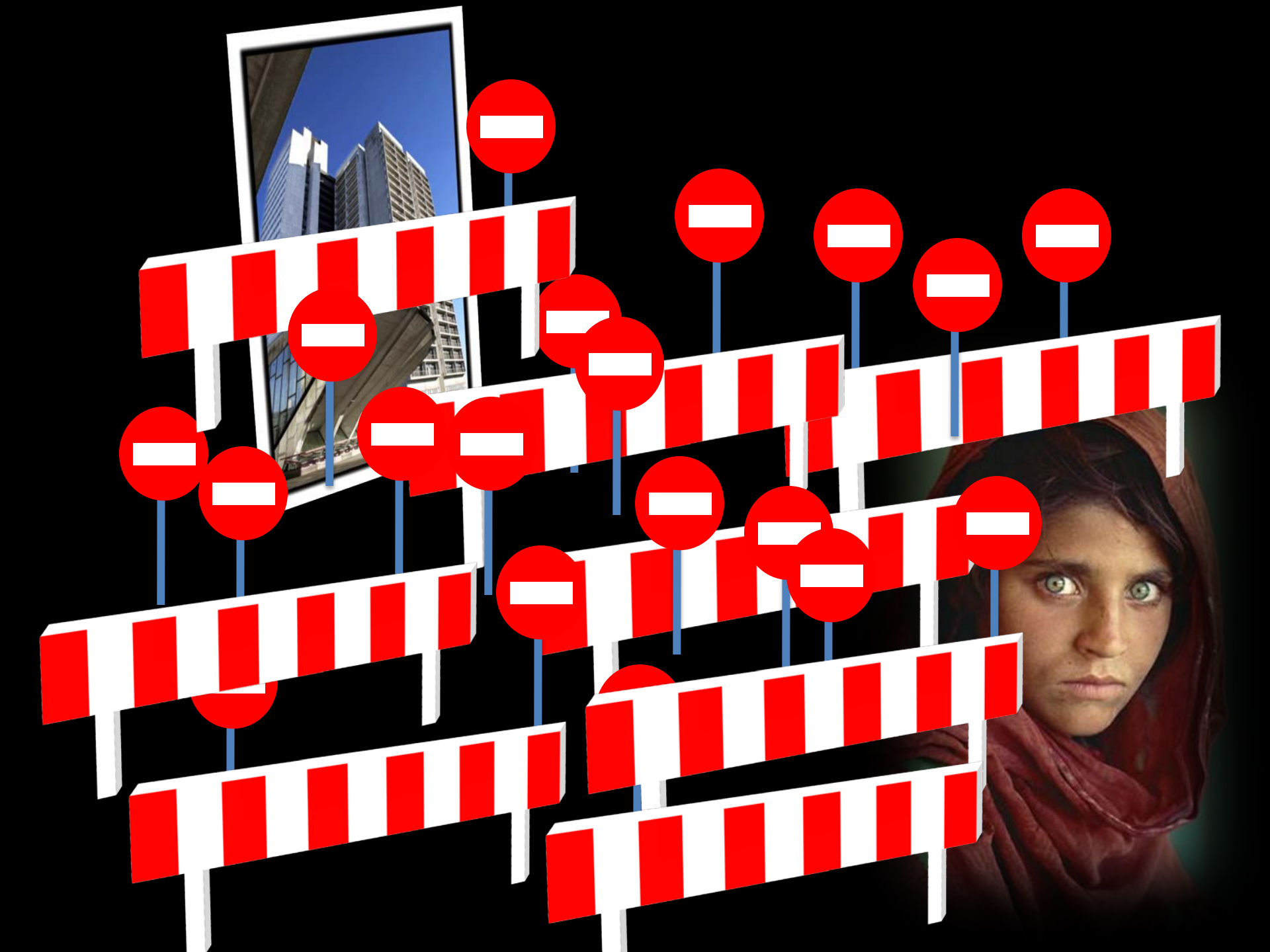
Infections: cause of death (Holland)

- 1995-2000: all citizens
  - 74.000.000 personyears (~ 5% immigrants)
  - 297.000 deaths

Table 2: Absolute numbers and relative risks of death from avoidable causes for migrant versus native Dutch population by gender

List of conditions (ICD[a]-10 code)	*Absolute numbers of death[b]*		*Relative risk[c] (95% Confidence interval)*	
	Men	*Women*	*Men*	*Women*
HIV/AIDS (B20-24)	80	8	3.03 (2.39–3.85)	2.20 (1.05–4.64)
Liver cancer (C22)	46	26	2.33 (1.72–3.14)	2.49 (1.67–3.71)
Hepatitis A, B, C, D, E (B15-19)	23	8	8.54 (5.28–13.8)	7.82 (3.50–17.49)
Diseases of infectious origin	*243*	*103*	*2.06 (1.81–2.35)*	*1.86 (1.53–2.27)*
Pneumonia & flu (J10-18)	77	42	1.25 (0.99–1.57)	1.13 (0.83–1.54)
HIV/AIDS (B20-24)	80	8	3.03 (2.39–3.85)	2.20 (1.05–4.64)
Liver cancer (C22)	46	26	2.33 (1.72–3.14)	2.49 (1.67–3.71)
Hepatitis A, B, C, D, E (B15-19)	23	8	8.54 (5.28–13.8)	7.82 (3.50–17.49)
Tuberculosis (A15-19, B90)	13	12	5.10 (2.80–9.28)	12.98 (6.85–24.61)
Chronic rheumatic heart dis. (I 00-09)	4	7	3.28 (1.17–9.19)	5.71 (2.59–12.60)

Stirbu I, BMC, 2006



”We don’t want manipulated data”

Danish politician when confronted with health data by social and ethnic status

Social determinants of health are alive, real and kicking

- and not just scientific toys invented to keep scientists occupied

Death separates….but how?

Social determinants of health

Social determinants of health

Are a 900 pound gorilla in the room

- Stares at you
- Too big to leave the room
- Can’t ignore it for long

Inattention blindness & the social gorilla

- We know social determinants are there so why do we try to ignore them?

- Common wisdom?
- Convenient presumptions & facts of life:
  - Poor are poor because they were born to be?
  - They were born like that
  - They have choices too….

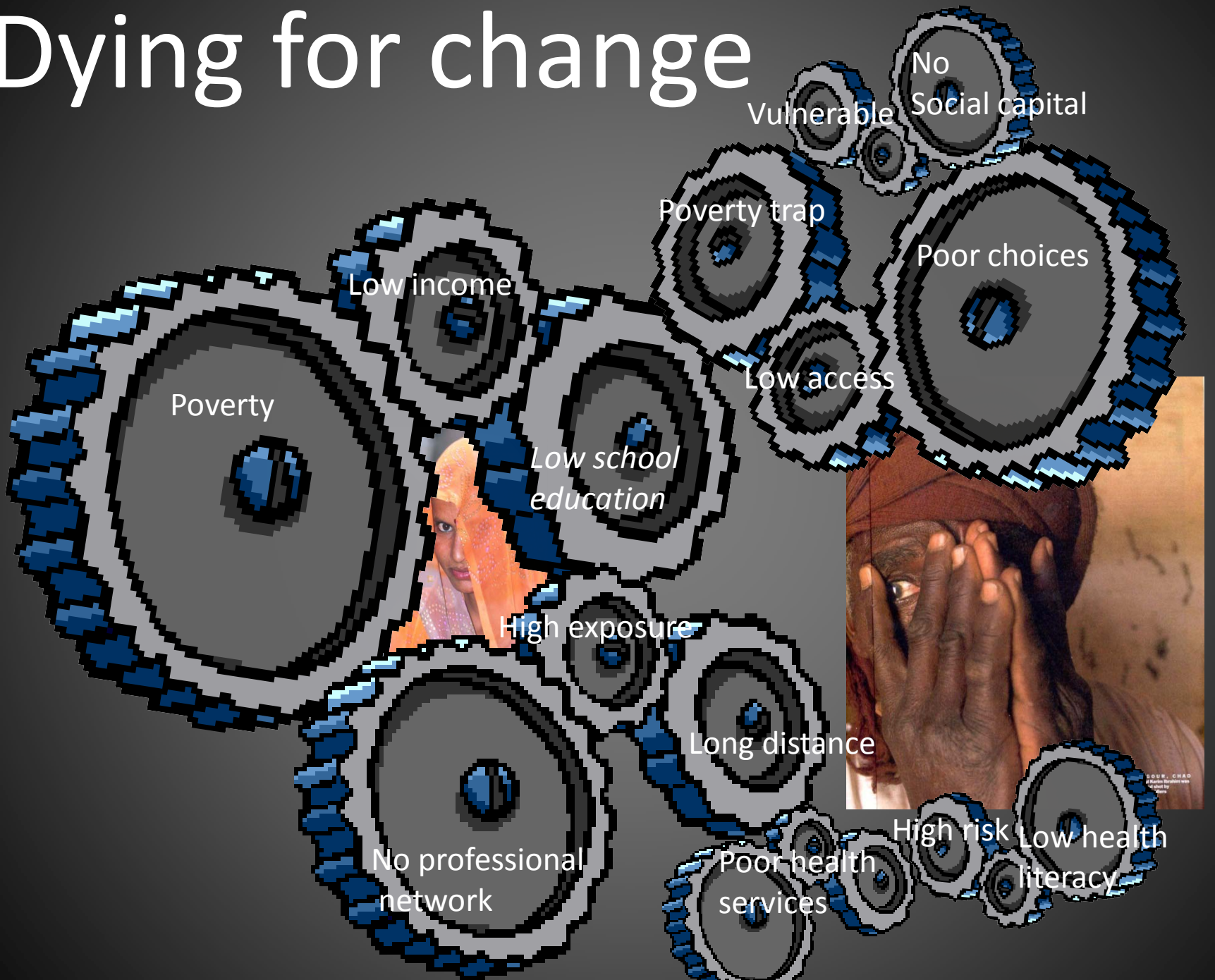
Poor people = poor choices

"People in poor countries are sick not primarily because they are poor but because of ***other social and professional organizational failures including health delivery***, which are not automatically ameliorated by higher income"

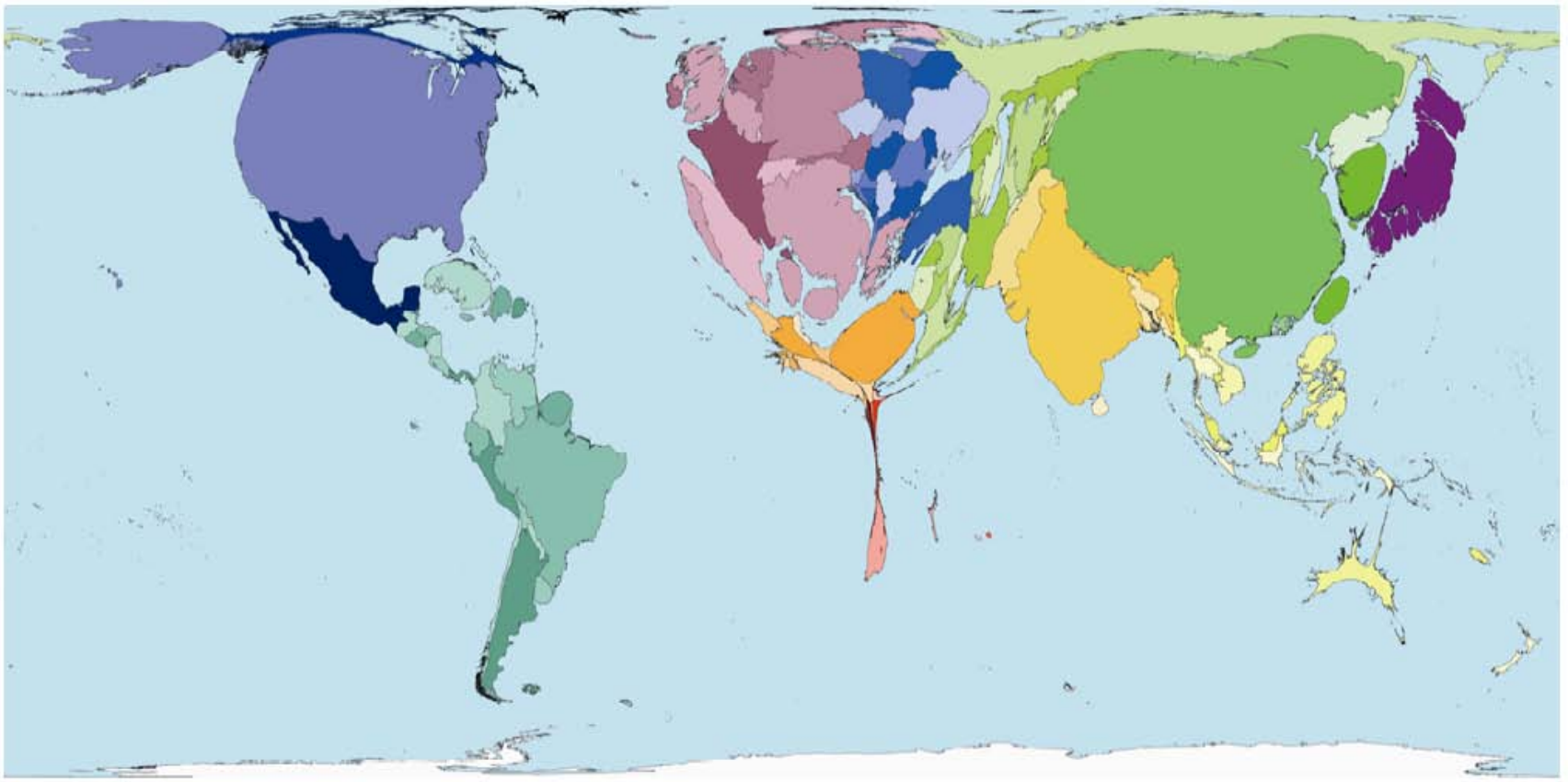
Angus Deaton, WIDER Annual Lecture, September 29, 2006.

Poor people poor choices poor health

Dying for change



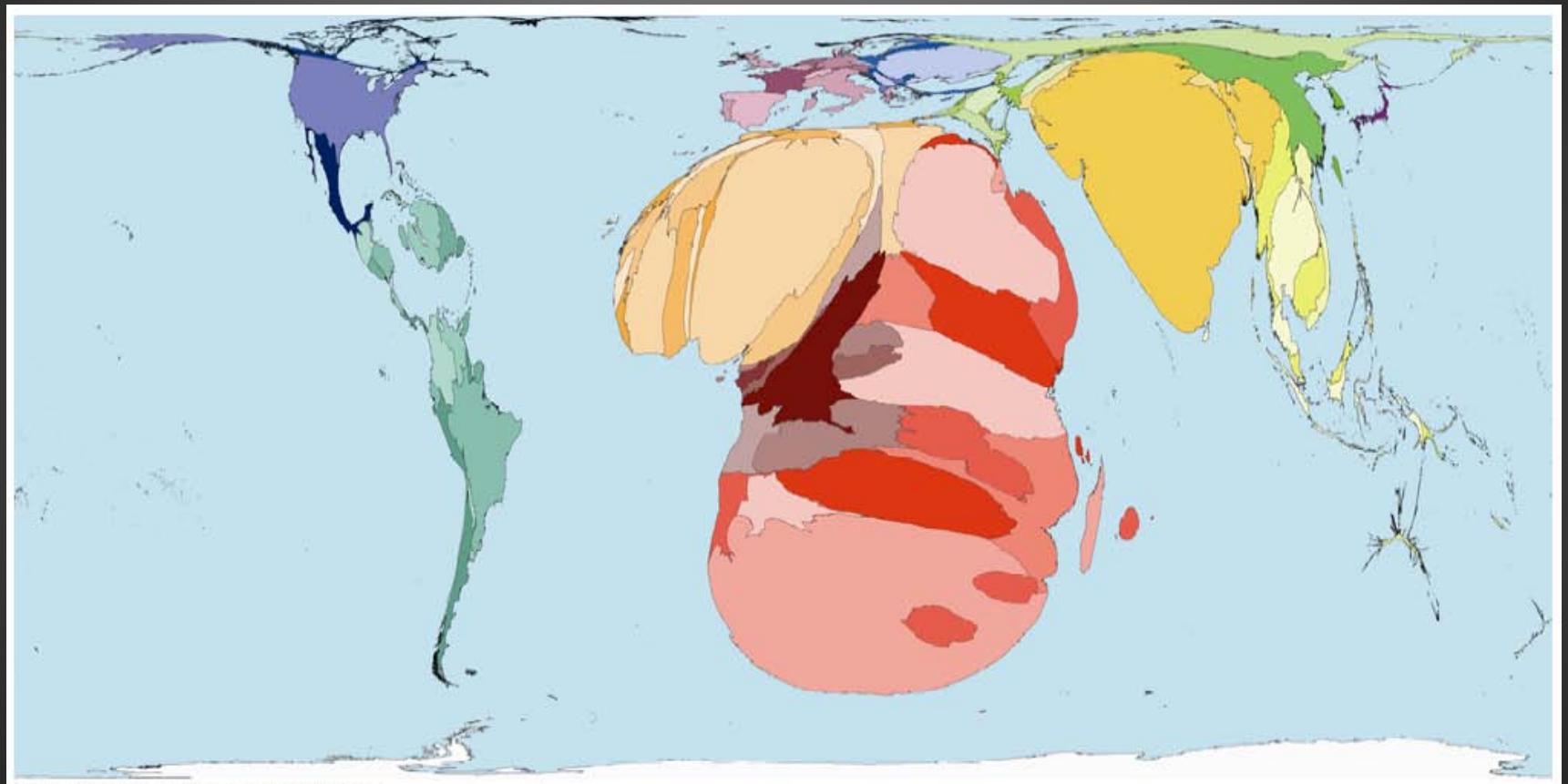
Number of doctors per inhabitant



doi:10.1371/journal.pmed.0040001.g003

Figure 3. Physicians Working: Worldmapper Poster 219

HIV/AIDS prevalence



doi:10.1371/journal.pmed.0040001.g005

Figure 5. HIV/AIDS Prevalence: Worldmapper Poster 227

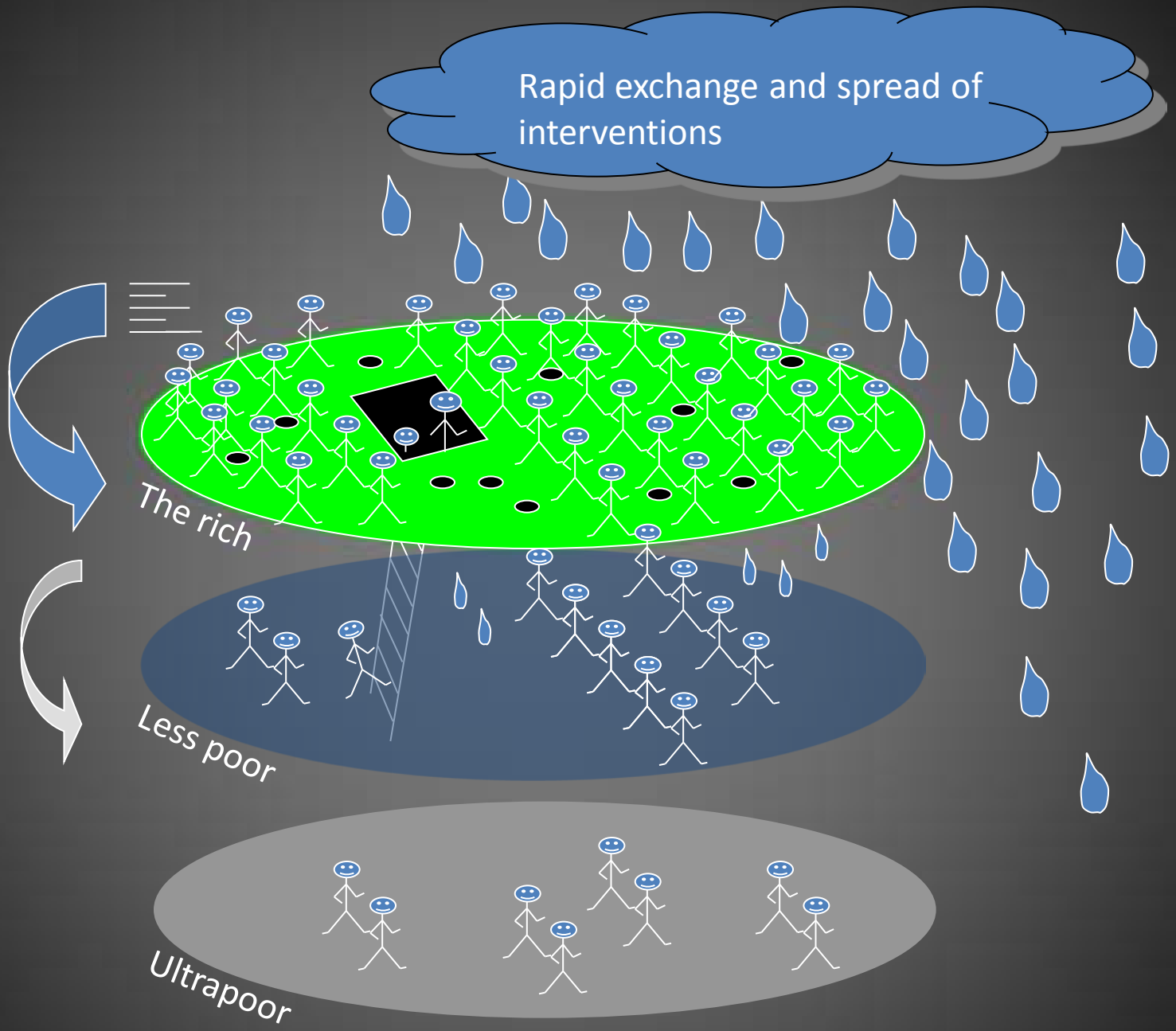
How many child deaths could be avoided?

	Estimated under-5 deaths prevented	
	Number of deaths ($\times 10^3$)	Proportion of all deaths
Preventive interventions		
Breastfeeding	1301	13%
Insecticide-treated materials	691	7%
Complementary feeding	587	6%
Zinc	459 (351)*	5% (4%)*
Clean delivery	411	4%
Hib vaccine	403	4%
Water, sanitation, hygiene	326	3%
Antenatal steroids	264	3%
Newborn temperature management	227 (0)*	2% (0%)*
Vitamin A	225 (176)*	2% (2%)*
Tetanus toxoid	161	2%
Nevirapine and replacement feeding	150	2%
Antibiotics for premature rupture of membranes	133 (0)*	1% (0%)*
Measles vaccine	103	1%
Antimalarial intermittent preventive treatment in pregnancy	22	<1%
Treatment interventions		
Oral rehydration therapy	1477	15%
Antibiotics for sepsis	583	6%
Antibiotics for pneumonia	577	6%
Antimalarials	467	5%
Zinc	394	4%
Newborn resuscitation	359 (0)*	4% (0%)*
Antibiotics for dysentery	310	3%
Vitamin A	8	<1%

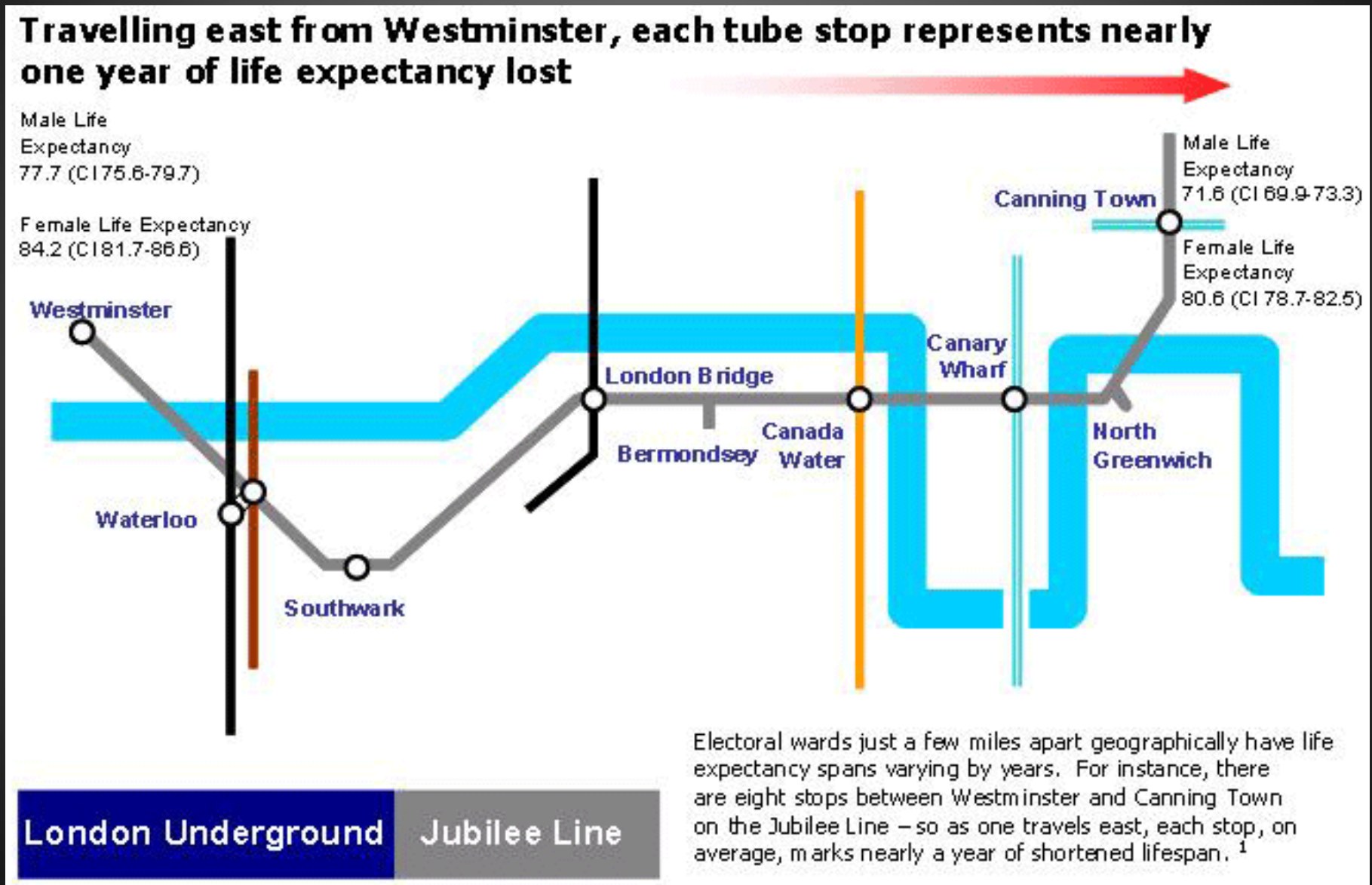
*Numbers represent effect if both levels 1 (sufficient) and 2 (limited) evidence are included, value number in brackets shows effect if only level-1 evidence is accepted. Interventions for which only one value is cited are all classified as level 1.

Table 2: **Under-5 deaths that could be prevented in the 42 countries with 90% of worldwide child deaths in 2000 through achievement of universal coverage with individual interventions**

64% of deaths could be avoided simply by using existing interventions


Rapid exchange and spread of interventions
The rich
Less poor
Ultrapoor

Life expectancy: Not underground fiction



[1] Source: Analysis by London Health Observatory using Office for National Statistics data. Diagram produced by Department of Health

Children in poor countries die earlier

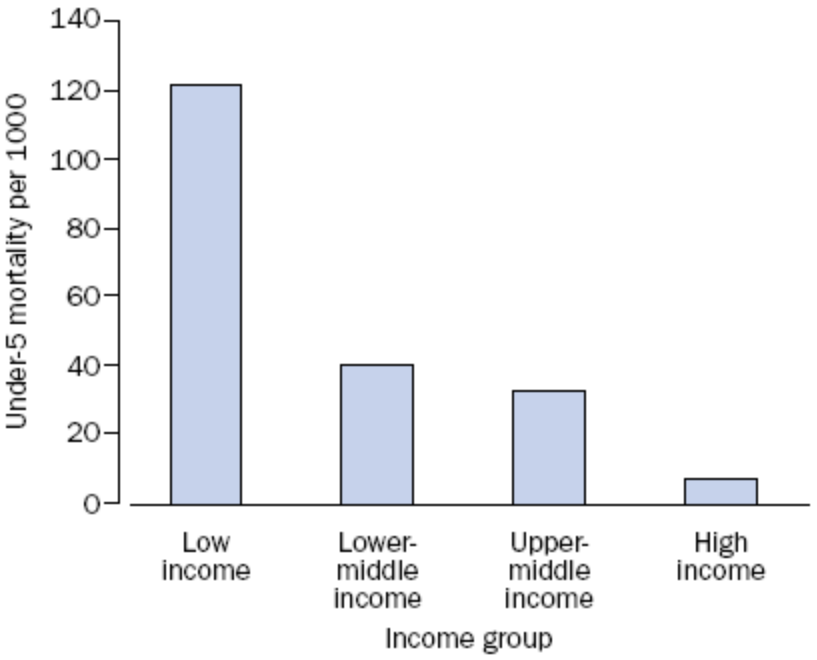
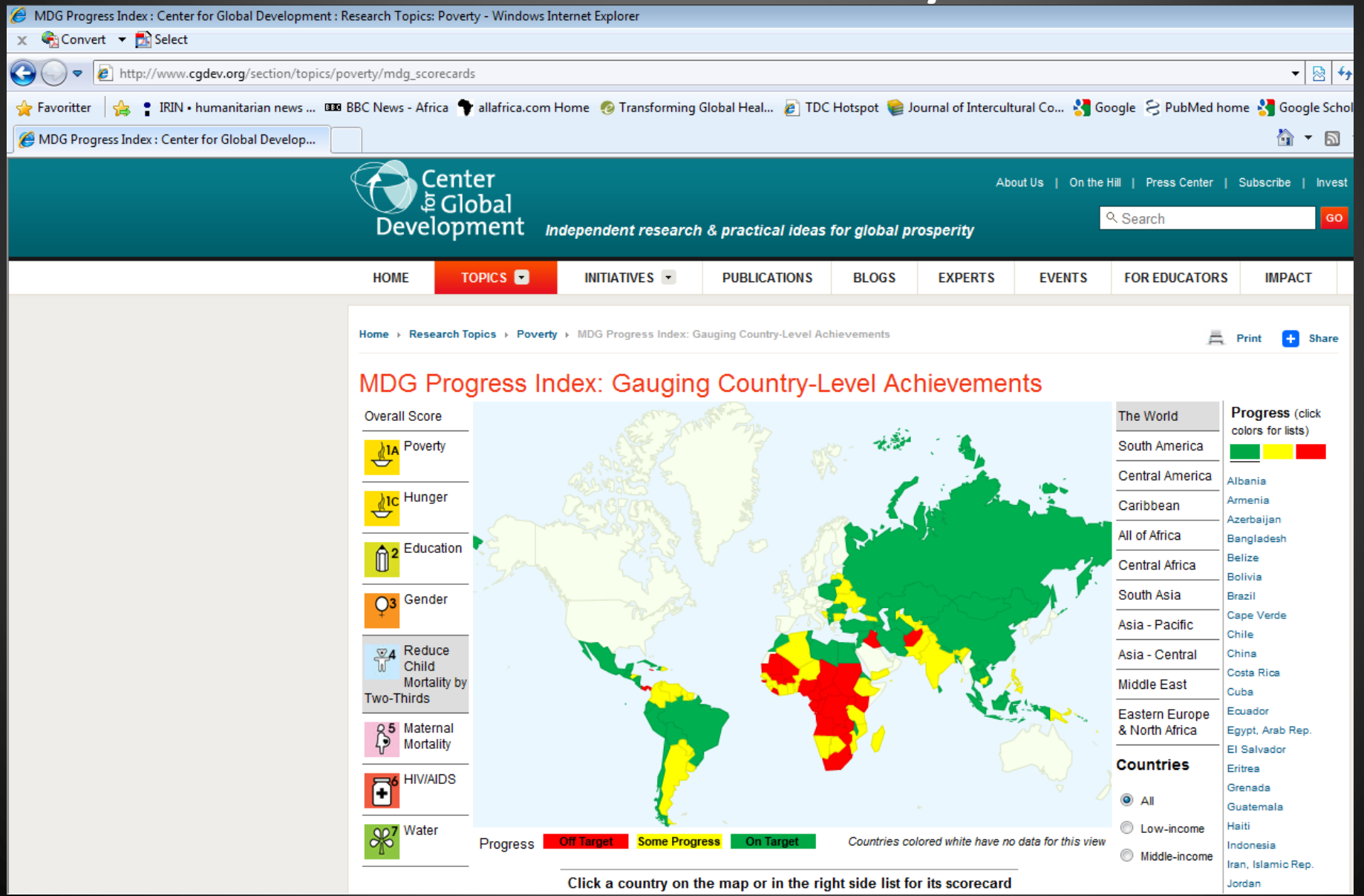


Figure 1: **Under-5 mortality rates by income groups of countries**
Based on data taken from UNICEF[1] and the World Bank.[2]

Child mortality



Children from poor families die earlier

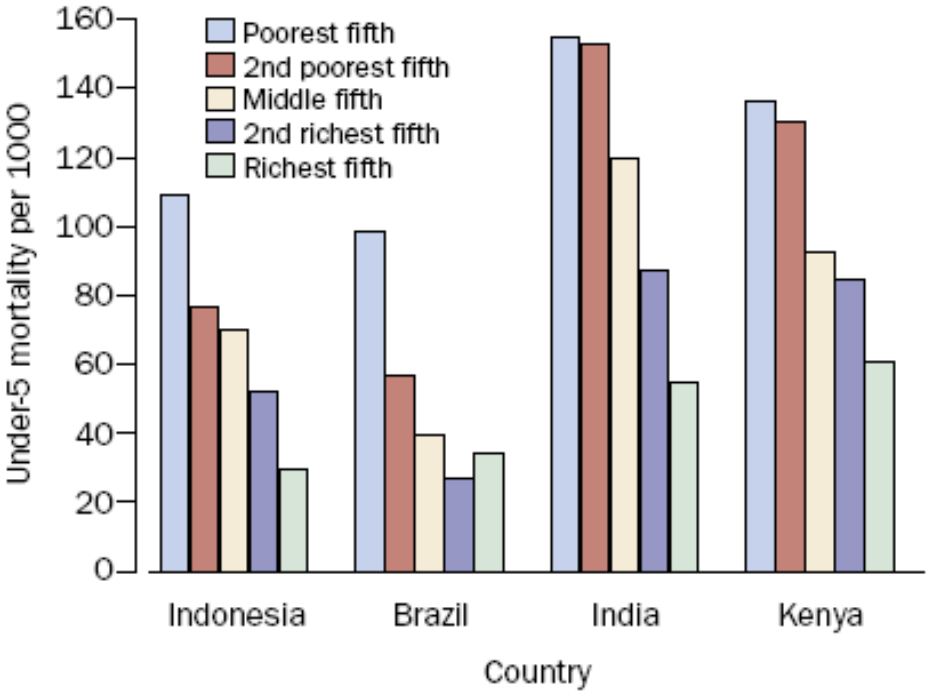


Figure 3: **Under-5 mortality rates by socioeconomic quintile of the household for selected countries**
Based on data taken from the World Bank.[6]

THE LANCET • Vol 362 • July 19, 2003 • www.thelancet.com

Education and mortality risk

Bangladesh

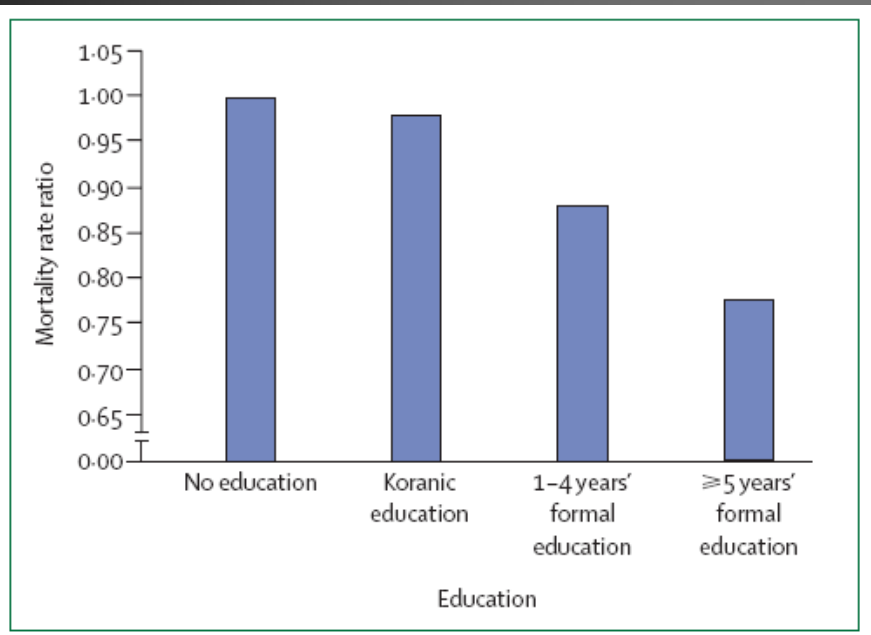


Figure 3: Mortality and education in men aged 45–90 years in Matlab, Bangladesh, 1982–98[11]

Russia

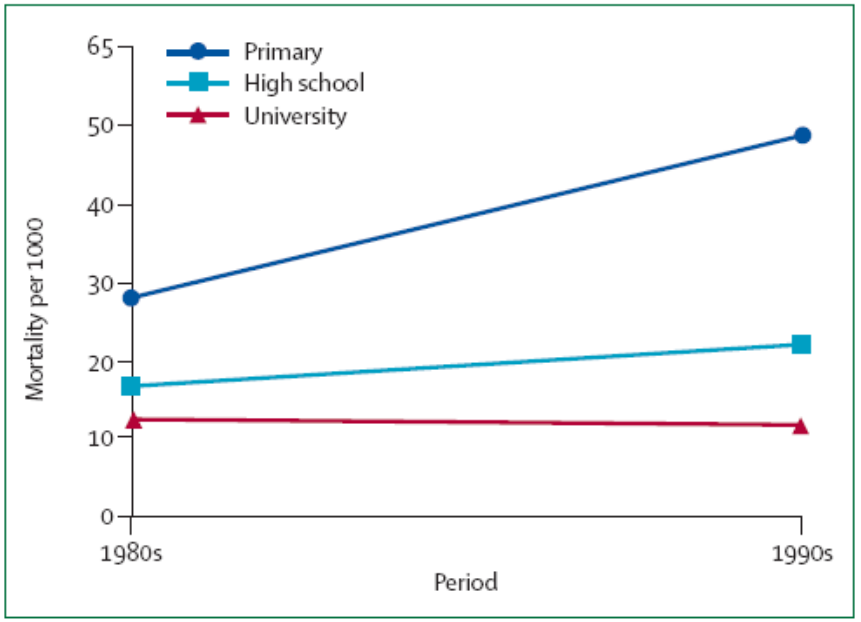
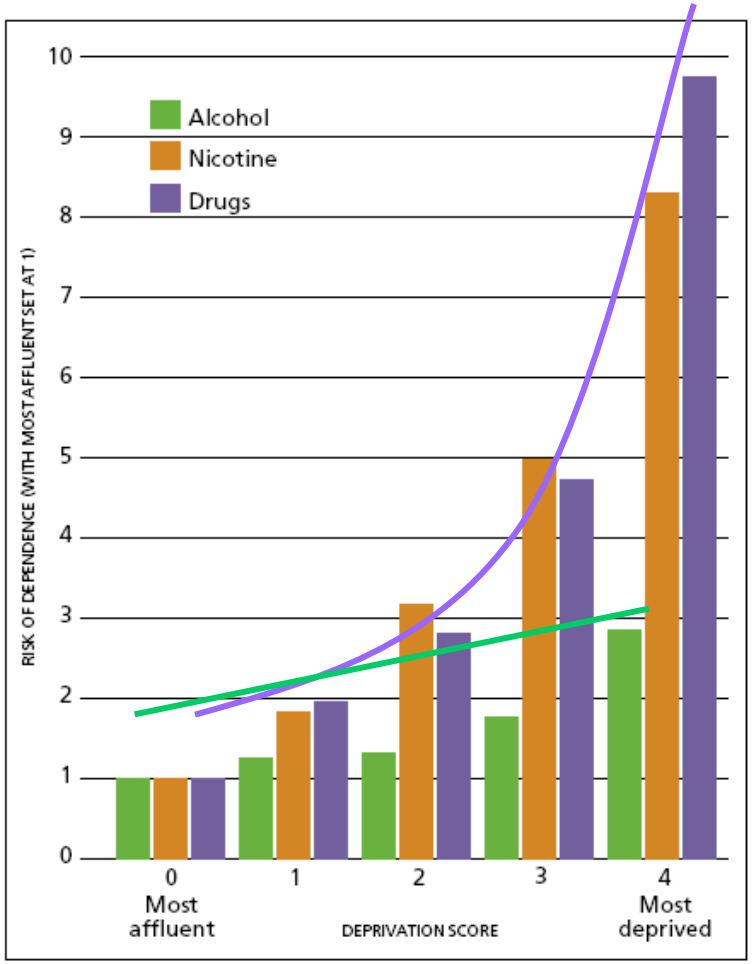


Figure 4: Increase in educational differentials in mortality between the 1980s and 1990s in St Petersburg men[16]

Gwatkin et al 2005, World Bank

Wealth and alcohol, cigarettes and drugs

Fig. 7. Socioeconomic deprivation and risk of dependence on alcohol, nicotine and drugs, Great Britain, 1993



The solid facts, WHO, 2nd ed, 2003

Smoking

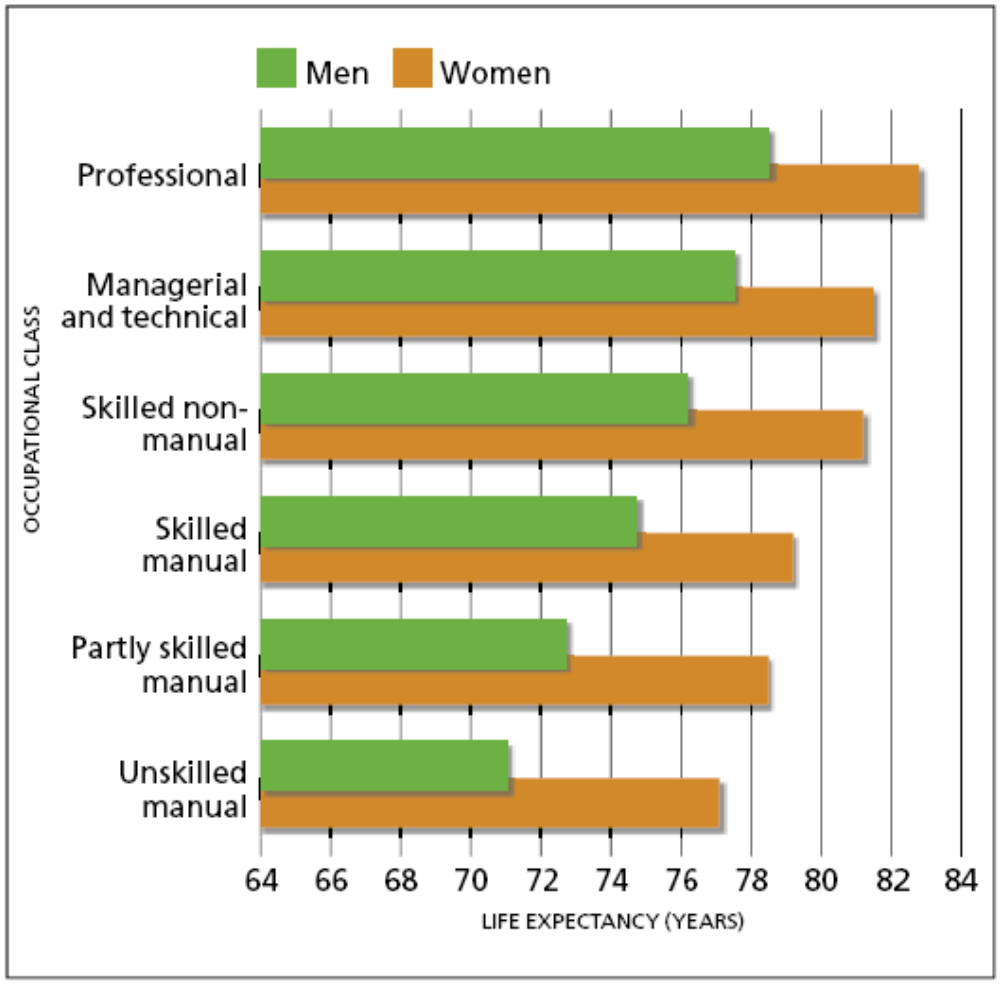
-and child health among the ultra poor:

- **Less vaccines**
- **More respiratory infection**
- **More malnutrition**
- **Higher mortality**

Tupasi et al, 1990
Bonu et al 2004

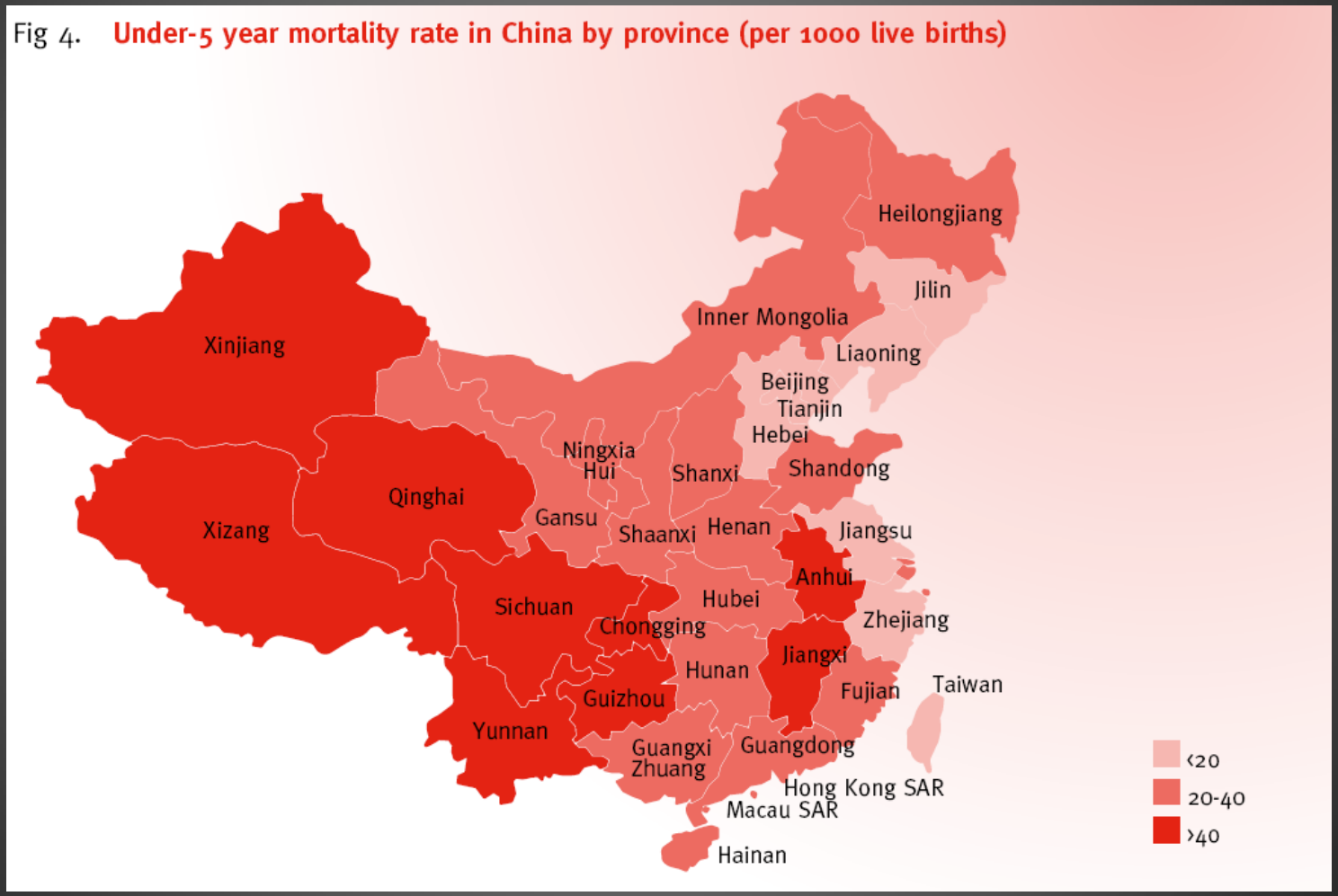
Occupation determines life expectancy

Fig. 1. Occupational class differences in life expectancy, England and Wales, 1997–1999



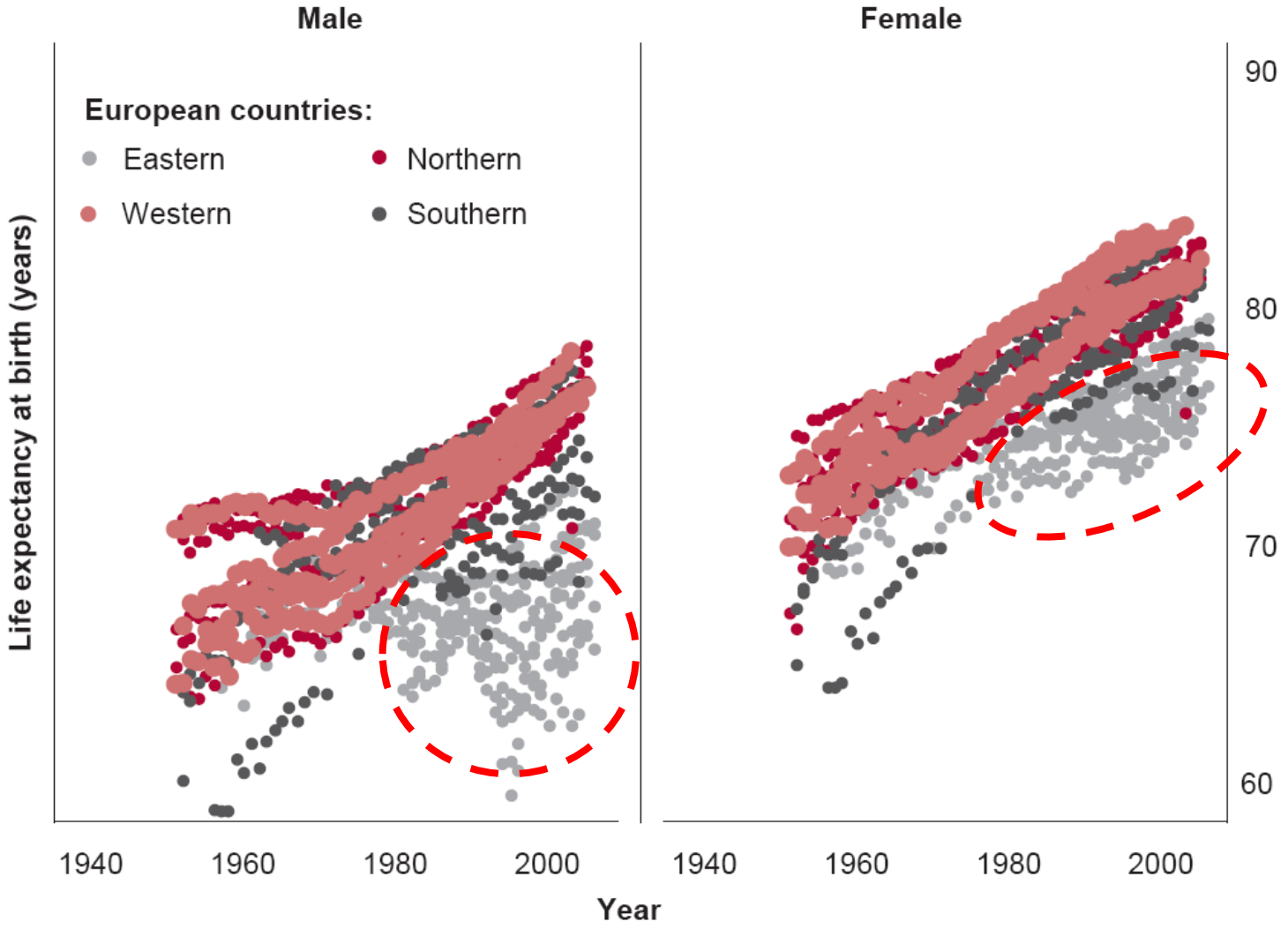
The solid facts, WHO, 2nd ed, 2003

China: child mortality



Presented by Werner Christie in "From inequity in health to equitable health services: the elements of a research agenda".
Source: Ministry of Health. *Maternal Child Health Surveillance System 2002,* courtesy of WHO China.

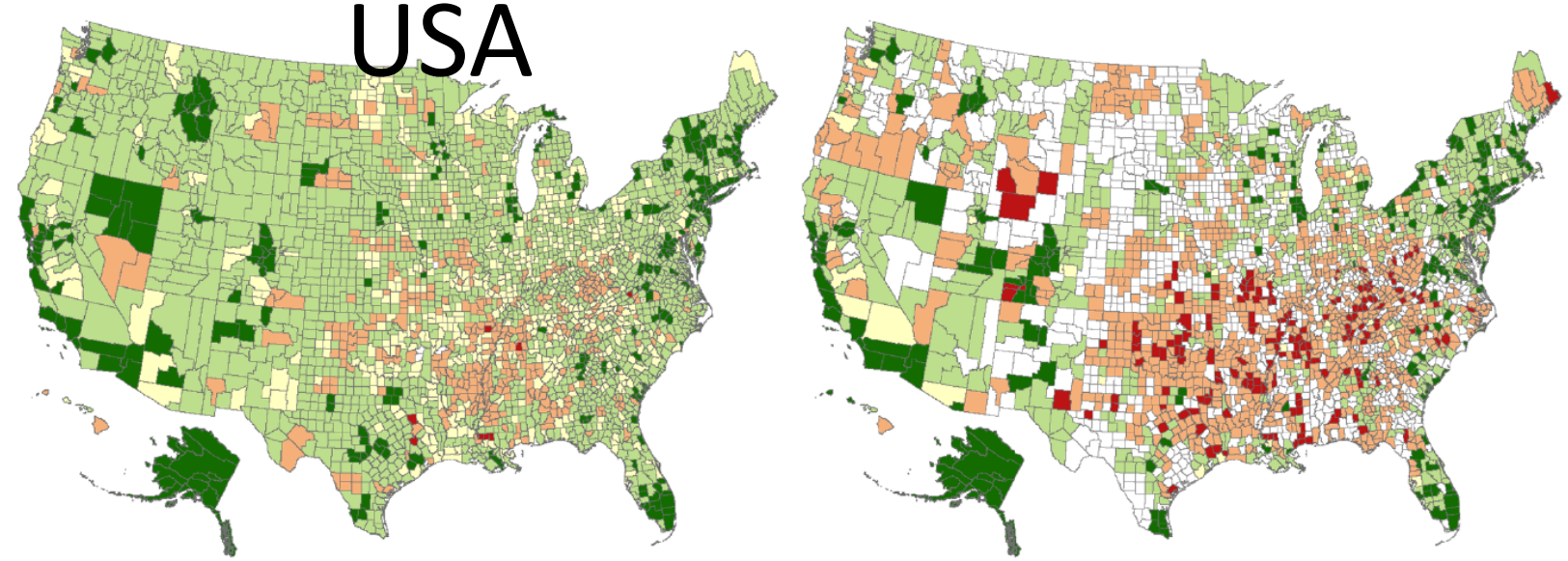
LIFE EXPECTANCY AT BIRTH IN EUROPE, 1950–2005



http://www.who.int/whosis/whostat/EN_WHS08_Full.pdf

1983-1999

USA



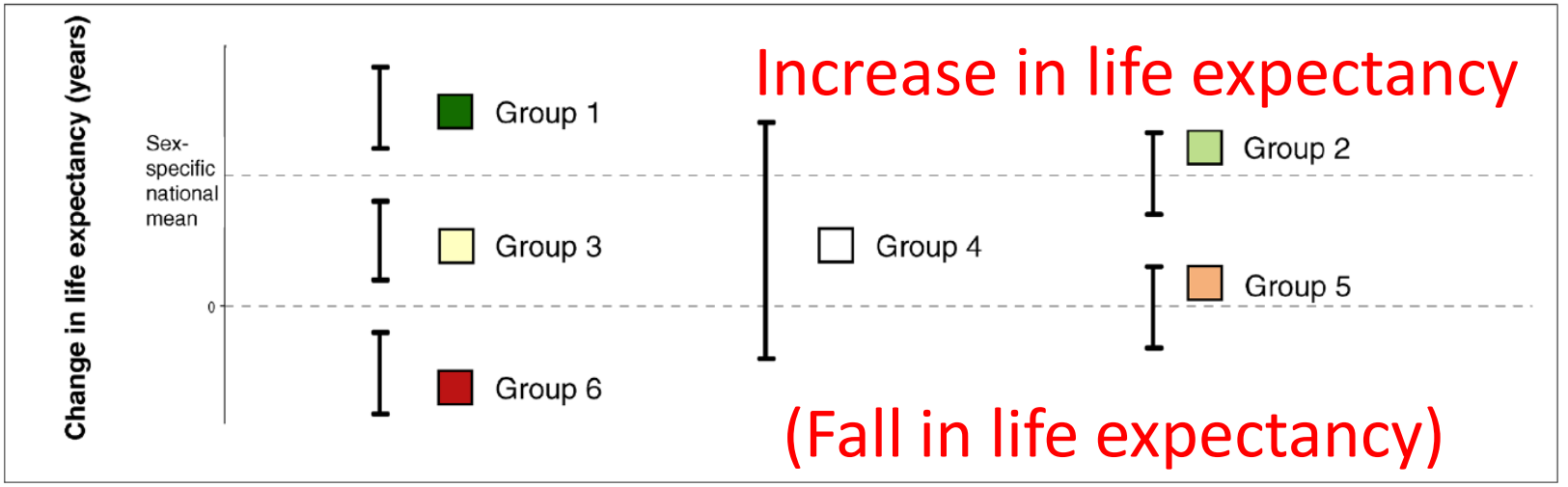


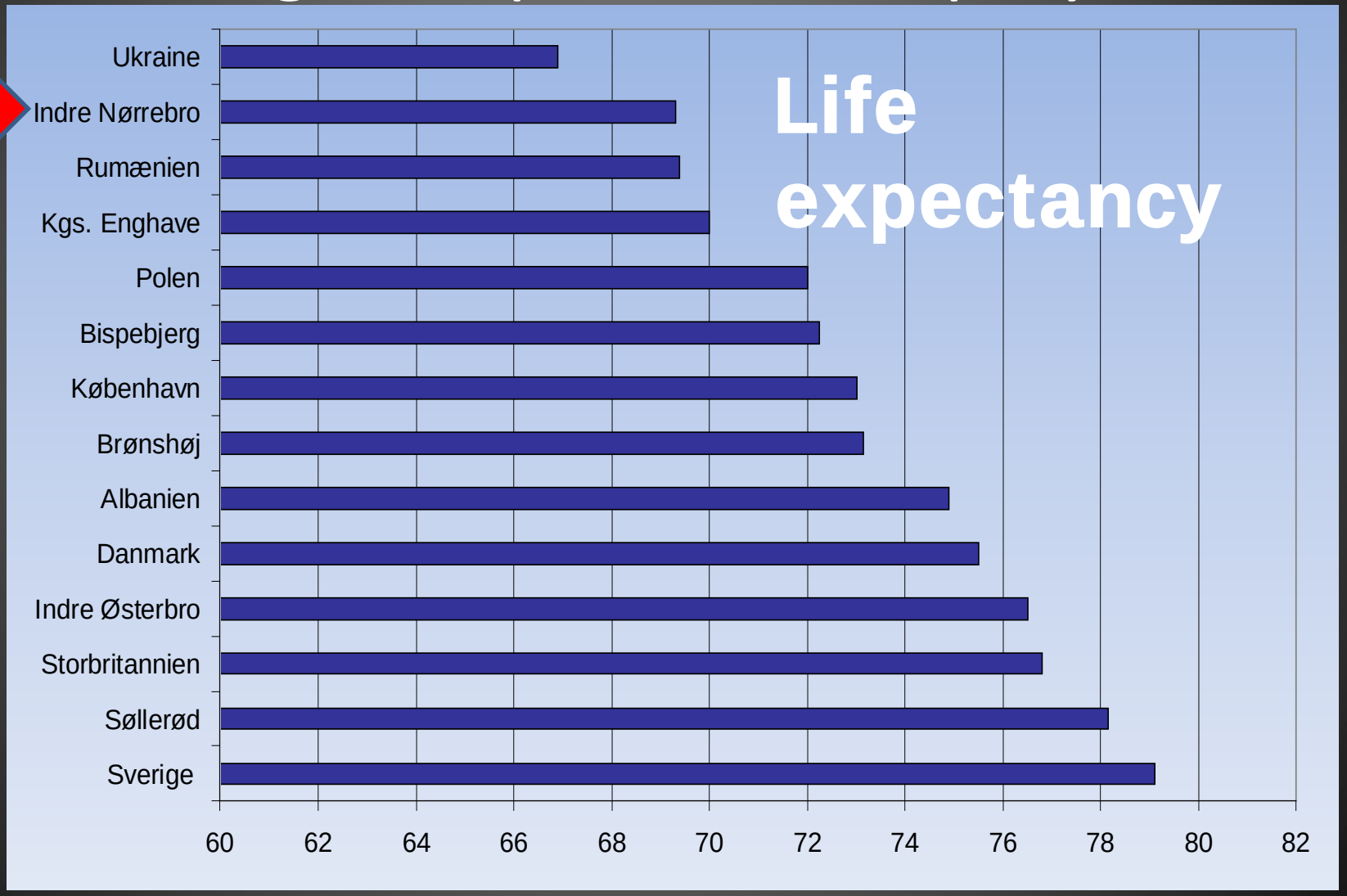
Figure 3. Change in County Life Expectancy in 1961–1983 and 1983–1999

Counties are categorized into six groups on the basis of how their life expectancy changed in relation to national sex-specific change in life expectancy (4.1 y for men and 4.8 y for women in 1961–1983; 3.1 y for men and 1.3 y for women in 1983–1999). Actual life expectancies are shown in Figure S1, and absolute changes in life expectancy are shown in Figure S2.

Group 1, life expectancy increased at a level significantly higher than the national sex-specific mean; group 2, life expectancy increased at a level

http://medicine.plosjournals.org/archive/1549-1676/5/4/pdf/10.1371_journal.pmed.0050066-L.pdf

And even in little Denmark we have managed to produce inequity….

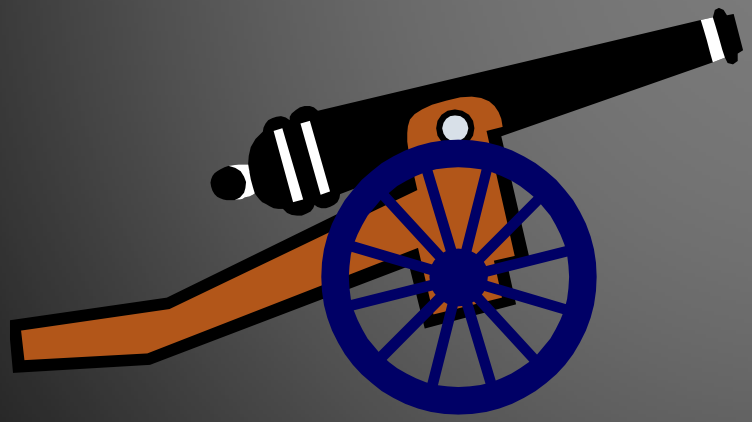


Didrichsen, Conference on social determinants of health, Copenhagen, 2009

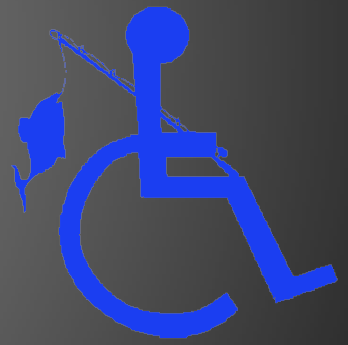
Living conditions and genetics – plenty of bullits and triggers:

"Genes load the gun. Lifestyle pulls the trigger"

Dr. Elliot Joslin



Equal access, but to what?



The bill please!

The poor with low education:

3,5 bill dkr saved had they been rich and educated

15-25 % of death and disease

Extra cost in health care per year: (ill health and early death)

27,2 bill dkr

Lost productivity (Sick leave and early death)

21,2 bill dkr

Sum 49,4 bill dkr

DAGENS MEDICIN

UAFHÆNGIG NYHEDSAVIS OM SUNDHEDSSEKTOREN

Søndag 31 august 2008

Søg efter: Søg

- Nyheder
  - Forskning
  - IT
  - Erhverv
  - Udland
  - Navne
- Blog
- Job
- Nyhedsbrev
- Spørg SSI
- Ferieservice
- Kalender
- Bøger

Avisen

- Leder
- Debat
- Stikpillen

Tip en ven | Udskriv siden

Danmark taber 49 mia. kr. årligt på ulige sundhed

2008-08-29

Hvis lavt uddannede og udsatte grupper var lige så sunde som resten af befolkningen, kunne sundhedsvæsenet spare 27,2 mia. kr. En skærpet indsats mod tobak og alkohol og bedre behandling af psykiske sygdomme vil give hurtige resultater, fastslår professor Jes Søgaard.

Regningen for de store forskelle i danskernes helbred er enorm. Sundhedsvæsenet bruger hvert 27,2 mia. kr. på at behandle sygdomme, der følger i kølvandet på lav uddannelse, arbejdsløshed og andre former for social ulighed. Det viser nye beregninger fra Dansk Sundhedsinstitut (DSI), der bygger på en undersøgelse foretaget for EU-kommissionen.

»Hvis de lavt uddannede havde samme sygelighed som resten af befolkningen, ville sundhedsvæsenet kunne spare 27,2 mia. kr. « siger professor Jes Søgaard, der er

Relaterede artikler

- Målrettet hjælp skal rette skæve Danmark op
- Jobtræning i fitness-centeret
- Leder: Ned med paraderne

Ulighedens pris

- Sundhedsudgifter:

Report, Dansk Sygehus Institut, Aug 2008

Tuberculosis Treatment Disparities, Kenya

DOTS for Rx of Smear +ve TB	Expected Efficacy	Case detection	Diagnostic delay	Visits to providers	Patient Adherence	Cost of Care	Actual Effectiveness	Least Poor:Poorest Ratio
Poorest	98%	low	high	high	high	high	20%	4
Least Poor	98%	high	low	low	high	low	80%	

Sources of disparities

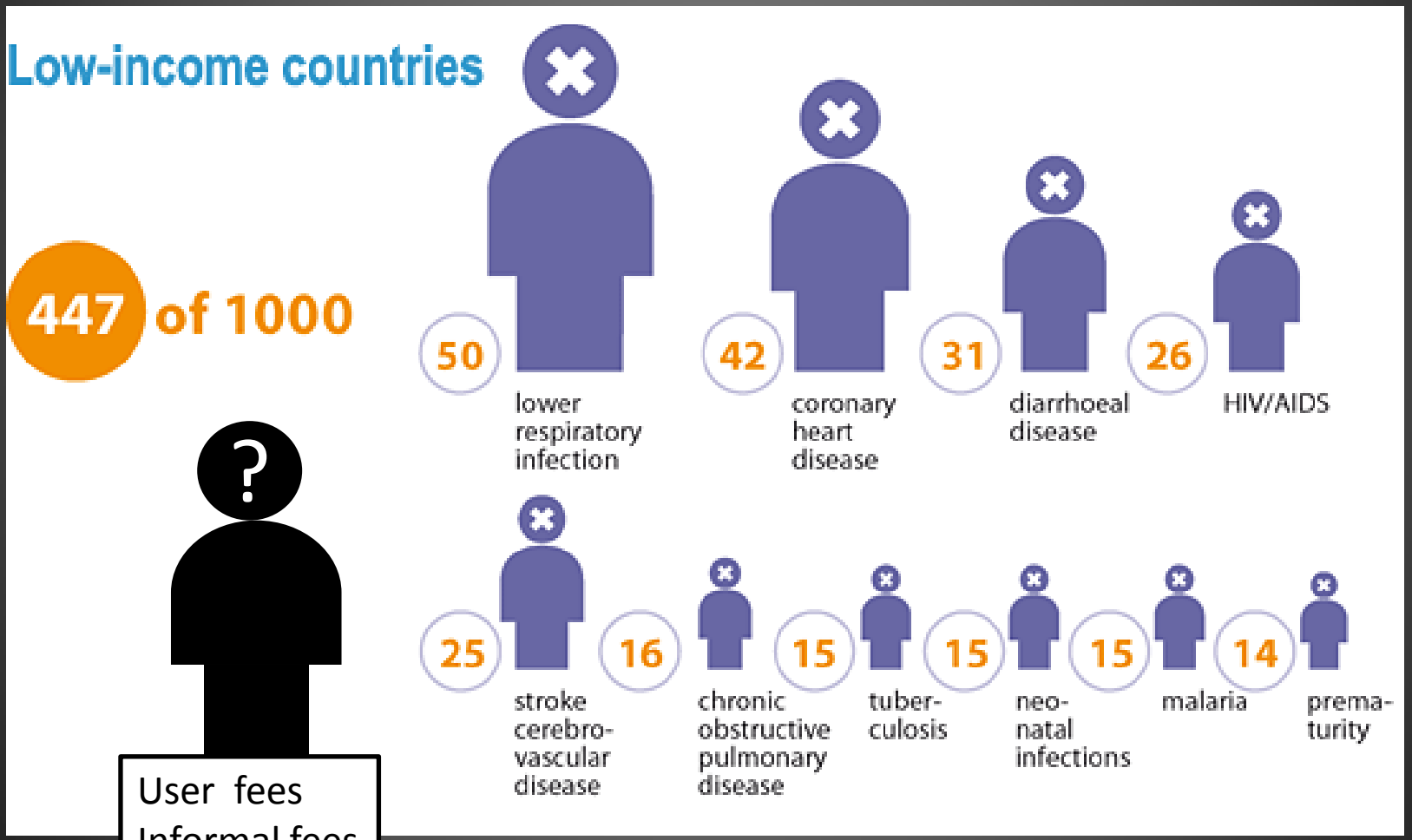
More equitable service provision requires action on the social determinants of health

Adapted from data from Hanson et al 2003 and from framework of Peter Tugwell

World Health Organization

Global health case 4

And the nominees as top 10 killers are:



User fees: 3

or a global disaster?

Neccessary evil

Benin: Birth complications cost 26% of average yearly household expenditure: patients left the hospital too early

Borghi J, Hanson K, et al. *Health Policy Plann* 2003, **18:** 383–90.

Cote d'Ivoire: time spent looking for cash delayed access to emergency care and increased mortality

Gohou V, Ronsmans C, Lacou L, *Trop Med Int Health*, **9:** 406–15

Burkina Faso: User fees catastrophic in emergency or"technological" interventions and push poor people into a poverty trap

Tin Tin Su, Kouyate B, Flessa S. *Bull World Health Organ* 2006, **84:** 21–27

Guinea-Bissau: knowing a medical doctor = no fees

Sodemann et al, TMIH, 2006

Tanzania child mortality study 208 childhood deaths:

21 % had paid unofficial fees at least once

86 % paid more than 1500 shillings

Sodemann, rasch et al, unpublished

Poor TB patients are 5 times more likely

To pay impoverishing payment for supposedly free treatment

WHO.org, The solid facts: social determinats of health, 2007

India

- The free public health care is just as expensive as private health care

Seeberg J et al 2008

User fees

Never evaluated properly before global introduction

Never monitored properly

Palmer N, Mueller DH, Gilson L, Mills A, Haines A.
Lancet. 2004 Oct 9-15;364(9442):1365-70. Review.

User fees

Governments failed to protect the poor after the introduction in

Benin, Kenya and Zambia

Gilson L, Kalyalya D, Kuchler F, Lake S, Oranga H, Ouendo M. Health Policy. 2001 Oct;58(1):37-67.

User fees

An irreversible medical disaster

Poverty gap was sparked by user fees

Cambodia: Jacobs b et al, *Health Policy Plan. (2004) 19 (5): 310-321.*

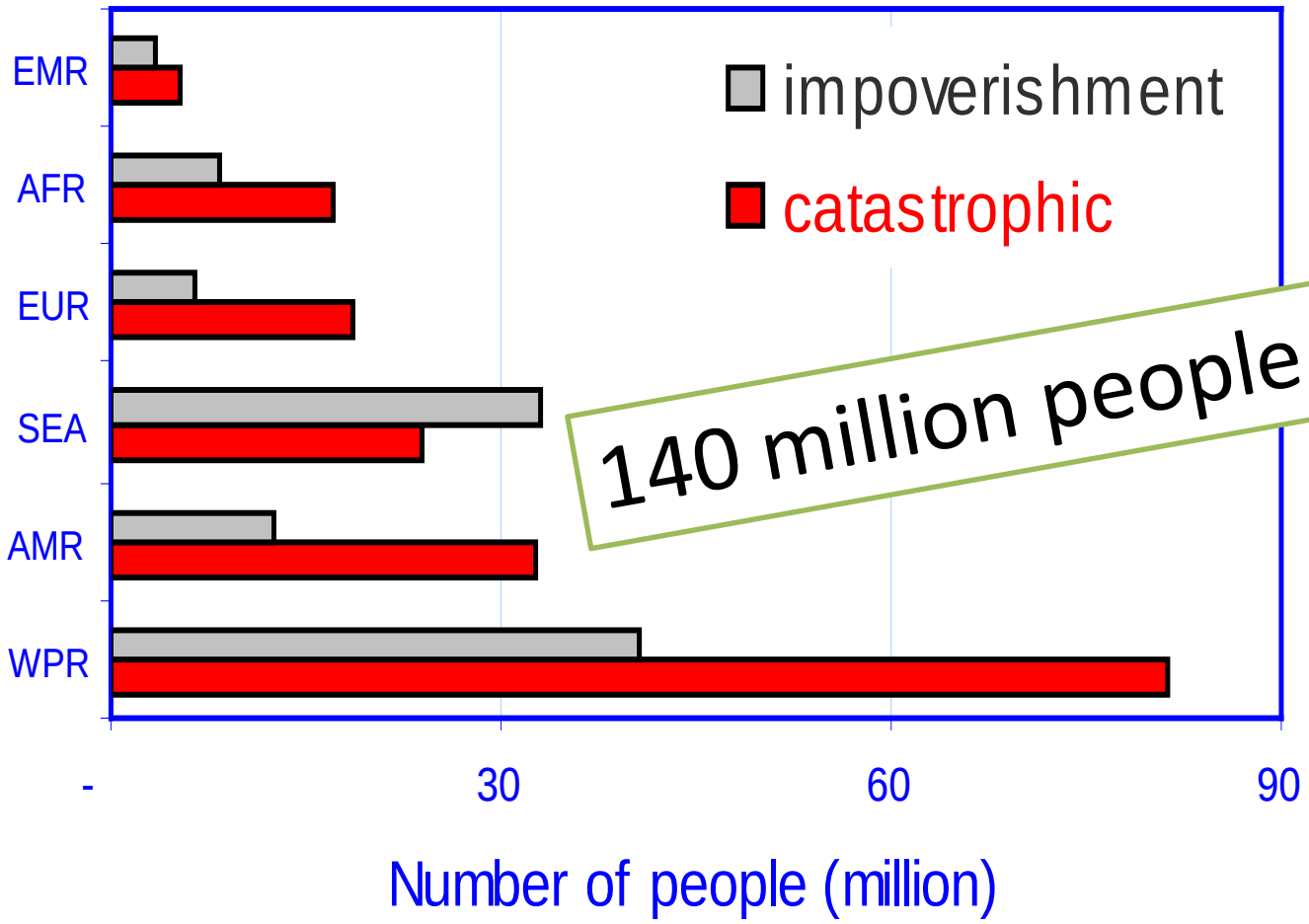
User fees

After abolishment:
Catastrophic health expenditures among the poor did not fall

- Unofficial/informal fees
- private pharmacies

Xu K, Evans DB, Kadama P, Nabyonga J, Ogwal PO, Nabukhonzo P, Aguilar AM. Soc Sci Med. 2006 Feb;62(4):866-76.

Number of People Suffering Financial Catastrophe and Impoverishment Due to Health Spending



Global health case no. 5: Hiv/AIDS

How the circumcision solution will increase hiv + STI prevalence

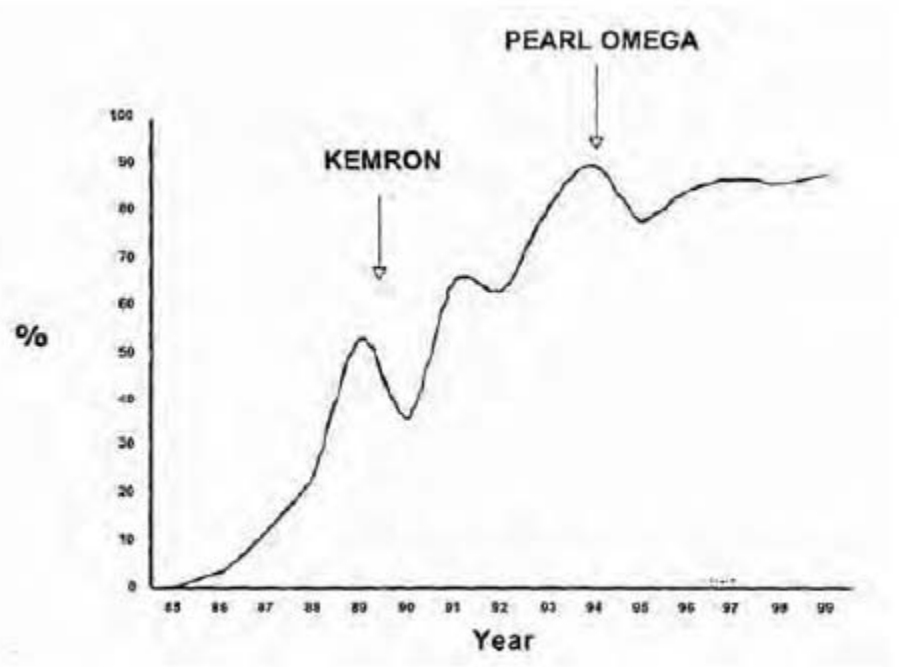
- **Confusing and illogical message**
  - Circumcision prevents HIV……but you still have to use condom
    - Why use condom ***after*** circumcision?

- **Other**
  - ***> 20 studies show no effect on population level***
  - 3 identical RCT but not blinded studies….
  - STIs
  - Condoms are better – why a less effective?
  - Tested in communities where circumcision is not customary
  - Optimal age not definite – ethics (children)
  - All men have to be treated (how?)– more expensive
  - Carrried out in a high risk population
  - ARV is changing the risk picture constantly

Connolly et al, 2002
Van Howe et al, 2011

Hiv literacy, ethics and media drugs

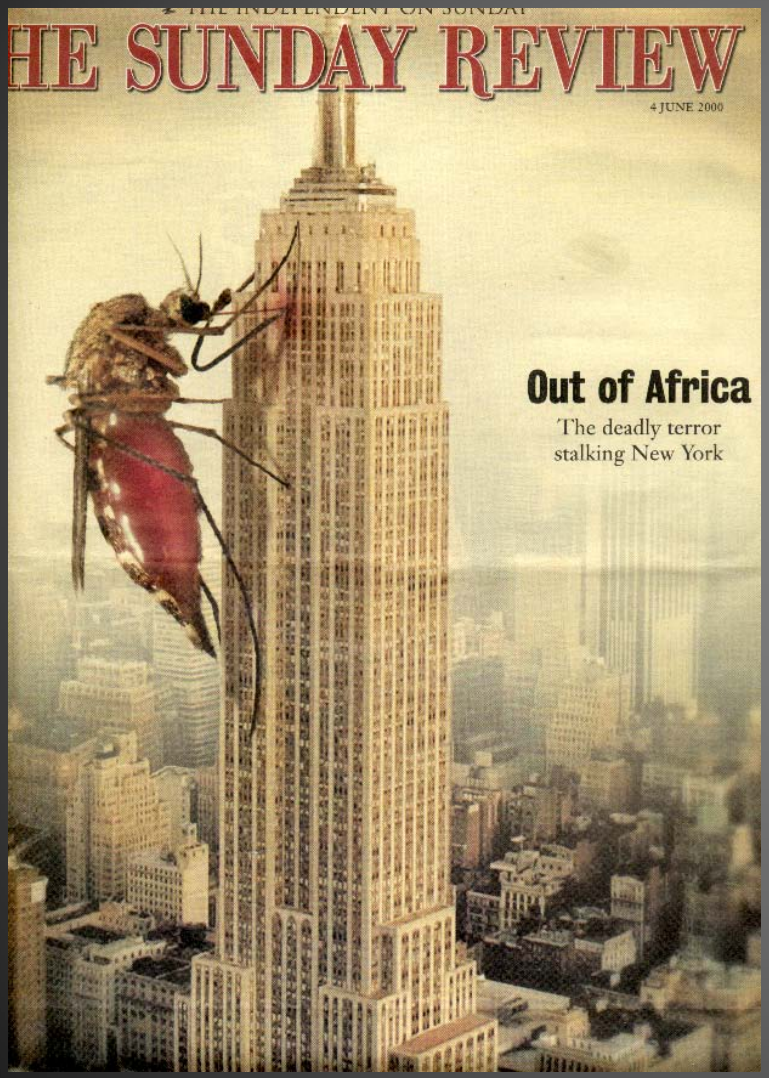
- **”Kemron” og ”Pearl Omega” were completely fake cures for Hiv**
- **Announced by respected physicians**
- **- and increased hiv risk behaviour for several years**



Source: Jha et al. (2001)

Damien de Walque, working paper 239, 2011, www.cgdev.org

The future is not what it used to be

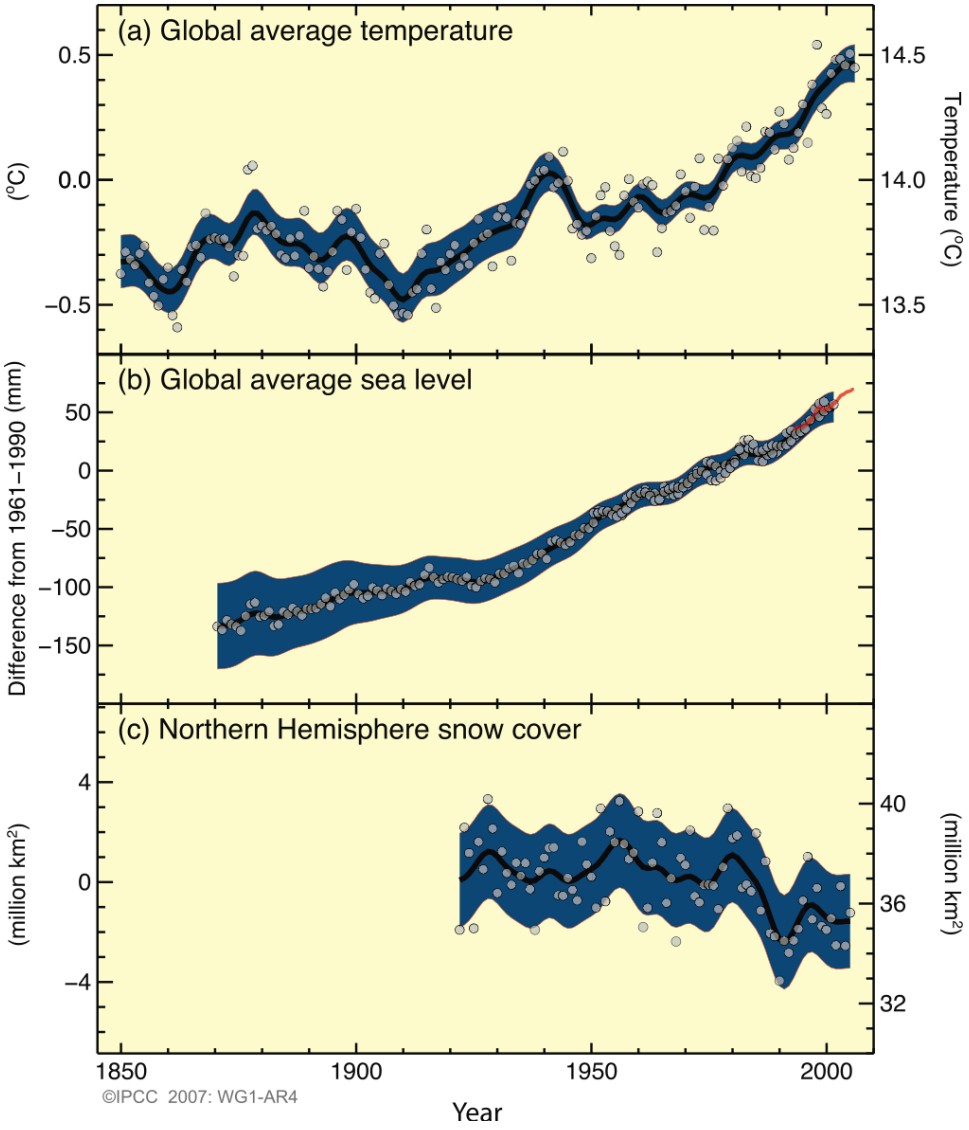


Global warming is unequivocal

Rising atmospheric temperature →

Rising sea level →

Reductions in North Hemisphere snow cover →



Source: IPCC Summary for Policymakers: WG I (2007).

A. Haines 2008

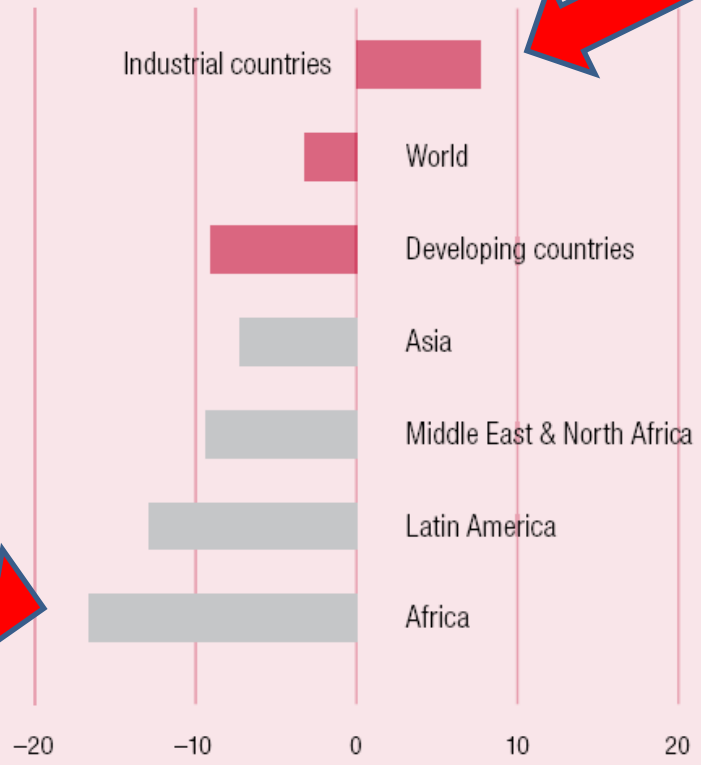
Aral sea (Kazakhstan)

Cause is one thing

But it doesn’t change the effect

Figure 6 **Climate change will hurt developing country agriculture**

Change in agricultural output potential (2080s as % of 2000 potential)



Source: Cline 2007.

Human Development report 2007/2008

Renal failure and heat waves….

Australia

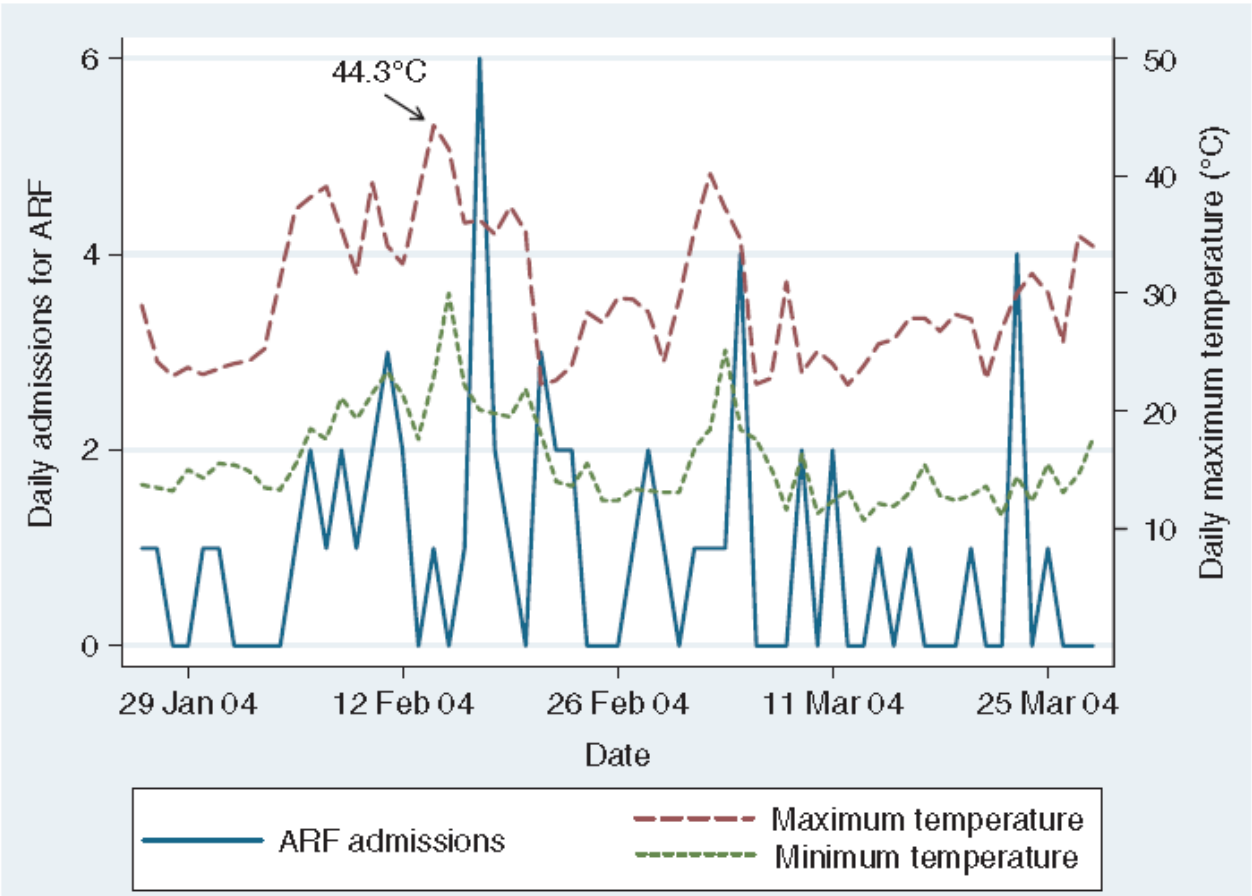


Figure 1 The relationship between daily hospital admissions for ARF and temperature during February and March 2004 when three heat waves were recorded

et al, Int J Epidemiol, 2008

Anopheles mosquitoes and disappearing forest Kenya

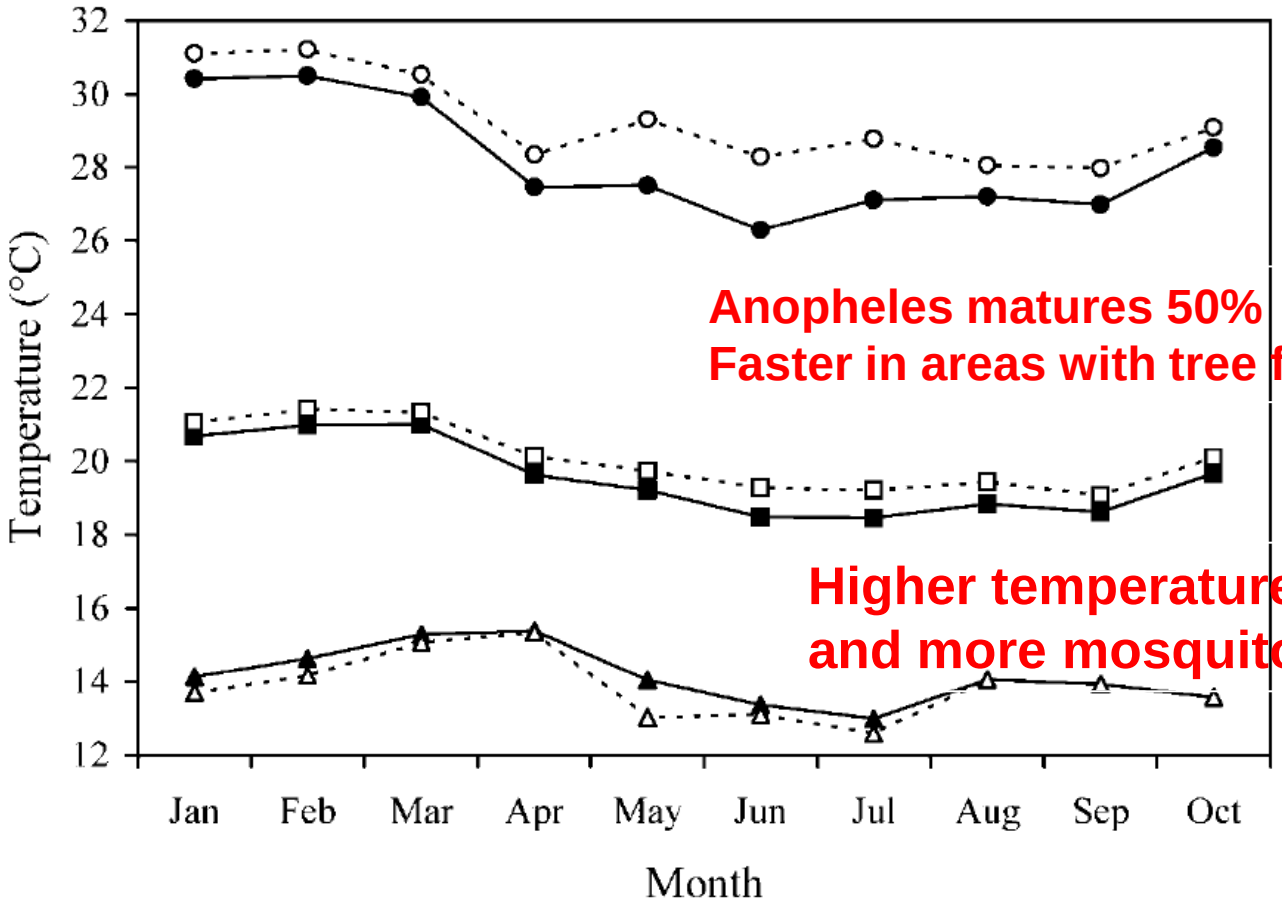


FIG. 6. Comparison of the maximum (○), mean (□) and minimum (Δ) temperatures recorded within huts in deforested agricultural lands with the corresponding maximum (●), mean (■) and minimum (▲) temperatures recorded within huts in forests. This graph was produced by Afrane *et al.* (2005), using data collected in western Kenya, and is reprinted here with the permission of the Entomological Society of America.

Pasqual et al 2006,Patz et al, 2006 og Lindblade et al 2000

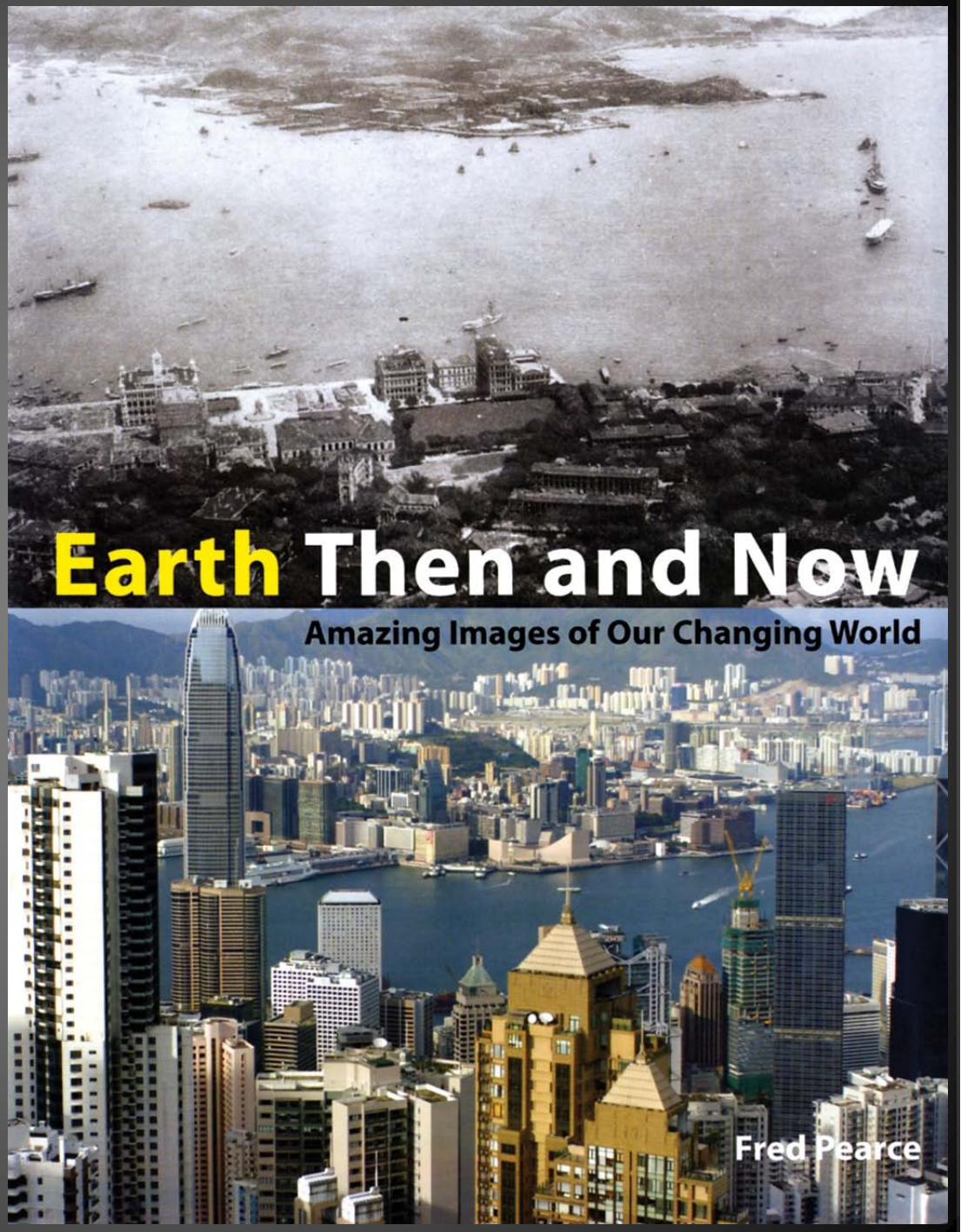
The anatomy of a malaria disaster: Amazon delta (Peru)

- > 80% tree felling→ ***200 x More bites*** from Anopheles darlingi (vs. < 30% tree felling)
- ***Every 1% increase in tree felling = 8 % increase in A. darlingi***

Patz J, Johns Hopkins, 2003

Urbanisation

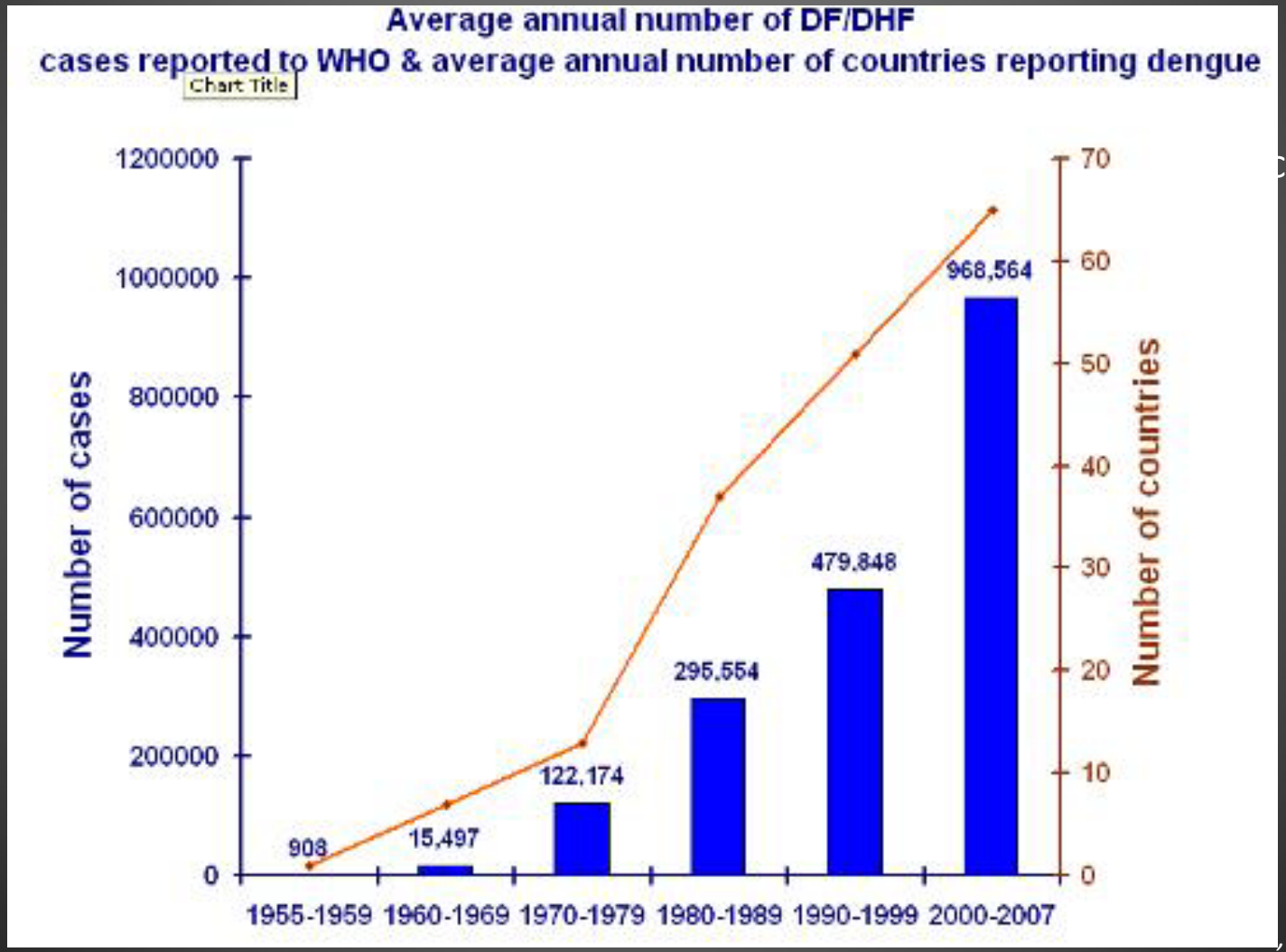
60 % live in urban areas



Dengue

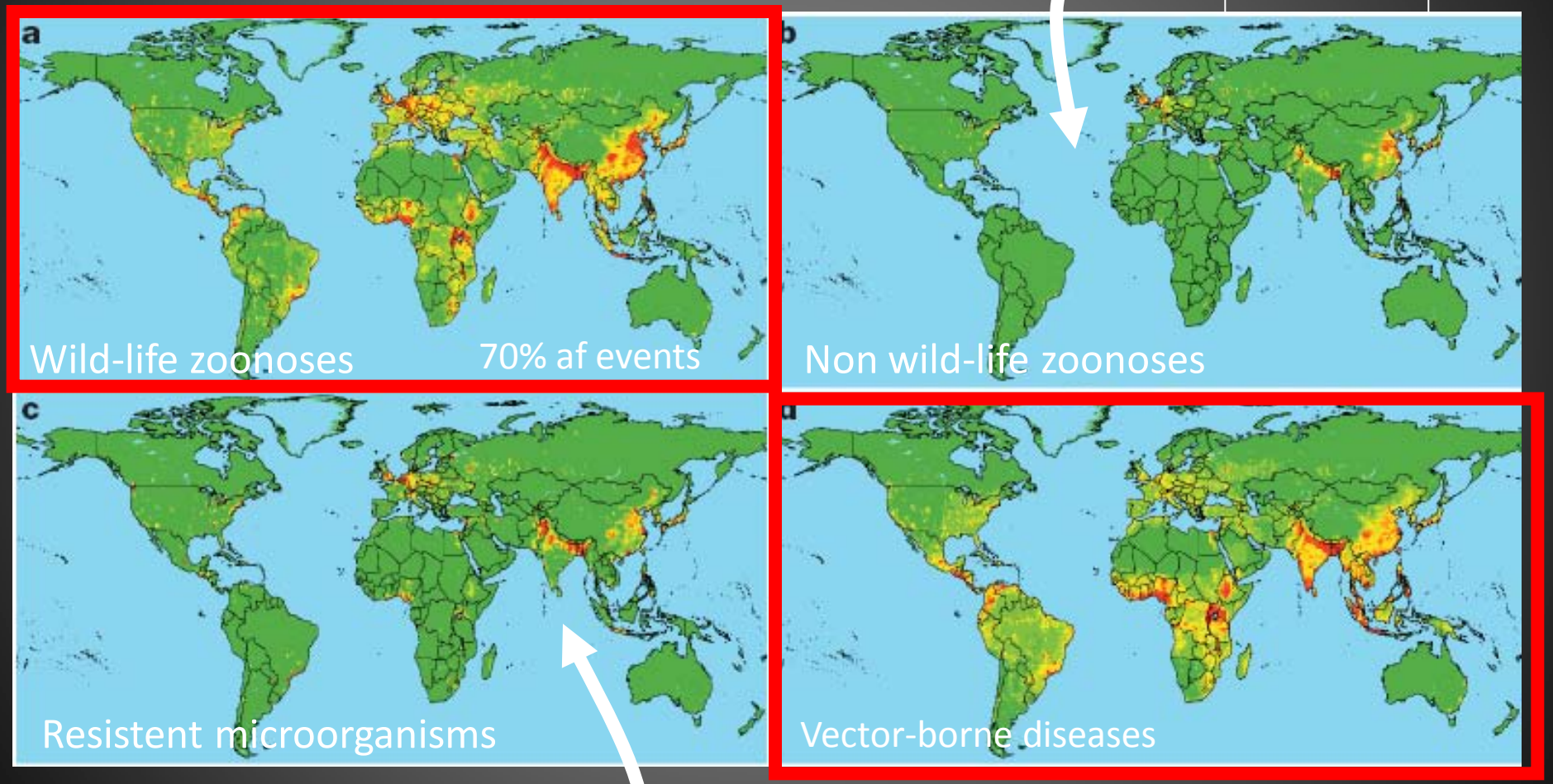
Cases

countries



, 2007

Relative risk of Emerging Infectious Disease event 1940-2004

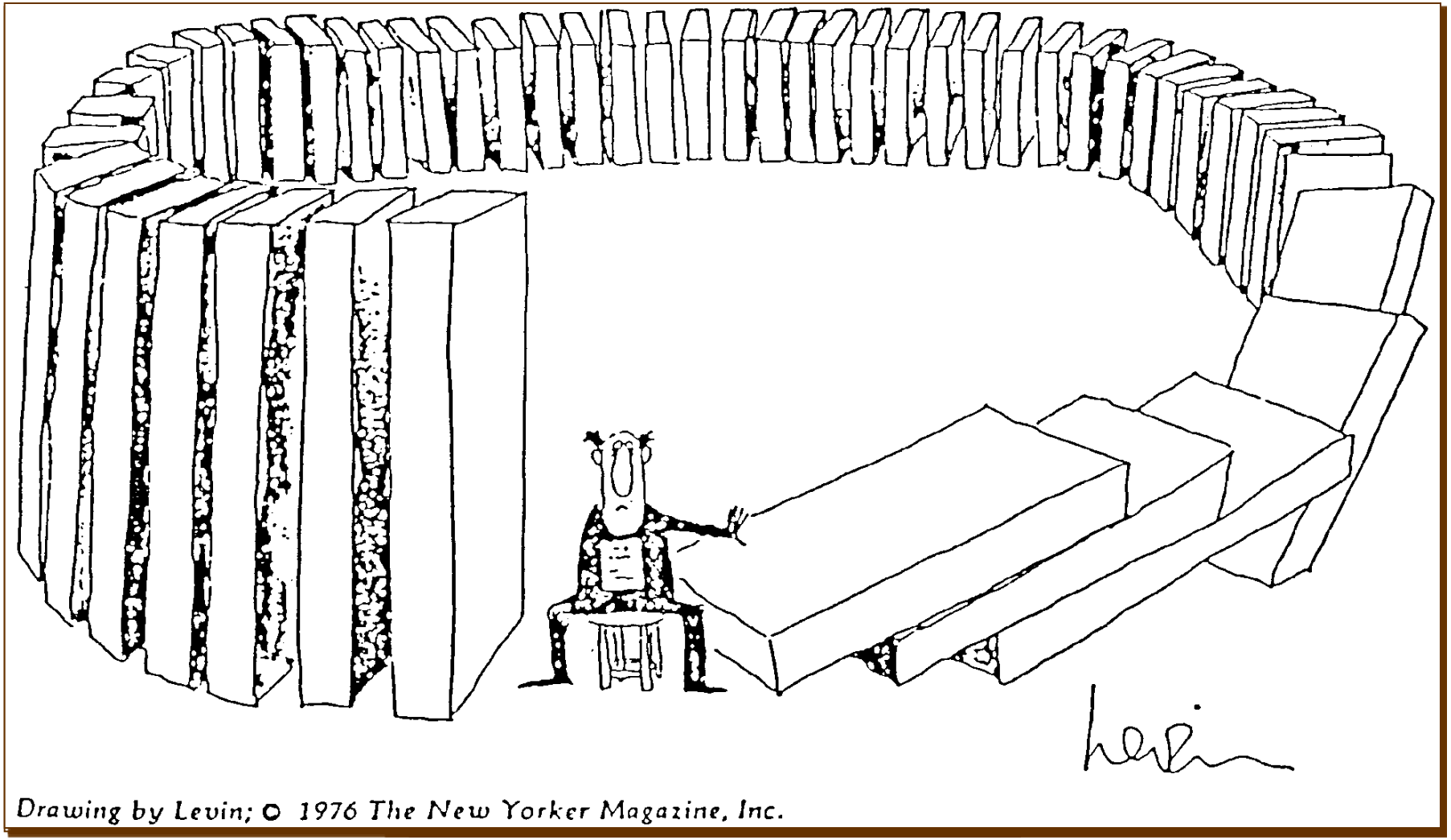


Jones et al, Nature, 2008

The next decades

- 3 of 4 top economies will be in Asia
- Competition for energy, land, water, commodities
- Demographic growth and ageing
- Pandemic of non-communicable diseases
- R&D and higher education landscape evolving
- Overall growing interdependence

Solve health problems or wait till they hit us really hard



Boredom shortens your life

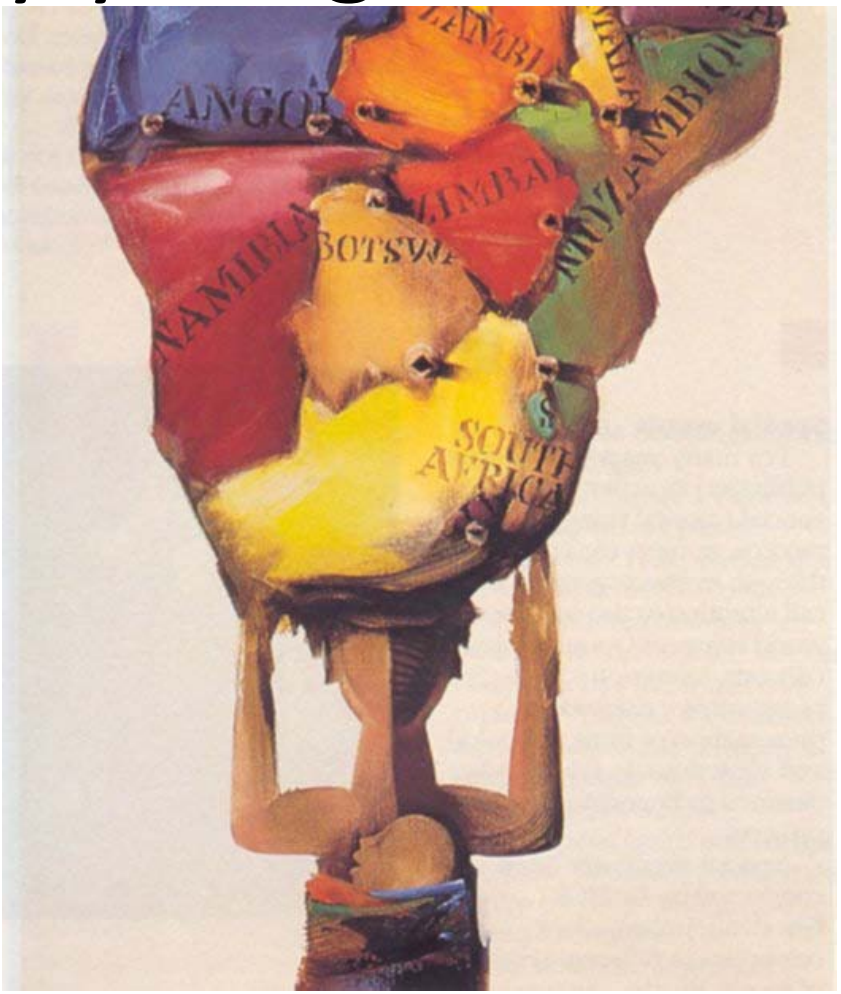
help
I'm bored

help I have ants in my pants	help I don't like my eyebrows	help I have no purpose	help I need a vacation	help I've never been kissed
help I don't know what I want	help I am ugly	help I am being followed by a dog	help I'm a prude	help I love someone who doesn't love me
help I don't know what to wear	help I feel horny	help I'm shy	help I don't know if I am gay	help I don't know what to do for my birthday

Try global health

Martin Shipley et al, Int J Epid 2010

Thank you
and may your globe be with you



Because there’s no planet B

The right to count

-and to BE counted

- and to be counted right