

A humanitarian approach to travel medicine?

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When MSF recently piloted travel medicine services for people travelling along migration routes in Greece, various ethical challenges and moral dilemmas emerged.

Travel medicine (TM) as a specific field emerged in the 1980s, driven in great part by the pharmaceutical industry catering for tourists from northern countries visiting tropical areas. However, why should travel-tailored health care be reserved for wealthy travellers? What about the millions of vulnerable people forced to flee their homes in the face of violence, natural catastrophe and extreme poverty, who run much greater health risks than tourists?

At Médecins Sans Frontières (MSF) we have been providing acute health care to displaced people for decades but little attention has been paid to continuity of care along migration routes. In order to develop a more comprehensive approach for people on the move, we decided to pilot a formalised TM service within our projects in Greece. However, there are a number of ethical challenges and moral dilemmas inherent in such an approach.

Travel medicine is meant to help healthy travellers avoid illness and to provide support and resources to travellers with pre-existing morbidities. It is about empowering the traveller to look after his/her own health thanks to adequate knowledge (health promotion, patient education), pertinent information (available resources before, during, and after travel) and medical means (therapeutics, vaccines). (Extracted from MSF's definition of TM)

Ethical challenges

Within the TM community, the drive to expand services to migrants came from the infectious disease specialists – not surprising, given the role that migration has played over millennia in the spread of disease. It is thus in the interest both of travellers/migrants and host communities to develop sound policies to limit infectious disease spread. However, this raises three concrete ethical challenges for MSF.

Firstly, how do we raise awareness of the importance of monitoring potential disease spread and health promotion for groups at risk while avoiding scapegoating? (For example, the majority of new cases of HIV infection in France in the heterosexual population are occurring in migrant communities from sub-Saharan Africa.¹)

Secondly, is it morally acceptable to screen population groups for infectious diseases if we are unable to ensure them with appropriate follow-up? (For example, we know that Pakistan has a very high prevalence of viral hepatitis but if we screen a Pakistani migrant without legal papers will we be able to guarantee s/he accesses care if s/he develops the disease?)

Thirdly, could a positive result for a contagious disease be used as a reason to refuse entry into a given country, lead to *refoulement* or justify containment policies? (Infection with tuberculosis, for example, has often been used in the past to turn back migrants at border crossings.)

Additionally, MSF has data showing that, in the context of the European 'migration crisis', health is not the primary concern of migrants. Instead, their over-riding goal is reaching their destination. This priority may directly conflict with our own value system as health-care providers, which is to protect the physical well-being of our patient. In addition, there are several ways in which we can involuntarily and indirectly contribute to harm.

Example A: *A diabetic patient attending an MSF clinic tells us that she is planning to leave Athens on foot with smugglers, with the end goal of reaching the United Kingdom.*

If we feel that such a journey is a major risk for the patient's health, should we try to dissuade her? But what are her living conditions in Athens? Perhaps she is running



MSF staff taking care of children in the vaccination site in Elliniko.

health risks also by remaining where she is? If we know that certain routes are safer than others, should we tell her? If we give her several months' supply of insulin, are we indirectly encouraging her to undertake a risky trip? Might she be tempted to sell it to pay smugglers or simply to survive? What if we encourage her to seek health advice during her trip and she is denounced by a health-care provider and sent back to Greece?

Example B: *The MSF clinic team had arranged for Ms C to have a Caesarean section. In her eighth month of pregnancy she informed us that she would shortly leave Greece by plane for Germany. The doctor told her that this would be risky and that she should postpone the journey until she had delivered safely in Greece. Ms C insisted, however, that she had no other choice but to leave. She had borrowed money for the flight tickets. The social worker encouraged her to rethink her decision and offered to contact the travel agency and change the tickets to another date. Ms C began to weep. She said she regretted she had not come to see us earlier but that now she was not able to change her decision. We insisted she think it over and agreed to contact her the next day to discuss other options. We called her several times but she never answered.*

In view of the duty to protect both the mother and the unborn child, was our 'paternalistic' attitude justified, even though it must have added to her stress? If the airport officials had contacted us asking to confirm

she was physically able to travel, would we have opted for the patient's values above our medical values? If Ms C had gone into labour on the plane with negative outcomes for her and/or her child, would that justify us over-riding patient values in future similar circumstances, for example by informing airport officials of a patient's condition so that s/he be prevented from boarding the plane?

Health passports

Anecdotal data from our Greek project indicate that giving people a record of their health information can be very useful not only for the patient but also to avoid wasting limited resources. For example, we know of instances where patients have been re-vaccinated or screened repeatedly; it happens too that patients are unsure as to the exact name and/or dosage of a specific treatment they have been taking. Instances of this sort are exacerbated by language and translation issues, not to mention different levels of health literacy.

However, the proposal to launch a health 'passport' led to great controversy within MSF. Opponents pointed out that it could be used by border authorities to trace the individual's country of entrance in Europe (thus 'justifying' *refoulement*), that it could put the patient at risk within his/her own family or community (if they were identified, for example, as having experienced sexual violence) and that more generally it could

lead to abuse or stigmatisation. Proponents of the passport argued that it would empower the patient, prevent waste of time and resources, and ultimately favour better quality of care. Consequently, we decided that issuing such passports should be on a voluntary basis only, after the patient has been told all practical and theoretical risks (and can therefore give informed consent), and that the passport should be provided as a single hard copy. In parallel, we are exploring technological solutions to ensure optimal patient confidentiality and security.

Too much information?

Experience has taught us that transparency is preferable to a top-down, paternalistic approach. However, are there instances when is it morally justifiable to retain certain information if we deem it is useless for the patient and that it would only add to his/her stress? This is an important question because information overload, especially when that information is difficult to comprehend or threatening, can lead to considerable distress and confusion for the patient, all the more so when it is provided through an interpreter. Furthermore, in a refugee/migrant context most of our patients are dealing with numerous sources of anxiety relating both to their past and to their present.

While informing patients of risks with a view to protecting their health, we have a moral duty to suggest coping strategies and not just enumerate dangers. For example, it is useless to tell a single woman leaving with smugglers that she is likely to get raped, because a) she probably already knows it and b) we should not add to her anxiety. Instead, we can tell her the story of one of our patients who was travelling on her own and how she paired up with another woman so as never to be alone, especially in 'danger zones' such as toilets and showers. Danger avoidance and coping strategies should be part and parcel of basic health advice.

Equity in access

We would like to end with some thoughts about the principle of equity in access to quality health care. First, TM services should

be available to vulnerable migrants whether registered or unregistered because the right to access adequate health care is and must remain universal. Second, migration itself has been shown to be a social determinant of health status; in addition to genetic and environmental risks, a person who has migrated has increased health risks compared with the person who has not migrated.² Third, health-care providers and public health authorities have a duty to protect the health of both host populations and migrants in the best interest of all concerned. This holds true not just for communicable diseases but also for illnesses with more complex causes such as depression or cancer; primary, secondary and tertiary prevention strategies are also important, regardless of social or legal status.³

Fourth and finally, a society should be judged, among other characteristics, on its efforts to provide care to those most in need. Many migrants have multiple vulnerabilities that must be addressed. As doctors, nurses, midwives, psychologists, public health planners and social workers, we believe it is crucial to provide refugees and other migrants with access to basic health care in a way that respects their confidentiality and security, and also avoids any type of political instrumentalisation. The humanitarian challenge of providing medical care to people on the move is likely to grow in the coming years and we must be ready to meet it through establishing sound principles and strategic planning.

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1. Le VIH sida en France en 2018 (French only) www.vih.org/dossier/vihsida-en-France-en-2018

2. Davies A A, Basten A and Frattini C (2010) 'Migration: A social determinant of migrants' health', *Eurohealth*, Vol 16, No 1 bit.ly/Davies-Basten-Frattini-2010

3. Gushulak B D, Weekers J and MacPherson D W (2009) 'Migrants and emerging public health issues in a globalized world: threats, risks and challenges, an evidence-based framework', *Emerging Health Threats*, 2:1 bit.ly/Gushulak-Weekers-MacPherson-2009