Perspectives of primary health care providers on migrant patients’ adherence to TB treatment

Sónia Dias¹, Ana Maria Tavares², Ana Gama¹ and Ana Cristina Garcia²,³

¹ Escola Nacional de Saúde Pública, Centro de Investigação em Saúde Pública & GHTM, Universidade NOVA de Lisboa, Portugal. sonia.dias@yahoo.com; anafgama@gmail.com
² Global Health and Tropical Medicine (GHTM), Instituto de Higiene e Medicina Tropical (IHMT), Universidade Nova de Lisboa (UNL), Portugal. ana.tavares@ihmt.unl.pt; anacristinagarcia@ihmt.unl.pt
³ Departamento de Epidemiologia, Instituto Nacional de Saúde Dr. Ricardo Jorge (INSA), Portugal. anacristinagarcia@ihmt.unl.pt

Abstract. This study aimed to explore health care providers’ perspectives about migrant patients’ adherence to TB treatment and related factors, and debate on the value of using a qualitative research approach in a health topic traditionally researched through quantitative methods. The study was conducted through individual semi-structured interviews with 17 health care providers working on TB healthcare services in Lisbon. This qualitative approach allowed us to gain a clearer insight into the migrants’ adherence to TB treatment and related factors as expressed by health care providers. The use of a qualitative approach in this study had several advantages, but also some limitations. Globally, the use of a qualitative approach in this study contributed to produce rich, relevant and useful knowledge that may be helpful to inform health policies and good practices for the promotion of TB-treatment adherence among a most vulnerable population like migrants.

Keywords: qualitative approach; semi-structured interview; Tuberculosis; treatment; migrants; health care providers.

1 Introduction

Tuberculosis (TB) is considered a global health problem; despite of the decreasing figures in European countries (Rodier, Dara, Acosta, & Dadu, 2014), Portugal is still one of the Western European countries with higher notification rates in recent years (Perdigão et al., 2014). TB incidence has been increasing in Portugal among the foreign born population (DGS, 2018). TB incidence rate is 83.7/100,000 population among migrants, 5.4 fold higher than in the native-born population (DGS, 2018). Previous studies referred a higher risk of TB associated with regions with higher concentration of immigrants, HIV/AIDS infection, and poor living conditions (Couceiro, Santana, & Nunes, 2011).

Indeed, international migration has been posing challenges to European health systems in their effort to provide accessible, equitable and quality care to diverse populations (Priebe et al., 2011). The health care use by migrant populations and the patient-provider relationship is known to be influenced by the performance of health care providers, cultural competences and attitudes, beside migrants’ own socio-demographic characteristics, beliefs and expectations (Dias, Rodrigues, Silva, Horta, & Cargaleiro, 2010; Priebe et al., 2011; Rocha, Darsie, Gama, & Dias, 2012).

Research has been approaching the perspectives of health care providers on the provision of care to migrant populations (Dias, Gama, Cargaleiro, & Martins, 2012; Priebe et al., 2011). However, literature is still scarce on studies approaching the perspectives of health care providers from primary care settings dedicated to TB diagnosis and treatment, on the provision of care to migrant patients with TB or HIV-TB, especially considering the Portuguese context. In addition, qualitative approach has
been increasingly used in health research to better understand the complex and interrelated influence of multiple factors at individual, social and contextual levels on health issues, like health care provision (Dias & Gama, 2018).

This study used a qualitative research approach to explore health care providers’ perspectives about migrant patients’ adherence to TB treatment, related barriers and facilitating factors. This paper also aimed to debate on the value of using a qualitative research approach in a health topic traditionally researched through quantitative methods.

2 Methodology

2.1 Study Design and Population

A qualitative study was conducted through individual semi-structured interviews. Participants consisted in health care providers (doctors and nurses) working in primary care settings related to prevention, treatment and diagnosis of tuberculosis in Lisbon Region, Portugal.

2.2 Data Collection

A convenience sample of 17 health care providers (14 women and 3 men, 11 nurses and 6 doctors) was gathered through snowball sampling. The providers were contacted by email or phone call and were invited to participate after objectives and details of the interview were explained. Health care providers were asked to recommend a peer that could potentially participate in the study. Time and location of the interview was arranged according to each participant’s preference and availability. Each interview took about 40 minutes, and was audio recorded according to participant’s consent. The interview guide covered 2 main topics: adherence to TB treatment among migrant patients; barriers and facilitating factors of migrants’ TB-treatment adherence. Sampling of participants was performed in parallel with data collection, and was concluded when saturation of responses was reached. After the interview, participants were asked to complete a brief questionnaire for sociodemographic characterization. Data was collected from September to December of 2017.

2.3 Data Analysis

All the interviews were transcribed and transcripts were verified through audiotape recordings for accuracy. Data were analyzed using a thematic analysis approach that is commonly used in qualitative research (Nowell, Norris, White, & Moules, 2017). In a pre-analysis phase, data were converted into segments of information with relevant ideas and concepts in order to create the categories of analysis. In a following phase the data were organized according to the defined categories. Finally, the results were analyzed and interpreted. In the cases where a statement could fit in more than one category or categorization was uncertain, a discussion was held between two researchers to reach consensus. To maintain participants’ confidentiality, names of interviewees and other providers/institutions were removed from the transcripts. Quotes were chosen to illustrate the themes that emerged from data analysis.
2.4 Ethical Considerations

Ethical approval was granted from the Ethical Committee for Health of the Health Administration of Lisbon. Participation was voluntary and informed consent was obtained from all participants. Confidentiality of all information and participants’ anonymity was guaranteed.

3 Results

3.1 Migrants’ Adherence to TB Treatment

Participants expressed different perceptions on the adherence to TB treatment among migrants, when compared to nationals. According to the majority of the interviewed health care providers, migrants’ adherence to TB treatment is not much different from nationals: “It is like any other patient, we need to motivate them every day and every time they come to consultation (...)” (Doctor). Although other participants perceived migrants’ treatment adherence to be worse than among nationals, a few considered that migrants’ adherence as being better than among nationals: “They come very motivated. When comes to drop-out maybe there are more problems with nationals” (Doctor).

According to health care providers, the current strategy in use to ensure TB-treatment adherence – DOT (Directly Observed Treatment) – is non population-specific, being the same for migrants and nationals. Most interviewees considered DOT to be effective and a useful way to build a closer relationship with the patient: “It is important. Because in the first place we need to get to know the person that is in front of us, and one way is through DOT” (Nurse). Some interviewees, however, referred DOT to be inefficient since there is no legal obligation to complete treatment: “[It is not effective] neither on migrants or nationals, because it is all about individuals’ motivation (...). If we have someone who doesn’t want DOT, there is no way to obligate him, but in practice what people do is ‘you have to, you must, there is no other way’” (Nurse).

3.2 Barriers to Migrants’ Adherence to TB Treatment

Some barriers to TB-treatment adherence among migrants were mentioned by the health care providers. Migrant-specific factors including patients’ frequent mobility, especially to countries of origin, were referred by many interviewees as influencing treatment interruption or drop-out: “As treatment is long, sometimes they cannot stay [at the host country] as long as needed to complete treatment.” (Doctor).

Language constraints and the misunderstanding of the treatment plan was referred to hamper treatment adherence: “Sometimes we struggle for them to understand us and to complete treatment.” (Doctor). Also, separation from families was mentioned to impact treatment adherence, since patients need support to overcome treatment difficulties: “When they have family here they hold on to it and things go OK. When they don’t it is always a little more complicated.” (Doctor).

At cultural level, incompatibilities between religious practices and treatment schedules were also mentioned as impeding factors: “Whenever we have Muslim patients it is a problem to make them take the medication during Ramadan (...) they hardly cope with DOT at the schedules defined by the health services (...). They can only eat before sunrise, and we are not open before sunrise. (...) They constantly miss treatment during this time.” (Nurse). In addition, factors related to disease and treatment were mentioned as barriers to TB-treatment adherence, namely difficulties with pill burden and demanding treatment, interruption for symptoms relief, difficulties in travelling to the health
services due to disease severity, and presence of other pathologies such as HIV: “If these two diagnoses are done it is very difficult, because they are two difficult diseases, they demand treatment, patients’ power of will, might have side effects, and sometimes can lead to patients’ drop-out” (Nurse).

Other participants also referred frequent HIV and TB doctoral appointments and differences between HIV and TB treatment plans as factors hampering adherence to TB treatment: “They even compare: ‘So I have so many HIV pills to take daily, and you do not trust me [to take TB treatment alone]? I take those to HIV!’ We frequently have this dichotomy that the patients question” (Doctor).

The low socioeconomic status of migrant patients was also mentioned as a factor for non-adherence to TB treatment, as the costs related to missing work may have an impact on the patient income: “Many of these patients have their jobs but have never payed taxes. They have to work to make a living, if they get sick they have no income, and have no way to pay their bills” (Nurse).

Some health care providers also referred implications of personal and behavioral factors in TB-treatment adherence, such as alcohol or drug use, non-cooperating personality or perceived social stigma.

3.3 Facilitating Factors of Migrants’ Adherence to TB Treatment

Some factors referred by the interviewees as facilitators for TB-treatment delivery and adherence was their flexible performance in approaching patients through different ways. Particularly, health care providers referred their flexibility to provide DOT in different locations to better suit patients’ needs: “We are open for the person to go where it is closer and more comfortable.” (Nurse).

The interviewees also referred to deal with cultural diversity by resorting to personalized explanations and motivational approaches according to the patient’s background and culture: “(...) we must go to the cultural level of the person and try to explain (...)” (Doctor).

Moreover, the close relationship and trust between migrant patients and the providers was mentioned as an advantage. Particularly, the presence of foreign-born health care providers at the health services, namely from the same region of origin, was seen by many health care providers as an advantage in approaching migrant patients and earning their trust: “The fact that they are migrants too and they are in the same situation, they can say ‘I understand what you are going through, I understand what you are feeling.’” (Nurse).

4 Discussion

This study explored the perspectives of health care providers about migrant patients’ adherence to TB treatment using semi-structured interviews. This qualitative approach allowed us to gain a clearer insight into the migrants’ adherence to TB treatment and related factors as expressed by health care providers. One of the added value of the qualitative approach relates to the fact that the context of data collection – individual interviews – was conducive to the open expression of personal opinions, enabling researchers to access participants’ perspectives and understand how each one constructs and interprets his/her own reality and experience concerning their migrant patients’ adherence to TB treatment. The researcher-interviewee interaction lead participants to feel comfortable and share their perspectives, which may help remove potential defensive attitudes towards talking about topics frequently associated with “political correctness” and ethical professional principles such as attitudes regarding care provision to migrant patients (Green & Thorogood, 2004).

In quantitative research on such topics, participants’ responses are often more influenced by social desirability leading to neutral answers in close-ended questions (Hyde, Howlett, Brady, & Drennan,
Similarly, previous quantitative research conducted by the authors using a structured questionnaire has shown that health care providers tend to report mainstream attitudes on the provision of care to migrant populations with TB and their adherence to treatment (Tavares, Garcia, Abecasis, Viveiros, & Dias, 2018). The data obtained on this type of research can provide a distorted view of the real situation limiting the evidence on needs for improving health care provision. In this study, by using individual semi-structured interviews we were able to obtain a deeper knowledge on participants’ personal subjective opinions on sensitive topics such as the existing difficulties and barriers in migrants’ adherence to treatment, rather than a marked point of view from a professional group.

The interviews setting was favorable in the sense that health care providers had the opportunity to develop their views and to clarify their opinions. Indeed, several studies have proposed that qualitative methods are a proper mean to approach potentially sensitive topics such as health of poor and minority groups (Hyde, Howlett, Brady, & Drennan, 2005; Ingham, Vanwesenbeeck & Kirkland, 1999).

In this study, participants expressed a variety of perceptions on the adherence to TB treatment among migrants, as well as on the related factors. A factor referred by most health care providers as hampering migrants’ adherence to TB treatment related to patients’ mobility. Indeed, frequent mobility and lack of support from family or community members were observed risk factors for TB treatment default among migrants in recent research (Rodier et al., 2014). Also, anticipated treatment side-effects were referred in this study and in previous studies as barriers to treatment uptake among TB-patients (Lorent, Choun, Malhotra, & Koeut, 2015). Another factor mentioned was the low socioeconomic status, particularly the costs related to missing work and subsequent impact on patients’ income. Differences in cultural habits and language were also factors mentioned to difficult treatment adherence, as well as personal behaviors as shown in previous research (Carlsson, Johansson, Eale, & Kaboru, 2014).

The strategy used to promote TB-treatment adherence was considered effective by most participants and useful in order to build a trustful relationship with the patient. Despite of the non-cultural sensitive established procedures to provide treatment and promote adherence, participants referred some aspects facilitating the approach to migrant patients, namely the patient-provider close relationship, the presence of migrant providers at the health services and the providers’ flexibility to provide DOT more conveniently to the patients. Efforts must continue on increasing such patient-centered treatment approach, in order to overcome some of the existing difficulties in completing TB treatment.

Limitations to this study must be acknowledged. The sampling approach used may have resulted in potential biases towards gathering a sample with relatively similar characteristics. Also, due to the inherent nature and characteristics of the interview technique and the participants’ sampling process, the views and perceptions expressed cannot represent those of the study population.

5 Conclusions

Despite migrants’ adherence to TB treatment not differing much from nationals according to most interviewed health care providers, barriers in migrants’ adherence to treatment still remain and relate to patients’ mobility, language difficulties, adverse treatment side-effects and low socioeconomic status. The use of a qualitative approach in this study contributed to produce rich, relevant and useful knowledge that may be helpful to inform health policies and good practices for the promotion of TB-treatment adherence among a most vulnerable population like migrants.
Acknowledgments. Global Health and Tropical Medicine Research Center (GHTM - UID/Multi/04413/2013). AMT was supported by the FCT through the grant PD/BD/105916/2014.

References


