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Evaluation of Applications Made To a Migrant Health Center in Elazığ

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Abstract

In this study, it was aimed to determine the demographic information of the immigrants who applied to the immigrant health center, the reasons for their application and the issues that should be given importance in the improvement of immigrant health. This research is descriptive and cross-sectional. The applications made to the immigrant health center within a year were evaluated. Statistical evaluations were made in SPSS 22.0 software, t and chi-square tests were used. During our study, 13,464 (74%) outpatient clinic, 4048 (22.2%) immunization and 692 (3.8%) family planning applications were recorded, 18,204 in total. The number of applications to the migrant health center per person was 1.28/year. It was observed that women applied to polyclinics more than men ($p<0.001$). The most common cause of outpatient admission was upper respiratory tract infection. As a result, it is observed that migrant women apply to immigrant health centers more than men. When the outpatient applications are examined in detail, the applications due to infectious diseases are the most frequent. It is thought that immigrants need training on Mother-Child Health and Family Planning (MCH/FP) and hygiene.

Keywords: *Immigrant health; immunization; family planning.*

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Elazığ'da Bir Göçmen Sağlığı Merkezine Yapılan Başvuruların Değerlendirilmesi

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Öz

Bu çalışmada, göçmen sağlığı merkezine başvuran göçmenlerin demografik bilgilerinin, başvuru nedenlerinin ve göçmen sağlığının geliştirilmesinde önem verilmesi gereken konuların tespiti amaçlanmıştır. Araştırma tanımlayıcı, kesitseldir. Çalışmamızda göçmen sağlığı merkezine bir yılda yapılan başvurular değerlendirilmiştir. İstatistiksel değerlendirmeler SPSS 22.0 programında yapılmış, t ve ki-kare testleri kullanılmıştır. Çalışmamız kapsamına alınan sürede toplam 18.204 olmak üzere; 13.464 (%74) poliklinik, 4048 (%22,2) bağışıklama, 692 (%3,8) aile planlaması başvurusu kaydedilmiştir. Kişi başına düşen göçmen sağlığı merkezine başvuru sayısı;1,28/yıldır. Kadınların erkeklere göre daha fazla polikliniğe başvurduğu görülmüştür ($p<0,001$). En sık poliklinik başvurusu nedeni üst solunum yolu enfeksiyonudur. Sonuç olarak, göçmen kadınların erkeklere oranla daha fazla göçmen sağlığı merkezine başvurduğu görülmüştür. Poliklinik başvuruları ayrıntılı incelendiğinde enfeksiyon hastalıkları nedenli başvurular en sıktır. Kronik hastalık ve AP nedenli başvuruların az sayıda oluşu dikkat çekmiştir. Göçmenlerin Anne-Çocuk Sağlığı ve Aile Planlaması (AÇSAP) ve hijyen konularında eğitim gereksinimi olduğu düşünülmektedir.

Anahtar Kelimeler: *Göçmen sağlığı; bağışıklama; aile planlaması.*

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Introduction

Global political balances can change any time and these changes cause inequalities in the distribution of war, food and resources. Wars, lack of food, and shortages in the resources push people to search for a place where they can live in better conditions. People leave their countries to settle in other countries for various reasons (Topçu, Başer, 2006; Aksu, Sevil, 2010). Concepts such as migrant and refugee are used while naming people who leave their countries and settle elsewhere. Migrant is a more general term to describe those who leave their country for compelling reasons in the refugee country and are at risk of life upon returning to their country. The term migrant at the international level does not have a fixed legal definition. Today, the term "mixed migration" is used interchangeably for both concepts (UNHCR, 2018). As a result of mixed migration movements for various reasons, the number of migrants globally reached 258 million according to 2018 global migration indicators. Among them, there were 124.8 million women, 36.1 million children, 4.8 million international students, 25.4 million registered migrants, 150.3 million worker migrants (GMDAC, 2018).

Nowadays, the number of migrants is increasing exponentially, and Turkey hosts the most refugees worldwide. The investigation of the numbers shows that 3.6 million Syrian refugees and around 365.000 from other nationalities registered with United Nations High Commision for Refugees (UNHCR) are within the scope of Turkey's host (UNHCR, 2020). Turkey has been exposed to migration throughout history due to its geographical location (Efe, 2018). Today, the number of migrants throughout the world increased exponentially, and Turkey is the country that hosts the highest number of migrant (Cetin, 2016). As a result of the civil war in Syria, Turkey accepted the highest number of the Syrians under temporary protection among neighbouring countries and the number of migrants has increased exponentially over time (Copur, Demirel, 2017).

As they occur as a result of various reasons, migrations also have effects. In addition to socio-demographic changes in the countries migrants go to, they also cause changes in terms of health with their genetic characteristics, infectious diseases, and lifestyles. The stress and poor living con-

ditions brought about by the new lifestyle partially explain the increased risk of developing diseases such as cardiovascular diseases, diabetes mellitus, and asthma in migrants (Hemminki, 2014). It has been stated in the literature that the most common health problems of migrants are injuries due to physical trauma, nutritional disorders, growth and development retardation, psychological problems, infectious diseases, sexual and physical abuse, unwanted and risky pregnancies, miscarriages, birth complications, chronic diseases and complications (Cooke et al, 2004; Karadağ, Altıntas, 2010; The Lancet Public Health, 2018; WHO, 2015). Women, who have an important place in public health, also play an important role in improving migrant health. Being a woman and a migrant brings together two disadvantages (Aksu, Sevil, 2010). Health problems of migrant women in Turkey involves infectious diseases which are inability to benefit from family planning services, inability to benefit from antenatal care services, miscarriage in hospital births, high births without health personnel at home, irregular menstrual bleeding, sometimes spontaneous miscarriages, and multiple and short-term pregnancies (Topçu, Başer, 2006).

Migrants experience serious problems in access to counseling and preventive services, basic health services, diagnosis, treatment, and drugs at a global level (Frantz, 2002; Homans, 2006; Refugue Concil, 2005; Refugee Surveillance report, 2007; WHO Bulletion, 2008). The main problems in this regard are as follows: cultural difference of migrants from their country of residence, language and communication problems, inability to adapt to the health system, hesitation to reveal violence, abuse and rape, financial difficulties in accessing a health institution, difficulty in paying for paid services, legal obstacles and healthcare workers with inadequate knowledge and experience about the problems (Breefing Statement, 2008; Frantz, 2002; Homans, 2006; Refugue Concil, 2005; Refugee Surveillance report, 2007; WHO Bulletion, 2008).

Due to the intensity of the Syrians under temporary protection in Turkey within the scope of community health center affiliated institutions regulation, there are migrant health centers (MHC) with workers who were Syrian. These centers are located in many provinces and are only for Syrians under temporary protection (Ekmekci, 2017). MHCs were put into

operation within the scope of SIHHAT PROJECT (SIHHAT PROJECT, 2020). MHCs are similar to family medicine practice in Turkey. Primary health care services, immunization, pregnancy follow-up, baby follow-up, iron supplementation, vitamin D supplementation, and polyclinic services are provided in the MHCs. These are centers that serve serve for 4.000 people in average, meet the physical and technical standards defined for family medicine, and consist of one physician and one health personnel. In addition to Syrian healthcare personnel, bilingual (Arabic-Turkish) patient guidance personnel and support services personnel are also employed in MHCs (HSGM, 2020).

The aim of this study is to examine the demographic characteristics of the Syrians under temporary protection, who applied to the migrant health center for 1 year, the reasons for application, and the change of the applications according to demographic characteristics. Applications are examined in terms of age group, sex, and reason of application. In the present study, effective solution of health problems is provided by identifying risky groups in the health problems of migrants. Providing needed health services to the group will ensure that healthcare services are cost-effective. In addition, detection of common health problems will guide the planning of preventive health services. With preventive health services, many health problems can be prevented before they occur.

Material and Methods

This research is descriptive and cross-sectional. The applications made to the MHC in Elazig between 01.06.2018-01.06.2019 were examined. The applications were recorded as outpatient clinics, immunization, and family planning (FP). There were 13,464 polyclinics, 4048 immunizations, 692 FP applications, of which 18,204 in total. Among the people who applied for immunization, 7 were excluded from the study as their date of birth could not be obtained. Applications were reached through the book and system records of the MHC. The age, sex, and reason for application of the applicant were obtained from the records. In addition, the vaccines made in the immunization applications, the number of living children, the total number of pregnancies, the last pregnancy interval, the FP method

used for the last three months, and the FP method applied in FP applications were included.

The age distribution of the Syrian migrants under the temporary protection population in Elazıg were obtained from the data provided by the Directorate General of Migration Management.

Ethical Permission: Ethical permission (01.08.2019-12-05) was obtained from Fırat University Rectorate Non-Interventional Research Ethics Committee for this study. Written permission was obtained from Elazig Provincial Health Directorate to use the data of the migrant health center.

Statistical analyses were made in SPSS 22.0 program. Percentages, mean, t-test and chi-square tests were used according to the characteristics of the variables. Means were given with standard deviation (mean ± SD), and $p<0.05$ was accepted as statistical significance.

Results

During the one-year period, there were 13.464 (74%) outpatient clinics, 4048 (22.2%) immunizations, 692 (3.8%) FP applications to the MHC, which equaled to 18.204 in total. The number of migrants in the province applying to the MHC per person was 1.28/year. In outpatient clinic applications, the mean age of the applicants was 20.12±19.20 (min:0, max:92) and 61.1% of them were female. Women made more outpatient clinic applications than men ($p<0.001$). In terms of sex distribution by age groups, women in the 18-49 age group were the group that most frequently applied to the outpatient clinic ($p<0.001$). The sex distribution of migrants' frequency of outpatient clinic applications by age groups is shown in Table 1.

Table 1. Sex distribution of the Syrians under temporary protection by age groups in outpatient clinic applications

Sex	Age				
	0-4	5-17	18-49	≥50	Total
	% (person)	% (person)	% (person)	% (person)	% (person)
Female	15.1 (2038)	10.5 (1407)	30.1 (4047)	5.4 (731)	61.1 (8221)
Male	17.0 (2286)	8.6 (1160)	9.2 (1244)	4.1 (551)	38.9 (5243)
Total	32.1 (4324)	19.1 (2567)	39.3 (5291)	9.5 (1282)	100.0 (13464)

It is observed that the number of applications per capita for women in the 18-49 age group was more than 4 times that of men. Table 2 shows the mean number of outpatient clinic applications per person specific to age.

Table 2. Mean outpatient applications per person specific to age

	Age				
Sex	**0-4**	**5-17**	**18-49**	**≥50**	**Total**
Female	1.4	0.77	1.4	2.0	1.28
Male	1.48	0.6	0.31	1.74	0.67
Total	1.44	0.68	0.78	1.88	0.94

When the reasons for the outpatient clinic application of migrants are examined, it can be seen that most of the applications were made due to upper respiratory tract infection (URTI) 33.2% (4464). As the second most common, general medical examinations for school and work due to health reports were found to be 11.7% (1580). It was also found that 9.0% (1209) of the applications were caused by dermatitis, 62% (751) of them were women, 38% (458) of them were men, and women had more applications for dermatitis than men (p=0.006).

There were 3 puerperium applications for 31 pregnancies under the age of 18, and 5 puerperium applications for 35 pregnancies above the age of 35 in the applications made to the outpatient clinic. Among the applicants, it was determined that the smallest gestational age was 12 and the oldest was 58.

The classification the reasons for outpatient clinic application were as follows: infectious diseases, chronic diseases, diseases caused by nutrition and vitamin-mineral deficiency (Nutrition related diseases, NRD) and other. The distribution of applications were 52.3% infectious diseases, 5.8% chronic diseases, 3.8% nutrition and vitamin-mineral deficiency diseases and 38.1% other diseases (Table 3). Applications due to infectious disease were more frequent ($p<0.001$) and when examined by age group, 73.9% of the applications due to infectious disease constituted of the 0-4 age group ($p<0.001$).

Table 3. Classification of outpatient clinic application reasons

	Infectious diseases	Chronic diseases	NRD	Other Diseases	Total
%	52.3 (33.2 URTI)	5.8	3.8	38.1	100
n	7047 (4464 URTI)	782	511	5124	13464

In applications for FP purposes (692), all of the applicants were women(virgül) and their mean age was 29.79±7.78 (min:13, max:49). The mean number of FP applications per capita among women aged 18-49 was 0.25. The mean number of living children was 3.84±2.09 (min:0, max:11), and the mean number of pregnancies was 4.71±2.65 (min:0, max:18). Looking at the last gestational intervals, 51.0% (353) of the applicants had a break for 1 year or less, 23.4% (162) for 2 years, 23.6% (163) for more than 2 years. Table 4 shows the distribution of FP method used in FP applications according to age groups in the last 3 months.

Table 4. Distribution of FP methods used in the last 3 months by age groups

Age range	FP method used in the last 3 months					
	None %(person)	Condom % (person)	OCS % (person)	IC* % (person)	IUD %(person)	Total % (person)
13-18	1.0(7)	0.6(4)	0.1(1)	1.0(7)	0.0(0)	2.7(19)
19-25	13.9(96)	2.3(16)	9.0(62)	5.8(40)	0.4(3)	31.4(217)
26-35	9.8(68)	5.3(37)	20.7(143)	5.2(36)	0.4(3)	41.5(287)
36-49	5.6(39)	3.3(23)	12.7(88)	2.5(17)	0.3(2)	24.4(169)
Toplam	30.3(210)	11.6(80)	42.5(294)	14.5(100)	1.2(8)	100.0(692)

*IC: Injectable contraception

Migrants were given 53.6% (371) OCS (oral contraceptives), 25.1% (174) injectable contraceptives, 21.2% (147) condoms for FP purposes. The birth date information of 7 out of 4048 applications due to immunization could not be reached and they were excluded from the study. The mean age was 1.7±4.02 (min:0, max:75). 90.4% (3653) of the applications belong to the 0-2 age group, 96.9% (3923) to the 0-4 age group.

Discussion

It was found that 61.1% of the MHC outpatient clinic applications were made by women and the mean age was 20.12. In the study of Bağcılar (2016), 57.7% of the Syrians under temporary protection were female and the mean age of them in Turkey was 35.9%. It was observed in the present study that women made more outpatient clinic applications than men ($p<0.001$). In terms of sex distribution by age groups, the high proportion of women aged 18-49 ($p<0.01$) drew attention. It was found that 32.1% of outpatient clinic applications were made for 4 years old and under. The number of outpatient clinic applications per capita for women in the 18-49 age group was more than 4 times that of men, and this indicates the target audience in preventive health services.

In this study, applications for infectious diseases were found to be the most common reason. This finding is supported in the literature, in that infectious diseases are among the most common health problems in migrants (Hemminki, 2014; Cooke et al, 2004; Karadağ, Altıntas, 2010; The Lancet Public Health, 2018; WHO, 2015). The high rate of infectious diseases can be explained by the fact that migrants do not live in good conditions in their countries of destination and they have difficulties in communication and organization in accessing preventive health services, as shown by other studies (Burns, Imrie, Nazroo, Jhonson, Fenton, 2007; De Graff, Francke, 2003; Howell, Barnett, Underwood, 2001; Norredam, 2011). The fact that the 0-4 age group is at the forefront in applications due to infection may indicate that this age group in need of parental care has not been cared consciously. It was seen that it was beneficial to provide family physicians with training on URTI, and it brought to mind that physicians in migrant health should be given training on this subject, since the most

common reason was URTI in this study (Hosoglu, Bozkurt, Tekin, Ayaz, Geyik, 2012). Migration causes an increase in chronic diseases (Deniz, Yıldırım, 2018). In this study, it was determined that applications due to chronic diseases were in the background. The admissions of migrants due to chronic diseases were 5.8% and therefore very low compared to the admissions made to family health centers due to chronic diseases in Turkey (Turker, Hakan, Baltacı, Dikici, Kara, 2015). It made us think that its reasons should be investigated. With increasing age, chronic diseases and functional insufficiencies increase, too (Oğlak, 2015). Chronic diseases are an important part of the deaths in the 20-64 age group which covers the productive period in human lifetime and are increasing in all countries of the world (Beaglehole et al, 2008; Bilir, Subaşı, 2006). Due to chronic diseases, the quality of life and self-care capacity of the individual are negatively affected, and morbidity and mortality risks increase. This situation has made chronic disease management a significant area of study (Kalender, Sütçü Çiçek, 2014).

The presence of a 58-year-old pregnant woman drew attention in the applications. In addition, 31 pregnancies and 3 puerperium under 18; 35 pregnancies and 5 puerperium over the age of 35 indicate risky pregnancy behaviors. In our study, 51.0% of pregnancy intervals were found to be 1 year or less, and risky pregnancies are among the health problems that migrants experience frequently (Cooke et al, 2004; Karadag, 2010; Aksu, Sevil, 2010). Application for FP per person in the 18-49 age group of women was 0.25 and it is seen to be insufficient. It was found that 30.3% of the applicants did not use any protection method in the last 3 months. Also, it is noteworthy that intrauterine device (IUD) was not included among the contraception methods applied. In addition to the training requirement of migrants on FP, the employees were also lacking in knowledge, and they need to be trained and encouraged about practices. Studies have found that the education of women in childbearing age is beneficial in the effective use of family planning, and the necessity of education of risky groups has been stated (Karadag, 2010). Education level of the majority of women Syrian refugees in Turkey is low or they are uneducated. Marriages under 18 are common. In the observations and statistics reported in the provinces,

birth rates are increasing rapidly (AFAD, 2014: 61). AFAD's Syrian women in Turkey (2014) report determined an increase in the birth rate. Turkey stated that they want to take advantage of the many emergency health services unless they know they face a health system different from the system in their country. In the study of (Barın, 2015), unregistered women stated that they had difficulties in reaching the hospital. In parallel with our study, it was found that Syrian women under temporary protection need support in FP.

Barın was found that immunization services are insufficient. (Barın, 2015). But it was founded that 90.4% of immunization applications were in the 0-2 age range, 96.9% (3923) of them were in the age range of 0-4. The fact that there are 2998 people between the ages of 0-4 among migrants in Elâzığ made us think that childhood immunizations were at a good level. It can be thought that the access of Syrian migrants under temporary protection to immunization services increased during the period between the two studies. Implementation of health policy for Syrians under temporary protection in Turkey is consistent with international law. (Aile ve Sosyal Politikalar Bakanlığı, 2015: 103).

Conclusion

As a result, it has been observed that the Syrian women under temporary protection apply to MHC more than men. Applications due to infectious diseases are the most frequent in outpatient clinic applications. The low number of applications due to chronic disease and FP draw attention. Causes should be investigated. Risky gestational ages and low gestational intervals indicate the areas in need of education for migrants. It has been observed that women need training on Child Health and Family Planning (MCH/FP) and infectious diseases to improve migrant health and therefore community health. MHC workers, especially nurses working in the MHCs are of great importance in improving the health of migrant women. These nurses should be trained to assist migrant women in family planning, infectious diseases, transmission routes and in solving other health problems. Also, specialists should be assigned at certain times in the migrant health center for the diagnosis and treatment of chronic diseases.

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