MTb

BULLETIN of the NETHERLANDS SOCIETY for TROPICAL MEDICINE and INTERNATIONAL HEALTH

Nº 02 / June 2015 - volume 53

PHOTO HANNEKE DE VRIES

MIGRANT HEALTH
CLINICAL AND PUBLIC HEALTH ISSUES

CONTENT

EDITORIAL - 2

PRACTICAL PAPERS
Local customs but a global issue: the case of female genital mutilation (FGM) - 3

Health consequences of torture for asylum seekers and refugees - 6

Incorporating resilience in the treatment of asylum seekers and refugees - 9

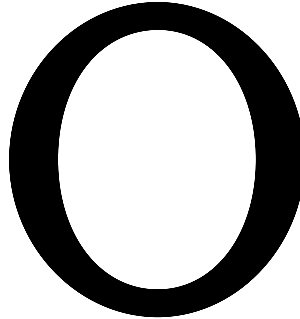
INTERVIEW
On a personal note, about Migrant Health - 11

LETTER FROM GAMBO
Coffee and contraception; linking health education to coffee drinking - 13

CONSULT ONLINE
A neonate with an extensive discolouration of the skin - 14

COVER PICTURE
Graduation Day in Ho Chi Minh City, Vietnam.

'MIGRATION ISN'T JUST FOR BIRDS'



One of the speakers at the ECTMIH-conference in Verona in 2009, dr. Manuel Corachán introduced his presentation on Travel Medicine and Immigrant Medicine with a remarkable quote.[1] In his opinion Travel Medicine and Immigrant Medicine are part of International Health, but unfortunately these fields of medicine seem worlds apart, as we don't pay equal attention to migrants from, and travellers to low- and middle-income countries.

Fortunately health professionals working in migrant health care have accumulated a wealth of expertise from working in LMICs. Many of the so-called 'tropical doctors' who are now working in the Dutch health system are able to apply their experiences and knowledge on tropical medicine – but also because of working in a multicultural environment – to the Dutch ('non-tropical') health care context.

Given that the number of refugees, asylum seekers, and internally displaced people worldwide exceeds 50 million people (2014)[2] it is essential for the health system of the host country to build capacity and gain knowledge on how to adequately respond to all health related problems that may occur among these immigrants.

Therefore in this edition of MT*b* we focus on migrant health in the Netherlands, among other things by looking at the *impact* of migration on a person's health and well-being; for some often a life-long felt burden. There is no simple solution for relieving the consequences and pain of traumatic experiences, such as torture or genital mutilation. Access to adequate and (culturally) appropriate prevention, care and treatment is needed to deal with such complex mental and physical traumas.

Current tragic scenarios from the Mediterranean Sea underline this need for well-trained professionals and compassion to deal with such conditions. As said, migration isn't just for birds, and it isn't likely to stop overnight.

HOPEFULLY THIS EDITION OF MT*b* CHALLENGES THE READER TO BE ALERT AND PAY ATTENTION TO THE SPECIFICS OF MIGRANT HEALTH AND WELL-BEING. IT IS NOT A CHOICE, IT IS AN OBLIGATION

HANS WENDTE

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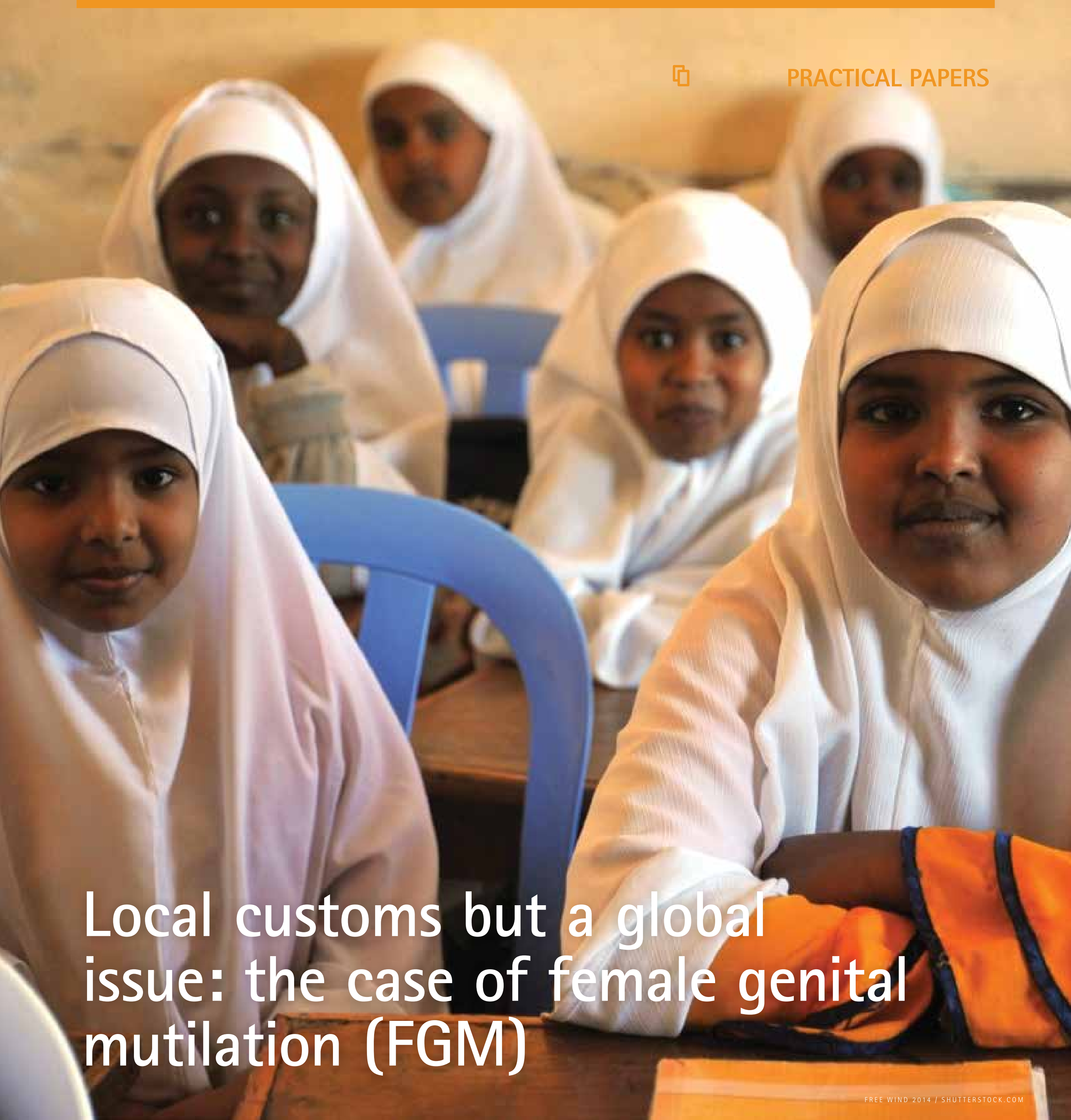

Local customs but a global issue: the case of female genital mutilation (FGM)

FREE WIND 2014 / SHUTTERSTOCK.COM

Hargeisa, Somalia - January 12, 2010

More than 125 million girls and women alive today have been subjected to FGM in the many countries in Africa, the Middle East and South East where FGM is performed. As many as 30 million girls are at risk of being cut over the next decade if current trends persist [1].

Migration resulted in the prevalence of FGM in Europe. There are an estimated 29,120 women with FGM living in the Netherlands. The majority of these women fall within the reproductive ages. This requires skills from doctors and other health care workers to discuss this topic, proper knowledge of the relation between medical and psychosocial complaints related to FGM, as well as knowledge of existing medical treatments or therapies [2].

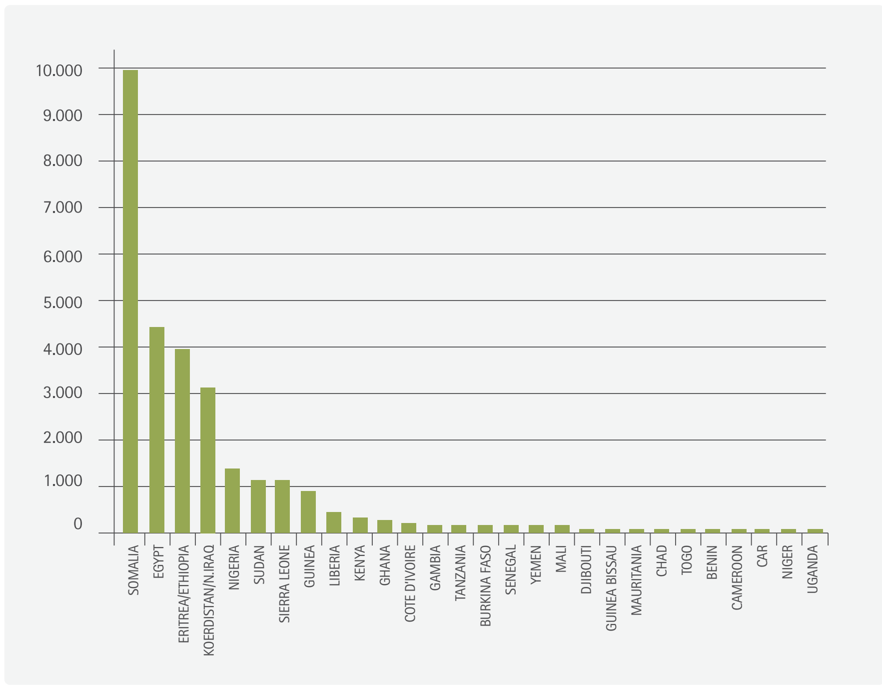

Fig 1 *Estimated number of women with FGM living in the Netherlands by country of origin (1-1-2012)* [2]

CLASSIFICATION [3]

Type I	Clitoridectomy - Partial or total removal of the clitoris and/or the prepuce.
Type II	Excision - Partial or total removal of the clitoris and the labia minora, with or without excision of the labia majora.
Type III	Infibulation - Narrowing of the vaginal orifice with creation of a covering seal by cutting and appositioning the labia minora and/or the labia majora, with or without excision of the clitoris.
Type IV	All other harmful procedures to the female genitalia for non-medical purposes, for example: pricking, piercing, incising, scraping and cauterization.

LONG TERM CONSEQUENCES

It is increasingly recognized that FGM causes complications throughout the life span, divided into three main areas: gynaecological, obstetric and psychological (including sexual function).

GYNAECOLOGICAL

A systematic review examined infection rates in 22,052 African women with FGM of all main types [4]. Types of infections identified included urinary tract infections, genitourinary tract infections, abscess formation, septicaemia and HIV. Infections were more frequent in women who had undergone type III. Although the study did not include a control group, the fact that more severe forms of FGM correlated with higher frequency of infections, suggested that FGM is a risk factor for infections.

Painful and unsightly scarring due to keloid has been reported. Also cysts can obstruct the vagina and cause pain. They can be very large and may require surgical excision. It is possible that a very narrow vaginal opening might slow down menstrual flow, while damage to the urethra during FGM may lead to fistula and urethral strictures [5].

OBSTETRIC

A study of 28,000 women with FGM across 6 African countries as well as a large systematic review involving almost 3 million participants from USA and Europe showed that women who have undergone FGM suffer more frequently from prolonged, difficult labour, have a higher rate of obstetric lacerations, more often require instrumental delivery, and have increased rates of obstetric haemorrhage. This may be due, in part, to the inelasticity of scar tissue [6-7].

Miscommunication, distrust, delays in seeking care, and avoiding medical interventions can contribute to negative obstetric outcome [8].

PSYCHOLOGICAL AND (PSYCHO)SEXUAL PROBLEMS

Limited research, with methodological limitations has investigated the impact of FGM on sexuality, including orgasm. In Egypt 250 women were examined and interviewed to investigate their psychosexual activity [9]. Results showed that women who were circumcised, complained significantly more of dysmenorrhea, vaginal dryness during intercourse, lack of sexual desire, less initiative during sex, being less pleased by sex, being less orgasmic, and having difficulty reaching orgasm than the uncircumcised women. Other psychosexual problems, such as loss of interest in foreplay and dyspareunia, did not reach statistical significance. A more recent study on 220 women in Egypt [10] showed that women with type II had significantly lower scores of desire, lubrication, orgasm, pain and satisfaction compared with the type I circumcised group.

Women with type II had higher scores of depression, somatization, anxiety and phobia than uncircumcised women. There was no significant difference between type I and type II on the psychological assessment.

Research among 66 women with FGM in the Netherlands also found signs of mental health and psychosocial effects as a result of FGM [11]. Symptoms of anxiety and depression were found. Also women with a milder form of FGM reported post-traumatic symptoms. A combination of type III, vivid memory, migration at a later age, low levels of education and inadequate support from the partner were concomitant with serious symptoms. This combination points to the fact that different integrated care models and interventions need to be used in order to reach these women.

CARE IN THE NETHERLANDS – TALKING ABOUT FGM

Many medical professionals find it hard to talk with women about their circumcision. They don't know how to start, what to say and what to ask. Part of the problem is that professionals rarely meet a woman with FGM and as a result don't develop this specific working experience. Women with FGM on the other hand are not always able to address their complaints. Some of them aren't even aware that their complaints are related to FGM [12].

The women's level of fluency in the Dutch language and the extent to which they feel comfortable in the Dutch (health) care system co-determines whether women talk about their symptoms. Many feel ashamed to talk about the subject. Certainly when the medical gaze is laid upon them, as a Sudanese women stated about when she was in labour:

You feel ashamed, you don't understand why they are so startled. A lot of service providers came to see me when I was in labour. They would leave the room to talk to each other and then come back to have another look at me. There were about six or seven doctors in the delivery suite with me. I started to feel scared myself... [11]

CARE IN THE NETHERLANDS: CONSULTATION DESKS

Between 2012-2014 a project started to gain insight how to improve health care for women living with FGM. In several Municipal Health Services and a Health Care Centre, a consultation desk was installed. Key persons from practising communities educate women with FGM, refer and sometimes accompany them to the consultation desks. The most important reason to involve a Health Care Centre is that most women present their symptoms to a general practitioner. Problem is that many general practitioners lack the knowledge to identify FGM as a possible cause for the complaints and to discuss this possibility with the women [12].

RECONSTRUCTIVE SURGERY

Since 2009, reconstructive surgery is possible in the Netherlands. With this surgery the external genitals that are cut away - the clitoris and possibly the labia minora – are recreated. According to a Swiss case study the surgery in combination with psychosexual therapy improves sexual function and has a positive outcome in pain reduction as well as in self body image. The safety and efficacy of clitoral reconstruction has been limitedly evaluated with a maximum of 1 year follow-up. Until more is known about the effects of this surgery, it is advised that this kind of surgery is combined with sexual therapy before and after surgery [13].

A Dutch working group of gynaecologists and a plastic surgeon with a tropical background who performs the reconstructive surgery, is currently writing the protocol Reconstructive Surgery after female genital mutilation.

CONCLUSION

With more than 29,000 women with FGM in the Netherlands and millions in their countries of origin, it is important for tropical doctors to be aware of the long term health consequences of FGM. With educating medical professionals there is still a lot to win in improving health care for women living with FGM. Showing respect and considering the impact of ancient local customs upon the women may help to reach out and provide the proper care they might need in the future - especially when giving birth.

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Health consequences of torture for asylum seekers and refugees

Many refugees originate from conflict areas where violence prevails. Detention, torture and violations of human rights cause a lot of suffering and make people flee their country. The violence and other traumatic experiences often result in both physical and mental problems. Medical doctors and other health care professionals have to deal with the special needs of this group.

· CASE ·

A man from Syria has recently arrived in a city. He consults the family doctor for his painful shoulders. On examination the doctor finds all movements of both shoulders impaired. The man gets painkillers for his pain. Upon the next appointment there is no improvement and he then complains about difficulties with sleeping. He recounts that he is always thinking about his country and his family and friends who are still there. Only during the following consultations he starts to unveil bit by bit his torture experiences. How he was beaten everywhere and was hanged with his arm pulled behind his back. How he suffers from shoulder pains and recurring nightmares about his torture experiences.

INTRODUCTION

Most of those who flee their country find (temporary) refuge in neighbouring countries. Only a minority applies for asylum in Europe. In 2014 around 400,000 persons applied for asylum in the EU. Some 24,000 (6%) arrived in the Netherlands.[1] Of this group more than 40% are Syrian asylum seekers. If a person requests asylum based on the United Nations Refugee Convention he is called an asylum seeker. When the asylum request is approved he gets a residence permit and is called refugee, which entitles him to getting a house in a municipality. This is usually the starting point to learn the language and to integrate in society.

An epidemiological study among asylum seekers and refugees in the Netherlands (from Afghanistan, Iran and Somalia) shows a high prevalence of both physical and psychological problems [2]. Half of the refugees expresses chronic pain. Despite the many psychological symptoms there is relatively little use of mental health care. Follow-up research 7 years later shows that the high prevalence of posttraumatic stress disorder (PTSD) persists in this group despite an improvement of experienced health in the period after receiving the residence permit [3].

TORTURE

Despite international treaties and conventions torture takes place worldwide and on a massive scale. Between 2009 and 2013 Amnesty International received reports of torture and other ill treatment committed by state officials in 141 countries, and from every world region [4].

An overview of torture methods can be found in the Istanbul Protocol [5]. This United Nations manual on the effective investigation and documentation of torture and other cruel, inhuman or degrading treatment or punishment was developed by legal and medical human rights organizations [6].

"SINCE THE TORTURE I HAVE PAIN EVERYWHERE..."

Some common methods of physical torture are: [5]

- Blunt trauma: hitting, whipping, clubbing, kicking, (with fists, clubs, rifles), falanga (beating of the soles of the feet)
- Sharp trauma: stab, cut (with knife, razor)
- Burning: use of hot material (iron, burning plastic, cigarettes), acids, hot spices in eyes or anus
- Crushing: standing on hands or feet, hammering, fingers between clamp or vice
- Positional torture: suspension on arms or legs, forced positions
- Electric shocks: mostly on fingers, toes, nipples and genitals
- Asphyxiation: keeping head under water (waterboarding), plastic bag around head
- Sexual torture: rape, direct trauma to genitals, objects in vagina or anus

PHYSICAL SEQUELAE AND SYMPTOMS

Some torture methods give specific physical sequelae [7]. Some examples:

- Scars are seen very often in all kinds of forms.
- Sequelae to the head are common. Victims of torture often report that they have been beaten on the head and that they have been unconscious. This can lead to brain damage. There may also be damage to the teeth or perforation of the eardrum caused by blows to the ear.
- Fractures can result from violent blows or crushes. Inadequate care can result in a bone infection or healing with malfusion and disability. Joint damage can occur from twisting and overstretching, like shoulder pain and impairment after hanging on arms.
- Nerve damage can occur by injuries because of tight cuffs at wrists or ankles but also by overstretching. Suspension with the arms behind the back can lead to shoulder capsule and also to brachial plexus damage, which might lead to a winged scapula (scapula alata).
- Damage of the genitals or anus by rape, electric shocks or bleeding. Testicular atrophy can result from beating the genitals.
- There are torture methods that give no physical sequelae. This is the case, for example, when administering electric shocks, near-suffocation and sexual violence. The absence of scars does not mean that no torture has taken place.

Depending on the specific aspects of a scar or medical finding it can support a story of torture and this can be used as proof in an asylum request.[8]

PSYCHOLOGICAL EFFECTS

The overall purpose of torture is breaking a person mentally through physical violence and fear of dying. Psychological symptoms often feature prominently.

There is a lot of scientific research into the psychological consequences of torture.[9] These consequences can be severe, long-lasting and disabling with high prevalence rates of PTSD and depression.[10] Common symptoms are intrusive recollections of traumatic events in thoughts, flashbacks and severe anxiety and distress when exposed to cues that provoke memories of the trauma. At the same time there is a tendency to avoid feelings and activities that provoke these memories, resulting in little social engagement. These symptoms are accompanied by an increased arousal with sleep difficulties, anger, and cognitive problems with concentrating and memory. Alcohol or drugs can be used as a way of self medication.

PAIN

Tortured refugees often relate their physical symptoms, mostly pain, to these torture experiences. It is good to realize that for

most torture victims the body was their weakest part, it made them suffer and they have doubts about the damage created by the torture. Pain and traumatization can reinforce each other.[11] It also leads to a different evaluation of threat and of painful stimuli. Pain may also remind the person of the traumatic experiences and thus lead to increased vigilance. The avoidance component of a PTSD leads to inactivity which also contributes to pain. The increased anxiety strengthens the perception and experience of pain. And some somatic symptoms can be physical expressions of anxiety like palpitations, tremor, nausea, dyspnoea. These somatic symptoms are, more than psychological symptoms, a reason to consult a physician.

TREATMENT

Refugees will often not express their torture experiences clearly to the physician. To be able to understand the context of some complaints it is useful to know more about the life story of a refugee. Asking for a history of torture can help to disclose, certainly in case of unexplained pains. They often feel ashamed to talk about these painful experiences. Realize that pain can be felt in parts of the body where someone was beaten, with or without visible scars or after-effects [12]. Conducting a physical examination helps to detect sequelae of torture and it creates confidence because the refugee feels being taken seriously. Exercises and physiotherapy help to diminish the tendency to immobilize. The mental aftereffects need a combination of psychotherapy, medication and social activation. Normal treatment guidelines should be followed by special attention to some specific elements like: the torture background of pain; the desire of being recognized and understood as a victim; cultural ideas about health and care.[13]

For the physical aftereffects of torture there are no specific treatment centres to refer to and specific treatment has to be found in the regional and university clinics. For the mental problems there are some mental health institutes specialized in refugee mental health.[14]

CONCLUSION

After returning to the Netherlands doctors in tropical medicine keep an interest in working for patients of different cultural backgrounds. Regularly, family practitioners in reception centres for asylum seekers or in low- income neighbourhoods have a background in tropical medicine. As the number of inhabitants with a refugee background rises refugee health care should be part of the curriculum of medical students and the training of family practitioners and specialists.

Physicians should be aware of the history of torture and violence in asylum seekers and refugees. Often the torture and the forced migration is a rupture in the life of refugees as they lose home, family and job. Physical and psychological symptoms can directly or indirectly refer to this cause. Addressing the possibility of torture experiences can be useful for a doctor as a starting point to help a refugee to overcome these traumatic experiences. Taking time to gain confidence and to give recognition are central focus points next to physical examination and asking questions about experiences in the past. And it is important to keep in mind that there is a lot of resilience in asylum seekers and refugees.[15] And also: physicians can empower them.

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Good news for the traumatized and their helpers
Incorporating resilience in the treatment of asylum seekers and refugees

"WHEN THE WIND BLOWS STRONG YOU BOW AND WHEN SHE IS QUIET AGAIN YOU BOUNCE BACK"

Many mental health workers think their ability to treat asylum seekers and refugees is limited. They are often overwhelmed with feelings of powerlessness when they are confronted with the complexity of psychiatric problems, the past traumatic experiences and the present living problems. However, there is no need for such feelings.

When I arrived in post-Biafra Nigeria (1983), I expected a lot of trauma-related problems but I discovered that only a few of my patients had such problems and only a few were known in the villages as war-affected persons. I discussed this with a nurse and she asked me: 'Well doctor, don't you know the law of the bamboo? When the wind blows strong you bow and when she is quiet again you bounce back'. Later I learned that the ability to bounce back from hardship and trauma is usually described as resilience.

RESILIENCE: THE ABILITY TO SUSTAIN AND TO RECOVER

Scientific research confirms that the majority of individuals survive all sorts of hardships with minimal distress, or with the ability to tolerate their distress, and move on with their lives in a positive manner.[1] How are they able to do so? Hobfoll developed the conservation of resource theory (COR-theory).[2,3] This theory implies that if people are able to regain their material, psychosocial and financial resources after experiencing adversities the chances of developing psychopathology are much less. Southwick and Charney interviewed a variety of groups of trauma-survivors and found ten, what they call "resilience factors": realistic optimism, facing fear, moral compass, religion and spirituality, social support, resilient role models, physical fitness, brain fitness, cognitive and emotional flexibility and meaning and purpose.[4,5,6]

This new knowledge is important in the prevention of psychopathology, but it is also helping to shape treatment programmes.[7,8]

With regard to asylum seekers and refugees we propose the following definition of resilience: *the capacity to maintain or regain health and function ability despite past experiences and to endure stressors of the asylum procedure and all daily living hassles (post-migration living problems).*[9,10]

TRAUMA-FOCUSED AND RESILIENCE-FOCUSED INTERVENTIONS

Epidemiological research shows high prevalence rates of psychopathology among asylum seekers and refugees.[11] Next to the traumatic experiences in their country of origin, they face many challenges, disappointments and adversities in the host country. Research among asylum seekers showed that the length of the asylum procedure has a higher risk for psychopathology compared to the traumatic experiences in the past.[12] In both asylum seekers and refugees the acculturation process, intergenerational difference in this process, language problems, discrimination, financial problems, worries about the family back home, lack of a solid social network and in many cases unemployment, are issues which all interfere with the treatment. In searching to find the most effective and suitable therapy these day to day stressors cannot be neglected. The debate of what kind of treatment should be given to asylum seekers and refugees is still going on. Nickerson et al. observe two contrasting approaches, namely trauma-focused therapy and multimodal intervention.[13] The trauma-focused approach is grounded in the contemporary cognitive behavioural framework, while the multimodal intervention tries to address not only the psychological reactions that may occur after traumas but also subsequent psychological stressors, physical health problems and resettlement and acculturation challenges. They conclude that 'trauma-focused approaches may have some efficacy in treating PTSD in refugees, but limitations in the methodologies of studies caution against drawing definitive inferences'. In their recommendations for further studies they emphasize the importance of recognizing the context of treatment delivery in terms of ongoing threats, the feelings of grief, anger over past injuries and the myriad of psychosocial difficulties with the resettlement process.

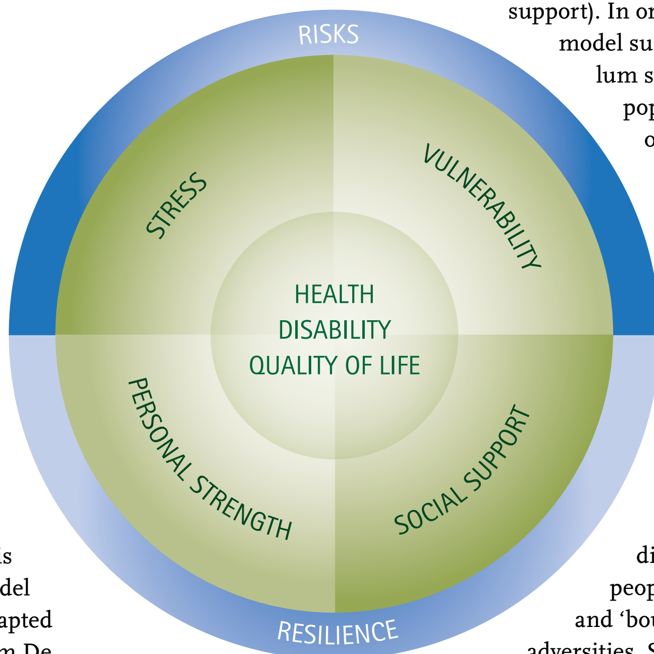
A resilience-oriented approach encompasses both trauma-focused

therapies and multimodal interventions: trauma-focused therapies can be added to a resilience-focused treatment programme, when needed, acceptable and possible.

THE ROTS MODEL

In the daily work with asylum seekers and refugees the psychiatrists and other staff members in the North Netherlands Centre for Transcultural Psychiatry De Evenaar, make use of the so-called 'resilience-oriented therapy and strategies' model (ROTS).

Figure 1 *Resilience-oriented model*



This model (adapted from De Jonghe et al.)[14] brings together the concepts of vulnerability and stress and two aspects of resilience, i.e. personal strength (e.g. coping) and social support.

The model is an expansion of the well-known stress-vulnerability model developed by Zubin and Spring.[15]

Vulnerability and strength are personal characteristics (internal factors) and stress and social support are ecosocial characteristics (external factors). The central question in shaping the treatment plan is: what can be done to lower the stress and vulnerability and what can be done to increase resilience (i.e. social support and personal strength). Working with this model means that during the first assessment the health complaints and the experienced traumas are explored as usual, but at the same time a lot of attention is given to the resources of personal strength and social support. Based on findings in the literature and on our own clinical experience, the resources of resilience can be classified according to the biopsychosocial model: *biological* (physical exercise, understanding the body, relaxation, treatment of medical illnesses), *psychological* (positive emotions and humour, acceptance, cognitive flexibility, empowering self-esteem, active coping), *social* (social relatedness, reconnecting the family, creating and enhancing social support). In order to make the model suitable for the asylum seekers and refugee population two kinds of resources are added: *cultural* (cultural identity, acculturation, language skills), and *religious/spiritual* resources.[9,10]

Research makes clear that there is great diversity in ways people are coping with and 'bounce back' from adversities. So the very starting point in the investigation of vulnerability and resilience is the perspective of the patient. In anthropological terms this refers to the so-called emic approach. In clinical practice the cultural interview developed by Groen* is used to include the cultural and religious aspects in this approach. In the resilience-oriented assessment and interventions this interview is an important tool. E.g. discussing cultural identity very easily opens the subject of self-esteem and discussing the psychosocial environment relates directly to the social support system.

The ROTS model has shown its effectiveness in the treatment of traumatized asylum seekers and refugees because the model emphasizes the healing ability (resilience) of the patient, helps in finding protective, supporting and strengthening factors, challenges to investigate a broad scope of interventions tailored to the individual situation and characteristics of the patient, is very easy to explain to staff members as well as to patients and their families, gives a shared frame of reference and involves the patient in his or her own healing and/or surviving process.

CONCLUSION

The problems of asylum seekers and refugees are numerous and a high percentage has or develops physical and mental health problems. Treatment possibilities are limited due to the experienced complex traumas, the ongoing stress and the existence of comorbidity of stress-related psychiatric disorders. Notwithstanding these limitations, however, treatment is possible. A resilience-oriented diagnostic and treatment model in which the concepts of stress, vulnerability and resilience (distinguished in personal strength and social support) are incorporated is very well applicable in all treatment modalities with asylum seekers and refugees. Tropical doctors are trained in the public health perspective and know the importance of the eco-social environment and the frame of meaning of their patients. These are all beneficial in the work with asylum seekers and refugees and connect naturally to a resilience-oriented approach. Some additional advices for daily practice are: investigate the domains of stress, strength, support and vulnerability, get to know your patient using an attitude of respectful curiosity, never isolate complaints from the person, observe the patient in her/his context, search with your patient for resources of resilience, be a resource of resilience yourself and very important: never lose hope for improvement.

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* *This interview is based on the Cultural Formulation of Diagnoses DSM-IV. The new DSM-version (DSM5) contains a (shorter) Cultural Formulation Interview (CFI) and Supplementary modules.*[16]

On a personal note, about Migrant Health

Interview with Bertha van Knippenberg-van den Berg

Amsterdam, 31 March 2015, Oudezijds Voorburgwal, red light district. After loudly ringing my bicycle bell to prevent the regular tourists from being run over, I carefully stop and lock up my bike and ring the doorbell at number 129. Before I know it I am witnessing an outpatient clinical consultation for a patient from Surinam with stomach complaints. An intern from the Academical Medical Centre is supervised by Bertha van Knippenberg-van den Berg, MD, making sure the patient gets the best possible care.

Can you tell us a bit about yourself? Who is Bertha van Knippenberg-van den Berg?
Years ago, I was working as a biochemical analyst in a University Laboratory and I noticed an internal drive to want to know everything about the human body. I wanted to be able to do exactly what all these doctors seemed to be doing: treat patients, and treat them well. After raising my children I finished my medical degree. I had the ambition to become a surgeon, but by that time I had become too old to specialize. I worked as a physician for infant health welfare (red.: known in Dutch as jeugdarts). After that I worked at the Bloodbank of a University hospital and later I became a coordinator of medical interns, something I still do within the Kruispost. In 2005 I read an article about the Kruispost, and a month later I was working as a GP and have been doing so for 2 days a week for over ten years.

What is Kruispost Amsterdam?
Stichting Kruispost started in 1983 and is a collaboration of the community of the Oudezijds 100 and the Johanniter Order. We are the medical department of the organization and our function is comparable to that of a General Practitioner. We offer medical and psychosocial care to those who, within the regular health care system, cannot find or are not given any help. We are open six days a week, with morning and evening office hours. Our care is focused on the homeless, the uninsured and rejected asylum seekers. Approximately 3,200 visitors seek our help on a yearly basis, which leads to at least 7,500 consultations a year. The figures of 2013 speak for themselves. Men between the age of 20 and 50 make up for the largest amount of our population and they mainly come from Brazil, the Philippines and Morocco. We mainly see gastrointestinal problems, vascular disease and dermatological problems. About 93% of our patients are uninsured and they regularly have a complicated medical, socio-economic and political background. Because of this we collaborate with psychosocial health care workers. There are a lot of psychological problems together with financial consequences. For example not being able to work and even homelessness. Our team is made up of 80 volunteers varying from receptionists and cleaners to General Practitioners, a surgeon, a neurologist, a dermatologist, a nurse practitioner in diabetic care, a physiotherapist, a dentist, a pharmacist, a social care worker, and a lawyer. Through lobbying, over the years we have been able to establish collaboration with Atal-medial with two departments willing to help us as diagnostic laboratory centres.

Very impressive, but what about funding?
Patients pay an amount per consultation, as much as they can. We rely heavily on donations, but do have some support from the government and health insurances. Our great strength lies in the fact that so many of us voluntarily contribute our time and try to provide the best of care, sometimes with the bare minimum. A challenge in which help is always welcome.

Define Migrant Health within Kruispost Amsterdam.
Helping patients, and not only medically, with the most hopeless situations originating from their cultural, social, economic or political status. I have seen that this is only possible with collaboration and a great deal of medical experience and skills and we are grateful to have so many experienced specialists contributing to that common goal.

What's typical about working at the Kruispost?
Recently our former head coordinator, Hannie van der Wensch, MD, retired after 25 years. One main thing became clear after several lectures given by co-workers. At the Kruispost we have the time to see the patient in his or her full, broad cultural and socio-economic status. A consultation doesn't necessarily have a time limit. We are able to do what many of us really want to do as a medical doctor. To have the time to treat the patient and not only the disease.

Greatest inspiration?
I don't think I have one specific person or event that has greatly inspired me to do what I do. Looking back my personal drive to gain knowledge and do good with it and to teach has brought me to where I am today.

If you could say anything about migrant health, what would it be?
What becomes clear is that on the governmental level something is going wrong. Asylum seekers are being allowed to enter the country but without being given the opportunities to become active members of society. Needing to stay within asylum seekers centres, without chances of schooling, working, collaborating on projects. If I translated that situation to anyone's life including mine it would cause great psychological dissatisfaction. And, well frankly,...make me depressed. Let alone if I were still carrying the problems that beset me in my country of origin, which might still have an impact on me and my children. We witness the lack of perspective, the hopelessness that comes forth out of this, and the vicious circle it creates. Don't say yes, if you cannot offer any perspective.

A piece of advice to future tropical medical doctors?
Always try your best to give your patient the feeling that you are on equal levels.

In many countries being a doctor is having a certain status. You might be seen as superior which causes a barrier to speak freely and therefore make known what the exact problems are.

A patient is not just a complaint, or symptoms leading up to a disease but a human being, and a product of a cultural background and upbringing. Be determined to look for the problem, and not be pressured by time. The patient will tell you the answer to his problem, if you can take the time to listen and see it in his or her context.

IN DUTCH A CONSULTATION ROOM IS CALLED 'A SPEAKING ROOM'. I THINK IT SHOULD BE A LISTENING ROOM INSTEAD

Note: For the annual report of 2013, see www.oudezijds100.nl

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Coffee and contraception; linking health education to coffee drinking

Ethiopia is one of the biggest coffee producers in the world, a fact that Ethiopians are eager to share with you. They are very proud of their rich coffee culture and are happy to invite you over for a so-called *'buna ceremony'* (coffee ceremony). The word ceremony here is to be taken seriously and sharing a coffee usually entails an undertaking of an hour easily. The coffee will be freshly made on the spot; green beans get washed, roasted, pounded and then the coffee is brewed. Drinking less than 3 cups is considered rude. Oftentimes *injera*, the other Ethiopian pride in terms of food and beverages, will accompany your drink, as well as freshly made popcorn. Being invited over for coffee therefore usually means your thirst and hunger will be quenched and satisfied completely.

Even though coffee is one of the major pillars of the Ethiopian economy, for the ordinary rural inhabitant a cup can be a real treat, due to the relatively high price. Often it is reserved for guests and used to accompany important life events. Working as the gynaecologist of a rural Ethiopian hospital, I noticed that one of these major events is the delivery of a newborn baby. Whenever women leave the hospital, a *buna* ceremony will be held in their house to celebrate the successful outcome of the pregnancy (a celebratory custom comparable to the eating of 'beschuit-met-muisjes' in the Netherlands, if you will).

Since it has such an important cultural meaning, one of my preceding tropical doctor colleagues introduced the coffee ceremony in the maternity ward. Until recently it was only being held occasionally, but I decided to make it a weekly event. I was hoping it would draw the attention of people in the surrounding communities of the hospital, possibly altering the hospital's image in a positive way and contributing to more hospital deliveries. The ceremony was intended for postpartum patients and their personal helpers ('astamammi'). But since we noticed that many more people were interested in a cup of coffee, I decided to invite all maternity and gynaecology inpatients as well as their 'astamammi'. Who after all can say 'no' to a free cup of coffee?

For several months now we have had a weekly *buna* ceremony. Besides celebrating the newborns, we are using this opportunity to educate people in an informal way. While the coffee is being prepared and drunk, we discuss several relevant health topics; antenatal care, delivery and all that comes with it, but also more general topics like contraception and birth spacing. Discussing all these subjects, we learned that many misconceptions exist, especially about contraceptives, such as their usage and possible side effects. In a country where 'gravida 10' in a patient file is not at all a surprising finding, and with birth rates still being very high, discussing birth spacing and contraceptive usage seems worthwhile.

Normally when I discuss these kinds of subjects during outpatient consultations, I do not have a lot of time to talk in depth about thoughts and practices concerning these issues. But during the ceremony I find out a lot about what is common practice amongst Ethiopian women and why. This definitely helps me understand my patient population much better, which makes it possible for me to serve them better by answering their health concerns more precisely. Whether our hospital delivery rates will also rise as a result of the coffee ceremonies remains to be seen.

Sometimes only 3 people attend a meeting, but other times as many as 25 people attend and lively discussions arise. Therefore the ceremony is a great opportunity for me to learn more about Ethiopians and their culture, their beliefs and (mis)understandings of health issues, as well as offering me a chance to educate them. Besides that, it gives me the opportunity during the often hectic days to kick back and enjoy the best coffee in the world myself!

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A neonate with an extensive discolouration of the skin

Figure 1

Figure 2

CASE REPORT

A child was born full-term in the delivery room of the Milange hospital. The pregnancy and birth were without complications and the mother already had two other healthy children. Immediately after birth, discolouration of the skin was observed. Throughout her whole body excluding the head, her skin was erythematous. This erythema was only mild on her chest, abdomen and back, but more severe on the right arm and leg. In general there was no sharp edge with normal skin. Moreover, a grey-blue discolouration was noted on the right leg and right side of her abdomen. All skin lesions were not raised above the level of the skin (figure 1). Furthermore, a remarkable finding was the raised capillary refill; the photo was taken more than two seconds after releasing pressure (figure 2). Also, the right leg was edematous. The erythema seemed painless and on further physical examination, nothing else abnormal was found.

Consult Online was asked for a differential diagnosis and advice in treatment.

SETTING

Milange hospital is a district hospital located in the north of Mozambique on the border of Malawi. Milange district has around 700,000 residents. The hospital has a capacity of 98 clinical beds. It collaborates closely with the local health care centre, in which the outpatient clinic of the hospital is situated. The nearest referral hospital is at the other side of the border in Mulanje, Malawi.

ANSWER OF THE SPECIALISTS

Two of the specialists responded within a few days. One mentioned the Klippel-Trenaunay-Weber syndrome, which includes an extensive port-wine stain with underlying venous and/or lymphatic malformations involving an extremity. Because of the blue macula in addition to the capillary malformation, the diagnosis phacomatosis pigmentovascularis was said to be most likely. For the skin lesions, no treatment is available nor is it necessary. However, this condition is associated with, among others, neurologic, ocular and skeletal disorders. The advice of the specialist was to perform further examination on co-morbidities.

BACKGROUND

Phacomatosis pigmentovascularis (PPV) is a rare, congenital disorder, characterized mainly by the presence of capillary malformations and pigmentary nevi. Since the first case, described in 1947, only around 245 other cases have been published [1,3]. Though the precise etiology remains unclear, it is thought to be based on a developmental abnormality of the vasomotor nerves and melanocytes, both derived from the neural crest [1]. Dermal melanocytosis occurs when fetal melanocytes fail to migrate to the dermis, causing a mongolian spot or blue nevus. The capillary malformation is present in most PPV types and is usually extensive. Furthermore, as many as half of the patients have other associated cutaneous lesions, most commonly nevus anemicus and café-au-lait spots [1].

Multiple types of PPV exist, but the most common is phacomatosis cesioflammea [1,2]. There are several classification systems. The first classification was developed by Hasegawa [2] and distinguishes type I-V. In addition, “a” or “b” are added to indicate extra-cutaneous involvement. Currently, the most practical classification is Happle’s system [1]. In this simplified, descriptive, classification system, there is no distinction between whether or not there are extra-cutaneous anomalies present (table 1).

It has been estimated that approximately 50 percent of patients have extra-cutaneous involvements, which are, as previously mentioned, mainly neurologic, ocular and skeletal disorders [1,2]. Neurologic abnormalities will usually be present in the first few months of life. These include among others, psychomotor retardation, seizures, intracranial calcifications, or cerebral atrophy. Common related ocular disorders are blue-gray scleral discolouration or glaucoma. There are several skeletal disorders described, such as discrepancy in the length of extremities, and scoliosis [3]. PPV without systemic involvement has a benign course and does not require treatment. The life expectancy depends on the presence and treatment of other associated conditions [1,3].

FOLLOW-UP

At the time of discharge, the skin abnormalities seemed to improve slightly, as well as the edema of the right leg. The patient will be seen in the outpatient clinic for follow-up and is referred to a hospital in Malawi for further examination on co-morbidities. In conclusion, extensive skin abnormalities in a neonate should alert to conditions such as phacomatosis pigmentovascularis and one should be aware that extra-cutaneous involvement might be present.

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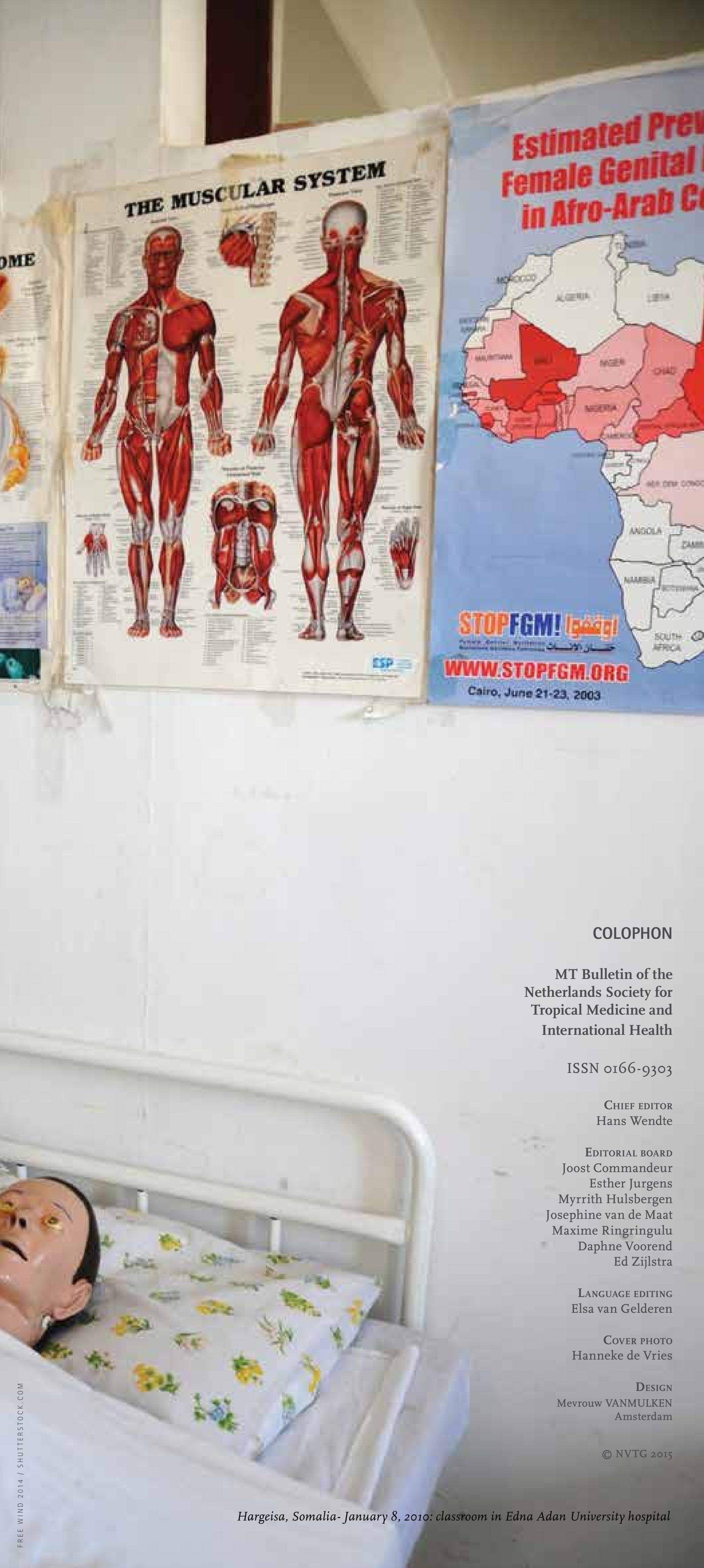
Table 1 Classification according to Happle [1]

Type	Happle’s classification	Vascular lesion	Pigmentary lesion
I a/b	Non-existing**	Nevus flammeus (port-wine stain)	-
II a/b	Cesioflammea	Nevus flammeus (port-wine stain) and/or nevus anemicus	Mongolian spot
III a/b	Spilorosea	Nevus flammeus (port-wine stain) and/or nevus anemicus	Nevus spilus
IV a/b	unclassifiable type	Various types of vascular nevi	Mongolian spot, nevus spilus
V a/b	Cesiomarmorata	Cutis marmorata telangiectasia congenital	Mongolian spot

*** In the traditional classification type I, the pigmentary lesion is a linear epidermal nevus. However, this is actually not a pigmentary nevus because it does not originate from pigmentary cells [1]. For that reason, according to Happle, type I does not exist.*



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Hargeisa, Somalia- January 8, 2010: classroom in Edna Adan University hospital

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MT Bulletin of the Netherlands Society for Tropical Medicine and International Health

ISSN 0166-9303

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