MTb

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MIGRANT HEALTH

CURRENT ISSUES

CONTENT

Cover photo taken in Barrydale, South-Africa.

HEALTH OF PEOPLE ON THE MOVE

"A refugee used to be a person driven to seek refuge because of some act committed or some opinion held. Well, it is true we had to seek refuge, but we committed no acts and most of us never dreamt of having any radical opinions". In his article, Tammam Aloudat from MSF Switzerland quotes the philosopher Hannah Arendt in her article on refugees in 1943.

Today, millions of people are again seeking refuge. According to UNHCR, nearly 34,000 people are forcibly displaced each day as a result of conflict or persecution.[1] An unprecedented 65.3 million people around the world have been forced from home. That means that 1 in every 113 people on earth is either an asylum-seeker, internally displaced, or a refugee. The vast majority of the world's refugees – nine out of ten – are hosted in countries close to their home country, led by Turkey, Pakistan, Lebanon and Jordan. Some 6% are hosted in Europe. These are staggering numbers, with staggering stories behind the numbers.

The theme of this MT*b* is migrant health. Interestingly enough, as Muijsenbergh points out in her article, most migrants start their journey in relatively good health – ironically called 'the healthy migrant effect'. You simply have to be healthy to travel the long and windy roads and seas to get here. The sad reality is that their health status gets worse along the way. It's often a very, very long way, and some travel up to 100 days according to an MSF study among Eritrean refugees in Calais.

Not all migrants have a healthy start though, as many leave situations of poverty or failing health services. The sexual and reproductive health rights of people 'on the move' are often violated, not only while on the move but already in their countries of origin, as Okur illustrates in her article. Ploem addresses gender bias in humanitarian aid and how we can avoid falling into the gender-stereotyping trap.

Once safe ground is reached, the health services can do their work. Two articles discuss the health status of asylum seekers, with Nijsten providing a general overview of the common diseases they present and Curvers et al. introducing a study on infectious diseases, a study which potentially can form the basis for a vaccination policy for adult asylum seekers.

Aarts et al. first take us on a historical journey to the early days of the 20th century when millions of Europeans migrated to the United States. The rather high rate of psychopathology found among the newly arrived immigrants was not well understood. Most of them left their homes voluntary, so how could this have affected their mental state? In the case of people who are forced to flee an unsafe and violent environment and have to withstand the many dangers en route, this is much easier to understand. The article on mental health concludes with two stories told by people who suffered from trauma and were able to find their way to a mental health institution in the Netherlands. Sherally explores ways in which the doctors currently being trained in international health and tropical medicine – the 'new' IHTM (AIGT in Dutch) doctors – can become proactively involved in migrant health. Her cry from the heart "not using this potential would be a pity" is valid. In the end, these doctors are trained to work on 'international health issues', whether in the Netherlands or elsewhere.

WE WELCOME YOU TO JOIN US AT THE SYMPOSIUM ABOUT MIGRANT HEALTH ON OCTOBER 28TH, 2016

ESTHER JURGENS AND JAN AUKE DIJKSTRA
EDITORS OF THIS EDITION

1. http://www.unhcr.org/figures-at-a-glance.html

Forced Displacement and Medical Humanitarian Choices

In Western Europe and the Middle East, we have been confronted with a refugee crisis of huge proportions during the past two years. The number of refugees is steadily increasing, and many of them are reaching Europe. Providing humanitarian assistance to refugees has up to now been carried out by NGOs and other agencies, but the current situation demands the engagement of a wider section of the medical profession to assist and to advocate for people who have been forcibly displaced.

GLOBAL TRENDS

A recent report by the Office of the High Commissioner for Refugees (UNHCR) shows that, in 2015, 65.3 million people were forcibly displaced. This marks a historic high and about a 20 million increase in less than four years [1].

Figure 1. Trend of global displacement and proportion displaced 1996-2015 (UNHCR)

Of that number, just over a third are refugees and asylum seekers while nearly 41 million people are displaced within their own country (Internally Displaced or IDPs). This is significant because, while refugees are more visible, extensive research conducted by the Centre for Research on the Epidemiology of Disasters (CRED) in 2013 showed that adult crude mortality rate (CMR) for IDPs is double that of refugees and also 75% higher in children. It also showed that acute malnutrition is 60% higher in IDPs compared to refugees [2].

Three countries in 2015 (Syria, Afghanistan, and Somalia) were the source of over half the forcibly displaced population. On the other hand, the list of major host countries of refugees included Turkey, Pakistan, Lebanon, Iran, Ethiopia, Jordan, Kenya, Uganda, The Democratic Republic of Congo, and Chad. Despite the media frenzy, European countries didn't make it to this list in 2015, while a small country like Lebanon, for example, hosted 183 refugees for each 1000 inhabitants (compared to the highest European proportion of 17/1000 inhabitants in Sweden and Malta).

CHANGING SITUATION AND CHANGING NEEDS

In 1997, after having worked through conflicts and crises, MSF compiled its knowledge and experience on working with refugees in a book that has become a major reference to humanitarians in responding to the needs of refugees [3]. What survives, nearly twenty years later, is its insightful list of priorities (Box 1).

Box 1

MSF Refugee Health Priorities 1997

1. Initial Assessment
2. Measles Vaccination
3. Water and Sanitation
4. Food and Nutrition
5. Shelter and Site Planning
6. Health Care in the Emergency Phase
7. Control of Communicable Diseases and Epidemics
8. Public Health Surveillance
9. Human Resources and Training
10. Coordination

However, the past twenty years have seen many changes besides the sharp increase in forced displacement. The nineties saw most refugees settling in camps such as the massive camps in Congo that followed the Rwandan genocide and were a turning point in providing medical humanitarian assistance to refugees for MSF and others. Some such camps still stand today such as Dadaab, the Somali refugee camp in Kenya, which still hosts tens of thousands of displaced people including a generation that was born there. Camps, however, are no longer the rule. Many refugees today do not settle in contained and reasonably serviceable camps. Also, due to the extreme violence and rapid changes in the conflict, IDPs such as those in Syria and Afghanistan have to move frequently and have no chance to settle at all.

Today, while many of the forcibly displaced are still in camps, many others are not. They are dispersed within host communities who suffer themselves in many cases from poverty and lack of access to essential services. Many are also on the move through precarious conditions that add to the suffering and despair that pushed them into displacement in the first place. A recent study by MSF Epicentre found that, of 425 refugees studied in Calais/France, the average period needed to reach their interim destination was 100 days. 61% of the refugees reported having health problems and over 65% encountered violent events during their trips [4].

WHAT IS BEING DONE?

As a medical humanitarian organisation, MSF addresses the medical and public health of people affected by crises. This has taken us to treat patients in a wide variety of situations. These include conflicts where we operate and support hospitals and provide basic services in places like Syria, Yemen, Central African Republic and South Sudan, as well as chronic crises such as in the Democratic Republic of Congo. We also help in managing epidemics and outbreaks, for example by operating Ebola treatment centres in West Africa and by carrying out mass vaccination campaigns for cholera in South Sudan and Zambia and for measles in Democratic Republic of Congo. MSF operated in 64 countries in 2015 and saw more than 8.6 million patients. We managed 340,000 HIV patients,

vaccinated more than 1.5 million for measles, and assisted in the birth of nearly a quarter of a million babies [5].

The provision of medical care for forcibly displaced populations is an activity we have been involved in for decades, but much of what we face today is different and can be challenging in ways that force us to adapt and change our activities [6]. First, the scale of displacement is one that goes beyond the capacity and willingness of the traditional humanitarian system (in itself not homogenous or in agreement on its goals and methods) to provide help. Moreover, as the conflicts in Syria, Yemen, Central African Republic, and other places have shown us, we have little ability to gain safe and guaranteed access to the people we strive to serve.

Second, the state of displaced persons is different in terms of where they settle. Today, as we face the wave of displacement, we are far from dealing almost exclusively with refugee encampments that provide an opportunity to quantify and logistically reach persons with the services needed. Open settings, host communities, and people on the move add different dimensions to the required response, which need to be understood and addressed [7].

Third, there is the changing legal and political framework. This ranges from the evolving politics and exercise of regulation and power by "traditional host" developing countries to the rapidly changing reaction and regulations of European states over the past two years.

MSF and other actors have reacted in a multitude of ways ranging from providing humanitarian assistance inside Europe, previously unimagined as a necessity, to providing search and rescue in the Mediterranean Sea. Many of MSF's experiences and reflections have been collected and analysed recently, for example in the Refugee Survey Quarterly [8]. In the meanwhile, humanitarian assistance continues its "traditional" work, ranging from medical care to providing water and sanitation and shelter in refugee camps, including those that have stood for over twenty years such as Dadaab and more acute centres such as the refugee camps of the Burundians in Tanzania.

The change in the situation is forcing a change in reflection in MSF as well as in other humanitarian actors, which impacts our technical, political, and ethical perspective. On the technical side, we are compiling our knowledge and experience to update our list of priorities. The twenty-year-old list that has served us and others well requires an update that addresses the changing circumstances and does not only take camps into account in order to enable us to serve the medical humanitarian needs of today's forcibly displaced people. On the political side, we will speak out about the situation and about the needs of displaced people and advocate for sustained and active humanitarian assistance in the shadow of a lack of political will and dwindling resources.

And finally, on the ethical side, as humanitarian actors we must continue to examine our ethical obligation and position vis-à-vis the displaced people we are serving and the powers that control their fate. How does this drive us to act, where do we stand, and how should we advocate?

WHAT SHOULD BE DONE?

Besides the work of medical humanitarian actors globally, medical professionals in host countries, including Europe, have an obligation towards people who arrive in their countries. There are the sick who need treatment, children who haven't got their vaccination, and traumatised persons who need psychological and social support. We have a medical as well as a humanitarian obligation, imposed on us by medical ethics, to providing impartial care to those who need it most. This is taking place in many cases. We have seen it on the Austrian-Hungarian border as well as in Greece, where refugees were crossing en masse. Many volunteers, including medics, provided food, care, medicine, and guidance to people who were exhausted and in despair. Yet, physician and nurses are not merely about diagnosis and treatment protocols. In my native Levantine Arabic, a physician used to be called "Hakeem" in the old days, a word that translates as "wise man". This is because, decades ago, physicians were perceived to have the education and knowledge that allowed them to treat people but also defend the defenceless and arbitrate disagreements.

CONCLUSION

Hannah Arendt wrote her article We Refugees in 1943; much of it still applies today [9]. She told us 'a refugee used to be a person driven to seek refuge because of some act committed or some political opinion held. Well, it is true we have had to seek refuge; but we committed no acts and most of us never dreamt of having any radical opinions'.

Today, we have people who need safe passage, access to health care, and all the help they can get to survive. They are, after all, fleeing conflicts fuelled by many of the very states refusing to provide them with shelter. MSF and other humanitarian actors are doing a part of what needs to be done, but this is no longer only the duty of medical humanitarian actors. The medical profession as a whole should be actively involved in treating refugees, supporting them, and speaking out on their behalf.

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Refugees and Dutch healthcare

Worldwide in 2015, 65.5 million people were on the move, fleeing war or persecution[1]; of them, 1.3 million reached Europe, and 58,000 arrived in the Netherlands – a sharp increase over the previous years[2]. The current newly arriving refugees are mainly from Syria, Eritrea, Iraq and Afghanistan. As many of them will be granted (temporary) permission to stay, we may expect that the number of refugees settling in municipalities and accessing regular healthcare in the Netherlands will grow in the next few years.
What are the main health issues among refugees in the Netherlands? What healthcare do they need, and what do doctors have to keep in mind when they are consulted?

HEALTH STATUS OF REFUGEES OFTEN GETS WORSE OVER TIME

Refugees who are able to undertake the sometimes dangerous and difficult journey to Europe are often relatively healthy compared to the general population in their countries of origin. This is called the "healthy migrant effect"[3]. However, after arrival in the host country, their health often deteriorates. Compared to the population in the host country, refugees rate their own health as worse, and the older they become, the larger the difference[4,5]. Factors that play a role concern social determinants of health: the length of the asylum procedure (the longer the procedure, the more mental health problems surface), the possibilities for family reunion (the sooner they can be reunited with their families the better), and most importantly for a healthy life, social support in their new environment as well as opportunities to obtain employment commensurate with their abilities and experience. Highly educated and young refugees have better prospects than less educated or older refugees[6]. When it comes to children's health, additional factors come into play, which may be either protective or carry further risks for a healthy development (see table 1)[6].

Table 1 Factors that influence the health development of children

Protective factors	Risk factors
Good (mental) health of the parents	Being a girl or a single, unaccompanied juvenil
High level of support and cohesion within the family	History of violence
Positive experiences at school	Having a single parent
In case of adoption, family of same ethnic background	Multiple journeys before reaching the host country
	Bad financial situation of the family
	Psychiatric problems of parents (especially the mother)

The most common health problems found among refugees in the Netherlands are stress related complaints and mental health problems, certain infectious diseases, diabetes, and reproductive health conditions[6].

MENTAL HEALTH PROBLEMS

Although refugees may appear quite resilient, they may have had traumatic experiences resulting in posttraumatic stress disorder (PTSD), depression and anxiety disorders; it is estimated that 13-25% of refugees in the Netherlands develop psychiatric disorders[6]. The actual development of such problems depends on the forementioned social determinants (participation in society, social support), preventive measures targeting the development of mental health problems and on timely diagnosis and treatment[7]. However, the use of mental health services is suboptimal among refugees. Avoidance of care often occurs due to taboos and stigma on mental health problems, mistrust or lack of knowledge about the Dutch healthcare system, or fear of being stigmatized. Children who flee their home country – with or without their parents – are prone to abuse, which may have long lasting implications for their mental development[6].

INFECTIOUS DISEASES

Refugees seldom pose a risk to public health in their host countries[8], but they are more at risk of certain infectious diseases due to the high prevalence in the country of origin. These include active tuberculosis, chronic hepatitis B and C, infection with HIV, parasitic infections, and multi-resistant microbes[6].

The prevalence of tuberculosis among refugees from Syria is low, so they are not screened for TB after arrival in the Netherlands. Among other refugee populations, however, it is high, especially among Eritrean and Somali refugees (100 times higher than among the Dutch general population)[6]. The prevalence of hepatitis B and C varies from country to country, but in general it is 2 to 10 times higher than in the Dutch population[6]. The HIV infection rate among migrants from Eritrea is seven times higher than in the Dutch general population[6].

DIABETES

Refugees who reside for a longer period in the Netherlands develop diabetes twice as often as other people of the same age[6]. This is attributed to physical

inactivity, overweight, chronic stress, and mental health problems. Asylum seekers with a PTSD diagnosis develop diabetes 1,4 times more often than asylum seekers without PTSD[9]. Diabetes is also more prevalent among lowly educated persons, and the outcome of diabetes care is worse among non-western immigrants[10]. These poor health outcomes are caused by limited health literacy, language barriers, and a lack of cultural competent healthcare. In Syria before the war, overweight was highly prevalent, affecting 23.5% of the adult population compared to 19.8% in the Netherlands[6]. Studies among previous groups of asylum seekers in the Netherlands have revealed a higher prevalence of diabetes among Syrians[6]. It is likely that an unhealthy lifestyle will be found among the current group of Syrians as well, with an elevated risk of diabetes. Overweight is less prevalent among Eritrean refugees, but the low level of education in this group will increase the likelihood that they develop diabetes.

REPRODUCTIVE HEALTH ISSUES

Unintended pregnancies, teenage pregnancies, induced abortion, and maternal morbidity are more prevalent among refugees, especially those from Africa. Causes of these elevated reproductive health risks include sexual violence, female genital mutilation, and a general lack of knowledge about contraception. Unfamiliarity with the Dutch healthcare system is another constraint. Some women refugees who are pregnant mistrust Dutch midwives or do not know the possibilities of antenatal care. Young female refugees and unaccompanied minors are at risk of sexual abuse, even when they are already in the Netherlands[6].

HEALTHCARE NEEDS OF REFUGEES

When a refugee who had obtained asylum in the Netherlands was interviewed, he said, 'Show me the way, explain how things work over here, teach me the language, and give me a job'[7]. This person emphasised integration into Dutch society as his main concern. The general experience of refugees with healthcare in the Netherlands is not always very positive. They complain about the family physician, whose role as gatekeeper is not well appreciated, as it hinders them in directly visiting the hospital. They also do not understand or appreciate certain typical features of Dutch healthcare culture. These include the small difference in status between doctor and patient (doctors accessing information during consultations), the emphasis on shared decision making ('What do you think yourself?') and the reticent policy on providing prescriptions for medication ('We only get paracetamol'). Refugees indicate they want to receive more information about the healthcare system and about regulations and procedures[7].All refugees interviewed expressed a wish for compassionate doctors, who take enough time to get to know their patients and who show interest in their cultural background. Besides, recently arriving refugees need interpreters to overcome the language barrier[11]. These barriers and healthcare needs expressed by the recent group of refugees, are consistent with the known barriers migrants encounter in accessing good quality healthcare[11,12]. Sometimes, financial barriers play a role, for example in accessing dental care.

THE NEED FOR CULTURALLY SENSITIVE PERSON-CENTRED CARE AND FOR COMMUNITY ORIENTED PREVENTION

To prevent the health of refugees from deteriorating and to adequately treat the conditions from which they suffer, the Dutch healthcare system and health care workers in particular need to better adjust their care to the needs and concerns of refugees.

The social determinants of health among refugees need to be optimised. This asks for integrated actions of healthcare professionals, community workers, municipalities, social workers, and schools. An integrated, community oriented approach, which actively involves refugees, is needed to inform them about Dutch society and healthcare as well as healthy lifestyle and activities to improve their health literacy, with a view to strengthening their resilience and reducing mental stress.

Refugees, like anybody else, benefit from person-centred care, i.e. care that is tailored to their needs and background. To be able to deliver such care, health care professionals need cultural competences. These include a good dose of an open, non-judgemental, curious and compassionate attitude, a basic knowledge of ethnic and socio-economic health differences and conditions that often occur among migrants, and good communication skills to overcome linguistic and cultural differences and to interact with low-literate persons[11,13,14,15]. Very important is the use of interpretation services[11,15,16], which unfortunately has sharply decreased in the Netherlands since the government ceased to pay for these services in healthcare[17]. Several good sources of information on refugee care are available, including the website www.huisartsmigrant.nl and the Canadian guidelines for refugee care[14]. The main ingredient for good healthcare for refugees is something all doctors should be able to provide – a smiling face, a welcoming gesture, and sufficient time, compassion and respect.

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Sexual and reproductive health and rights of people on the move

Many refugees originate from conflict areas where sexual and reproductive health and rights (SRHR) are seldom prioritized, let alone in the settings where they seek refuge. In the Netherlands, SRHR is one of the main areas of focus within development policy [1]. With the increased influx of refugees to the Netherlands, medical doctors and other health care professionals are left with questions on how to deal with the special SRHR needs of refugees that include a wide scope of issues.

SRHR IN COUNTRIES OF ORIGIN

The Netherlands has a long history of immigration and is home to migrants with diverse norms and values regarding SRHR. Currently, with more than 85,000 refugees in the Netherlands [2], this diversity has only increased. These norms and values derive partly from laws in their countries of origin regarding (child) marriages, homosexuality, (sexual) violence etc. and partly from cultural and traditional customs. For instance, homosexuality is illegal in many conflict countries such as Somalia, Syria and Eritrea [3,4,5]. Gender-based violence is a major concern in Syria and, in addition, the lack of effective laws to address sexual violence, including marital rape, leaves Syrian women helpless in the case of violence. Awareness within the Syrian community of family planning and the health benefits of birth-spacing and pacing of births was low long before the conflict even started. [6] In Eritrea, sexual and reproductive health rights are not holding up to an acceptable standard. For instance, unmet need for family planning is high, and childbearing starts early with one in five women (aged 25-40) giving birth before their eighteenth birthday. [7] Female genital mutilation (FGM), with all its consequences for women during sexual intercourse and giving birth, is common practice with 83% of women being circumcised.

INCREASED VULNERABILITY ON THE MOVE: SRHR ISSUES AND NEEDS

Refugees are most vulnerable to all kind of problems arising from the lack of SRHR. Findings from Rutgers' fieldwork in Aysaita refugee camp in Ethiopia showed that the challenges with SRHR do not originate from the refugee camp itself but are brought in from home and magnified due to the population density in the camp and the lack of a future perspective.

Humanitarian conflicts create new risks and vulnerabilities. As existing service provision breaks down, refugees who already had poor health outcomes associated with poverty or low social status end up in even more precarious living conditions [8]. A Rutgers desk study and needs assessment among diverse humanitarian NGOs showed that SRH issues such as the lack of reproductive health care (especially post-natal care) and access to family planning services as well as (gender based) sexual violence (SGBV) are some of the reported risks and vulnerabilities that need more attention. The risk of SGBV increases during a crisis due to a breakdown in law, which may leave survivors with little support and perpetrators exempted from punishment. Sexual violence is

deployed as a weapon of war, used systematically to instill terror and humiliation and destroy societies at large [9].

Specific SRHR needs that arise or increase during migration may be different for different groups. Men may have different SRHR needs than women, as well as (unmarried) girls versus married women. As is made clear in the article by Rachel Ploem, 'Men's and boys' sexual and reproductive health needs are often embedded in a context of severe gender inequality' [10]. Frustration among young men due to unmet gender role expectations and practices that are rooted in local traditions and culture, such as arranged marriages and dowry, complicate the situation for young men without an income in the country of arrival. Violence is linked to a lack of future perspective and frustration, and these individuals may have mental health problems caused by trauma and (sexual) violence as well as the feeling of hopelessness in camps. Therefore, it is important to engage boys and men to address SRHR and GBV. Girls, however, have other SRH needs than men and boys. In some crisis situations, girls are married younger because their families hope to protect them from sexual violence or to ensure that they will be provided for and cared for [11]. Awareness campaigns are needed to protect girls from becoming child brides.

HEALTH PROVIDER'S PERSPECTIVE

In the Netherlands, several organisations working in the field of refugees have expressed concern regarding the limited attention for SRHR. The Central Agency for the Reception of Asylum Seekers (COA), responsible for the reception, supervision and departure of asylum seekers that arrive in the Netherlands, has prioritized sexual reproductive health. Agreements have been made with the public health services in the Netherlands (GGD) for these services to provide the most urgently needed services to refugees, including sexuality education, resilience training, and contraceptives. COA has indicated that there are many problems in the area of sexual and reproductive health in emergency settings, including sexually transmitted diseases, unwanted pregnancies, abortion, sexual exploitation, sexual harassment, child marriages, homophobic behaviour etc. These problems are attributed to a lack of knowledge, different sexual ethics, unequal gender roles, and language barriers as well as unfamiliarity with the Dutch care system, rules and regulations. There is a need for information and interventions that fit the needs of the target group. A lack of cultural sensitivity on the part of the health providers has also been reported. Until 2010, each region had information officers who spoke the same language and shared the same culture as the target refugees. Due to budget constraints, these services are currently not available.

CONCLUSIONS

Refugees are often not educated on sexual health and sexuality due to a lack of access to SRHR in the country of origin. SRHR issues should not be linked only to the refugee situation itself, as they may already be present in the country of origin. These risks affect women and girls as well as men and boys. Humanitarian aid often focuses on the needs of women and girls, while neglecting problems that men face and disregarding differences in need based on education, gender, age, and religion [7,11].

Besides the most commonly mentioned SRHR needs, "unspoken" concerns are equally important. Homophobia can be as crucial in the formulation of SRHR needs as the common and frequently reported need for family planning. Attributing "Western-society-defined" SRHR needs to refugees is a dangerous process since our emancipation, gender equality and LGBT rights may not be shared by refugees or may be framed differently. We should try to understand their point of view and their confusion about "our" norms and values. It's not easy for outsiders to adapt to a different perspective on sexuality and to adjust their attitudes regarding traditional gender roles.

Getting to know Dutch society and understanding its culture takes time. Besides cultural aspects, factors related to gender, social economic situation (SES), and illiteracy should also be taken into consideration when discussing SRHR. These factors may be even more important in solving SRHR issues than the refugee status itself. The involvement of a translator during a consultation may make it easier to communicate with the subject, but it may be distractive, as disclosure may be confrontational or troubling for the person in question. Attention to the "basics" – such as housing, work, rules and regulations, and learning the language – is essential during the naturalization process, and rightly so.

HOWEVER, THIS PROCESS IS NOT COMPLETE IF THE BASICS OF HOW TO DEVELOP OR MAINTAIN A HEALTHY SEXUAL AND REPRODUCTIVE LIFE ARE NOT EQUALLY ADDRESSED

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3. http://www.refugeelegalaidinformation.org/somalia-lgbti-resources
4. https://www.theguardian.com/commentisfree/2010/jul/07/homosexual-syria-persecution-lgbt-rights
5. https://www.unodc.org/res/cld/document/penal-code_html/PENAL_CODE_ERITREA.pdf
6. http://www.ippf.org/about-us/member-associations/syria
7. http://apps.who.int/gho/data/view.country.8300
8. https://www.ifpa.ie/sites/default/files/documents/Factsheets/srhr_in_conflict_emergencies_web.pdf
9. http://www.lawschool.cornell.edu/research/ILJ/upload/de-Brouwer-final-2.pdf
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NOTIFIABLE INFECTIOUS DISEASES IN ASYLUM SEEKERS IN THE NETHERLANDS, 2012–2015

In 2015, the influx of refugees into Europe more than tripled, with over a million refugees arriving in 2015. Syria, Iraq and Afghanistan account for approximately 80% of the refugees. Poverty, human rights abuses, and deteriorating security are also prompting people to leave countries such as Eritrea, Somalia, Morocco, Iran and Pakistan. In 2015, the number of asylum applications in the Netherlands was twice as high compared to the previous year (Figure 1). The increase in the Netherlands was mainly attributable to the increase of Syrian asylum seekers. Since 2012, notifiable infectious diseases in asylum seekers in the Netherlands have been monitored using Osiris, the Dutch notifiable infectious diseases database. Data on notifiable infectious diseases are collected by the municipal health services.

OVERVIEW OF NOTIFIABLE INFECTIOUS DISEASES

In this article, we provide an overview of notifiable infectious diseases reported in asylum seekers living in accommodation provided by the Central Agency for the Reception of Asylum Seekers (COA) in the Netherlands. Table 1 shows the number of notifications of infectious diseases in this group by year of disease onset in the period 2012-2015. When interpreting the number of notifications, the increase in the number of asylum seekers arriving in the Netherlands has to be taken into account. We will discuss the most frequently reported infectious diseases in asylum seekers: tuberculosis, chronic hepatitis B and malaria.

We have used the occupancy figures at the COA to calculate the incidence of notifications of notifiable diseases. For the occupancy per year, we calculated the mean of the occupancy on the first of each month from January of the given year up until January of the year after.

Figure 1. Influx of asylum seekers into the Netherlands 2012-2015 [1,2]

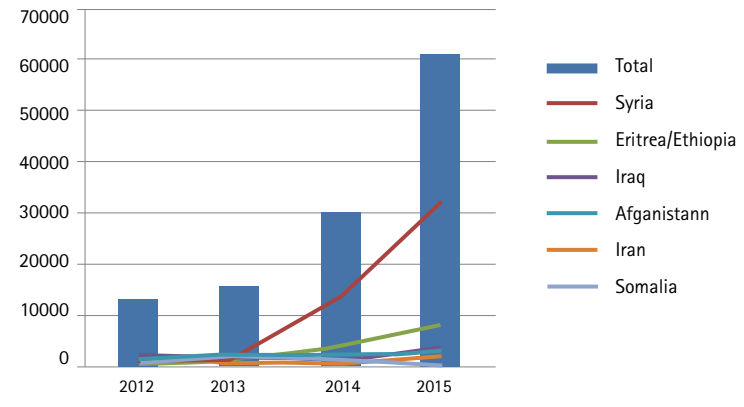


Table 1. Number of notifications of notifiable infectious diseases in asylum seekers by year of disease onset and as percentage of total notifications in the Netherlands, 2012-2015*

Group**		2012*** (%)	2013 (%)	2014 (%)	2015 (%)
Group A[1]		0	0	0	0
Group B1[2]	Tuberculosis[5]	N/A	N/A	79 (9.2)	106 (11.8)
Group B2[3]	Hepatitis A	0	2 (< 1.0)	2 (1.9)	9 (11.4)
	Hepatitis B Acute	1 (< 1.0)	3 (2.1)	2 (1.4)	1 (< 1.0)
	Hepatitis B Chronic	61 (4.6)	69 (6.1)	91 (8.5)	106 (10.6)
	Invasive group A streptococcal disease	0	0	2 (1.3)	1 (< 1.0)
	Measles	0	1 (< 1.0)	0	1 (14.3)
	Paratyphi C	0	0	0	1 (25.0)
	Pertussis	49 (< 1.0)	8 (< 1.0)	19 (< 1.0)	8 (< 1.0)
	STEC/enterohemorragic E.coli infection	2 (< 1.0)	0	1 (< 1.0)	1 (< 1.0)
	Shigellosis	0	0	3 (< 1.0)	4 (< 1.0)
	Typhoid fever	0	0	0	2 (11.8)
Group C[4]	Brucellosis	0	0	0	1 (11.1)
	Hantavirus infection	0	0	1 (2.7)	0
	Invasive pneumococcal disease (in children 5 years or younger)	0	0	0	1 (2.3)
	Legionellosis	0	0	0	1 (< 1.0)
	Malaria	4 (2.0)	6 (4.2)	106 (37.2)	126 (36.3)
	Meningococcal disease	0	0	1 (1.2)	0
	Mumps	0	0	0	1 (1.1)
	Psittacosis	0	0	1 (2.4)	0

* *The Table was sourced from the Dutch notifiable infectious diseases database 'Osiris' on 02 May 2016. The number of reported cases is subject to change as cases may be entered at a later date or retracted on further investigation. The longer the time between the period of interest and the date this Table was sourced, the more likely it is that the data are complete and the less likely they are to change.*

** *Notifiable infectious diseases in the Netherlands are grouped depending on the legal measures that may be imposed.*

*** *It was not until 2012 that the question 'if a person is living in an asylum center' was added to Osiris. Therefore, it could be that notifications in 2012 are an underreporting of the actual number of disease notifications in asylum seekers in 2012.*

1. *0 cases for MERS-CoV, polio, SARS, smallpox and viral hemorrhagic fever.*
2. *0 cases for diphtheria, human infection with zoonotic influenza virus, plague and rabies.*
3. *0 cases for cholera, clusters of foodborne infection, hepatitis c acute, paratyphi a, paratyphi b and rubella.*
4. *0 cases for anthrax, botulism, chikungunya, Creutzfeldt-Jakob disease, Creutzfeldt-Jakob disease –variant, dengue, invasive hemophilus influenza type b infection, leptospirosis, listeriosis, MRSA-infection (clusters outside hospitals), q fever, tetanus, trichinosis, West Nile virus and yellow fever.*
5. *It was not until 2014 that the question 'if the patient is living in an asylum center' was added to the tuberculosis questionnaire.*

N/A: not available

TUBERCULOSIS

In 2015, 106 cases of tuberculosis (TB) in asylum seekers were notified, accounting for 12% of all TB notifications in the Netherlands. This is a slight increase compared to 2014 (Table 1). The largest group accounting for TB cases in asylum seekers originated from Eritrea/Ethiopia (Table 2). In the last two years, most asylum seekers originated from Syria and among them TB is relatively uncommon. The incidence of TB notifications in asylum seekers in 2014 and 2015 was 0.4 per 100 persons. In 2015, the incidence of TB notifications in asylum seekers from Eritrea/Ethiopia and Somalia decreased compared to 2014 (Table 2). In 2015, cases of TB were only reported in asylum seekers in the age groups 5-17 and 18-50 years. The incidence of TB notifications per 100 asylum seekers in those age groups decreased slightly compared to 2014 (Table 3). In 2015, 25% of asylum seekers with TB were diagnosed with infectious pulmonary TB against 16% the previous year. Between 2010-2015, the proportion of infectious pulmonary TB of the total number of TB patients in the Netherlands varied between 23% and 26%. Asylum seekers and immigrants from countries with an estimated WHO-incidence of more than 200 per 100,000 populations and from specified other high-risk countries, such as Eritrea, are invited for a six monthly follow-up CXR screening for a period of two years [3].

CHRONIC HEPATITIS B

In 2015, 106 chronic hepatitis B cases in asylum seekers were notified, accounting for 11% of all notified chronic hepatitis B cases in the Netherlands. This is an increase compared to 2014, with 9% of all cases (Table 1).

Over the last two years, most notified chronic hepatitis B cases originated from Syria and Eritrea (Table 4). In the years prior to that, most cases originated from Somalia, Syria and Sierra Leone. The incidence of chronic hepatitis B notifications in asylum seekers staying in 2015 was 0.5 per

Table 2. Tuberculosis notifications in asylum seekers by country of birth and occupancy at COA by country of origin, 2014-2015

	2014			2015		
Country of birth	Notifications	Occupancy COA	Notifications per 100 persons	Notifications	Occupancy COA	Notifications per 100 persons
Eritrea/Ethiopia	45	2,957	1.5	68	5,205	1.3
Syria	2	5,398	0.0	9	12,861	0.1
Afghanistan	0	1,321	0.0	7	1,399	0.5
Somalia	14	1,568	0.9	7	853	0.8
Other	18	8,308	0.2	15	9,680	0.2
Total	79	19,552	0.4	106	29,998	0.4

Table 3. Tuberculosis notifications in asylum seekers by age distribution and occupancy at COA, 2014-2015

	2014			2015		
Age groups	Notifications	Occupancy COA	Notifications per 100 persons	Notifications	Occupancy COA	Notifications per 100 persons
0-4	1	1,821	0.1	0	2,337	0.0
5-17	15	4,115	0.4	21	6,037	0.3
18-50	63	12,530	0.5	85	20,132	0.4
50+	0	1,087	0.0	0	1,492	0.0
Total	79	19,552	0.4	106	29,998	0.4

Table 4. Chronic hepatitis B notifications in asylum seekers by country of birth and occupancy at COA by country of origin, 2012-2015.

	2012			2013			2014			2015		
Country of birth	Notifications	Occupancy COA	Notifications per 100 persons	Notifications	Occupancy COA	Notifications per 100 persons	Notifications	Occupancy COA	Notifications per 100 persons	Notifications	Occupancy COA	Notifications per 100 persons
Syria	6	517	1.2	7	1,089	0.6	14	5,398	0.3	26	12,861	0.2
Eritrea/Ethiopia	2	498	0.4	6	721	0.8	11	2,957	0.4	24	5,205	0.5
Somalia	6	1,764	0.3	11	1,840	0.6	3	1,568	0.2	4	853	0.5
Sierra Leone	7	242	2.9	6	250	2,4	3	277	1.1	2	257	0.8
Afghanistan	6	2,244	0.3	3	1,868	0.2	3	1,321	0.2	5	1,399	0.4
Unknown/Other	34	9,124	0.4	36	8,937	0.4	57	8,031	0.7	45	9,423	0.5
Total	61	14,389	0.4	69	14,705	0.5	91	19,552	0.5	106	29,998	0.4

Table 5. Chronic hepatitis B notifications in asylum seekers by age distribution and occupancy at COA, 2012-2015

	2012			2013			2014			2015		
Age groups	Notifications	Occupancy COA	Notifications per 100 persons	Notifications	Occupancy COA	Notifications per 100 persons	Notifications	Occupancy COA	Notifications per 100 persons	Notifications	Occupancy COA	Notifications per 100 persons
0-4	0	1,560	0.0	0	1,593	0.0	1	1,821	0.1	0	2,337	0.0
5-17	13	2, 816	0.5	18	3,281	0.5	7	4,115	0.2	5	6,037	0.1
18-50	46	9,071	0.5	50	8,910	0.6	75	12,530	0.6	98	20,132	0.5
50+	2	942	0.2	1	921	0.1	8	1,087	0.7	3	1,492	0.2
Total	61	14,389	0.4	69	14,705	0.5	91	19,552	0.5	106	29,998	0.4

100 persons, which is comparable to the years prior to that. The incidence of chronic hepatitis B notifications in asylum seekers from Sierra Leone has decreased over the past few years. In 2015, a slight increase was observed in the incidence of chronic hepatitis B notifications in asylum seekers from Eritrea/Ethiopia and Somalia compared to 2014 (Table 4). In 2015 and 2014, the incidence of chronic hepatitis B notifications per 100 asylum seekers was highest in the age group 18-50 years (Table 5). In 2015 and 2014, the incidence of chronic hepatitis B notifications in asylum seekers in the age group 5-17 was substantially lower than in 2013.

Asylum seekers in the Netherlands are not systematically screened for chronic hepatitis B. The incidence of acute hepatitis B infection in the general population in the Netherlands has been declining for more than 10 years, and has been below 1 per 100,000 since 2013. This suggests that the increasing influx of refugees from higher prevalence countries is not associated with an increasing transmission of hepatitis B within the Dutch population.

MALARIA

Over the last 2 years, an increase in malaria cases has been observed in the Netherlands. This increase is largely explained by the increase of malaria cases in asylum seekers. In 2015, 126 malaria cases in asylum seekers were notified, accounting for 36% of all malaria cases in the Netherlands (Table 1). In the years prior to that, only a few malaria cases were reported in asylum seekers. In 2014 and 2015, over 90% of asylum seekers with malaria were born in Eritrea or Ethiopia (Table 6). The total incidence of malaria notifications in asylum seekers slightly decreased in 2015. This decrease was also observed in the incidence of malaria notifications in asylum seekers from Eritrea/Ethiopia (Table 6). In 2015, the incidence of malaria notifications was highest in the age groups 5-17 and 18-50 (Table 7). This is comparable to previous years.

The parasite mostly responsible for the malaria cases in asylum seekers was Plasmodium vivax. In Dutch resident travellers (including work related travel), P. falciparum is the parasite that most often causes malaria (Figure 2).

DRAWBACKS

The surveillance of notifiable infectious diseases in asylum seekers as described in this article is based on disease notifications of asylum seekers living in asylum centres and collective reception centres of COA. Infectious diseases data on asylum seekers not living in COA centres (e.g. municipal emergency shelters) and refugees with a residence permit living in the community (including family reunification) cannot be obtained as such from the surveillance system. Furthermore, the surveillance of notifiable infectious dis-

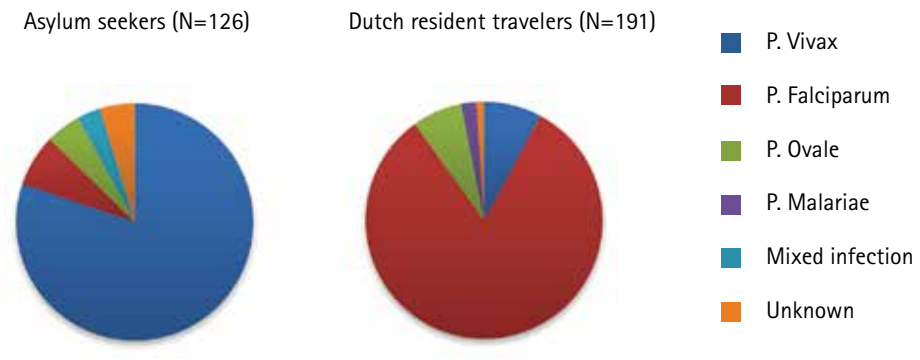
Table 6. Malaria notifications in asylum seekers by country of birth and occupancy at COA by country of origin, 2012-2015

	2012			2013			2014			2015		
Country of birth	Notifications	Occupancy COA	Notifications per 100 persons	Notifications	Occupancy COA	Notifications per 100 persons	Notifications	Occupancy COA	Notifications per 100 persons	Notifications	Occupancy COA	Notifications per 100 persons
Eritrea/Ethiopia	1	498	0.2	4	721	0.6	96	2,957	3.2	118	5,205	2.3
Unknown/Other	3	13,891	0.0	2	13,984	0.0	10	16,595	0.1	8	24,793	0.0
Total	4	14,389	0.0	6	14,705	0.0	106	19,552	0.5	126	29,998	0.4

Table 7. Malaria notifications in asylum seekers by age distribution and occupancy at COA, 2012-2015

	2012			2013			2014			2015		
Age groups	Notifications	Occupancy COA	Notifications per 100 persons	Notifications	Occupancy COA	Notifications per 100 persons	Notifications	Occupancy COA	Notifications per 100 persons	Notifications	Occupancy COA	Notifications per 100 persons
0-4	0	1,560	0.0	0	1,593	0.0	0	1,821	0.0	0	2,337	0.0
5-17	0	2,816	0.0	0	3,281	0.0	39	4,115	0.9	36	6,037	0.6
18-50	4	9,071	0.0	6	8,910	0.1	67	12,530	0.5	89	20,132	0.4
50+	0	942	0.0	0	921	0.0	0	1,087	0.0	1	1,492	0.1
Total	4	14,389	0.0	6	14,705	0.0	106	19,552	0.5	126	29,998	0.4

Figure 2. Plasmodium spp. in asylum seekers and Dutch resident travellers, 2015



eases does not provide insight in the occurrence of infectious diseases in asylum seekers that are not notifiable, e.g. scabies. There are indications that non-notifiable infectious diseases constitute the main disease burden in asylum seekers. The RIVM-CIb, in collaboration with NIVEL, the Asylum Seekers Health Centre (GCA) and others, has therefore initiated a pilot primary care syndromic surveillance project for non-notifiable infectious diseases in asylum seekers.

CONCLUSIONS

The influx of asylum seekers into the Netherlands doubled in 2015. Even though the large influx of asylum seekers was mainly attributed to the increase of Syrian asylum seekers, most infectious diseases reported in asylum seekers are in people originating from the Horn of Africa. The most frequently reported notifiable infectious diseases in asylum seekers in the Netherlands were tuberculosis, chronic hepatitis B and malaria. The incidence of notified infectious diseases varies by country of origin, and depends also on the countries visited en route and conditions there. There is a low risk of transmission of infectious diseases from asylum seekers to the Dutch population.[4]

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Note

This article will also appear in Dutch in a special issue on asylum seekers of the RIVM-publication Infectieziekten Bulletin, November 2016, www.rivm.nl/Onderwerpen/I/Infectieziekten_Bulletin



The role of the (resident) doctor of International Health and Tropical Medicine in the health of people on the move

IRONY

I was probably reviewing the anatomy of the uterus as another hundred people washed up upon the shores of Greece. And while the WHO (World Health Organisation) gathered to discuss the migrant crisis in Lampedusa, I was sending out applications for a paediatrics residency, since I figured the experience would be of benefit for my work abroad later. Meanwhile, as the doors of temporary asylum seekers' homes were being opened, teams of volunteers were being mobilised and discussions on the medical screening of new migrants were ongoing, I sat in the comfort of my home reading up on the impact of migration on public health, holding Skype-meetings with TROIE (the Association for Residents in International Health and Tropical Medicine) and conducting ongoing debates with myself on my next career moves. The irony was almost tangible: there I was, a nearly graduated doctor of International Health and Tropical Medicine (resident IHTM) with a self-proclaimed interest in migrant health and I was not involved – left out of the discourse.

A week later, I joined my first shift with the Dutch Red Cross at Heumensoord. Not much later, I registered for a conference in Oslo to actively participate in the biennial European discussion on migrant and ethnic minority health. And later that year I would book a plane to Lesbos to participate in the Stichting Bootvluchteling (Association for Boat Refugees) medical mission. But most importantly, I gladly accepted a proposal by my former supervisor in obstetrics and gynaecology (O&G), dr. van der Lans, to facilitate a more prominent role for and stimulate the potential of the IHTM resident in the migrant and refugee health discourse.

THE TROPICAL MEDICINE PROGRAMME

The Dutch training programme in International Health and Tropical Medicine is unique in the world. It has been duly recognised as an official post-graduate specialisation since January 2014 by the Royal Dutch Association of Physicians (KNMG). Residents can apply to one of two different profiles: surgical or mother-child. The surgical profile consists of nine months of clinical training in surgery and O&G, while the mother-child profile consists of clinical training in paediatrics alongside O&G. An additional 6-month residency abroad in a low-resource setting and the 3-month Dutch course in Tropical Medicine and Hygiene results in a broad and well-rounded programme, aimed at equipping young doctors with the skills required to work in an international setting. Currently, there are 75 residents being trained in 29 different hospitals all over the Netherlands.

Noteworthy is that the IHTM programme is a dynamic and continuous work in progress with the curriculum being adjusted to the medical and public health needs overseas and here in the Netherlands. So whereas my grandfather packed his doctor's bag to treat Dutch immigrants in Indonesia and my mother left the comfort of her home to combat malaria in Tanzania, I eventually see a role for myself here - on Dutch soil - providing expert care in a multicultural setting, and building on the skills acquired during my training and the additional experience gained abroad. (See also: Van Koloniale Geneeskunde tot Internationale Gezondheidszorg)[1].

WASTE OF POTENTIAL?

What kinds of career paths do these doctors of IHTM undertake? The RGS (Dutch commission for registration of medical specialists) currently counts a total of approximately 280 registered doctors of IHTM working in various fields. Recent research conducted by TROIE reports that about 34% of doctors of IHTM returning to the Netherlands eventually become medical specialists (such as gynaecologists and surgeons), 28% become general practitioners, and another 20% continue to fulfil posts in the international health scene or local public health field. The common sentiment is that graduates are a socially engaged group of doctors with a broad medical view, good clinical skills, expertise in health promotion and advocacy, knowledge of the management of health systems, and a feeling for the intercultural aspects of health care. Personal verdicts from former doctors of IHTM unanimously state that their training and experience contributed to their qualities as medical professionals in a Dutch health care setting today. Unfortunately, hard data concerning this added value is still lacking, which is one reason the Minister of Health has repeatedly denied the training programme structural funding.

And what about this group of 75 IHTM residents? What is their role in the current hot topic of migrant and refugee health? With this question in mind, we first drew a couple of conclusions for ourselves. After all, failing to make intelligent use of the enthusiasm and qualities of this group of residents would be a pity. Pro-active involvement in pressing humanitarian issues closer to home should be promoted. Also, in the current curriculum, the necessary CANMEDS competencies required to practise primary health care abroad are underrepresented.

DOUBLE-EDGED SWORD

The plan is quite simple. The resident IHTM structurally spends half a day a week seeing patients at the outpatient clinic of the GCA (medical centre for asylum seekers) of a designated asylum seekers' home throughout the course of his/her clinical training or during three consecutive months. The benefits are many. Through his/her work under supervision of the general practitioner (only registered GPs are

officially able to provide care in asylum seekers' homes), the resident is not only introduced to medical care for asylum seekers but also exposed to the organisational and public health aspects and coordination of this care. Additionally, the resident is able to provide a useful and engaged helping hand for the GP, also serving as a link between primary and secondary care and functioning as a facilitator for more integrative medicine. The hope is that this short residency will cause a ripple effect for the future, creating interest in migrant health upon return to the Netherlands. And the ideas do not end here. In later stages, this plan could be expanded to include an outpatient clinic run by the resident and his/her specialist supervisor focused on referrals from the GP or mid-wife. Currently, outpatient care of asylum seekers in the hospital is often still a strenuous and frustrating job, with barriers such as time constraints and difficulties in receiving translating services resulting in suboptimal care.

JOIN US!

Of course, the above plan has logistic, financial and perhaps political constraints. So we encourage you to join the session of TROIE and the WHIG (the Dutch Platform for Family Medicine and International Health) at the annual congress of the Netherlands Society of Tropical Medicine and International Health on Friday the 28th of October. What do YOU think is the role of the (resident) IHTM in the health of people on the move?

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FURTHER READING

https://www.coa.nl/nl/actueel/nieuws/tijdelijke-opvanglocatie-heumensoord

http://eupha-migranthealthconference.com/euphas-6th-european-conference

http://bootvluchteling.nl

http://www.knmg.nl/Opleiding-en-herregistratie/RGS-1/Opleiding/Tropenarts.htm

http://www.medischevervolgopleidingen.nl/rubrieken/algemene-competenties-canbetter/canmeds-competenties

https://www.nvtg.org/userfiles/files/AIGT_Opleidingsplan_Final_2012.pdf

https://www.werkenbijgca.nl/portal-outsite-portal-pagina/huisartsen

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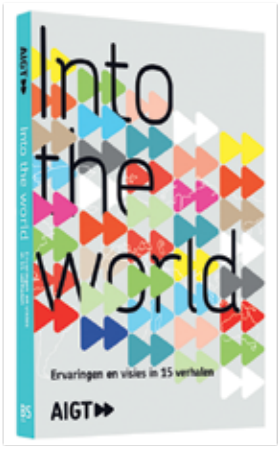
INTO THE WORLD CAMPAIGN

In a rapidly globalising world with growing needs for improving health for all, the importance of medical doctors specialised in International Health has never been so urgent.

A group of members of the Netherlands Society for Tropical Medicine and International Health (NVTG) has started an international campaign to raise awareness of the role of Dutch medical doctors in International Health and Tropical Medicine (IHTM), formerly known as tropenartsen in Dutch, which literally means tropical doctors. MDs in IHTM are trained in the Netherlands and in low-resource environments. They work worldwide in clinical and organizational settings where specific expertise is needed in tropical medicine and global health issues. They have learned to cope with the growing health problems resulting from globalisation, inequity in access to healthcare, and migration.

However, the IHTM postgraduate specialization programme, unique in the world, is in danger due to a lack of sustainable funding sources. The Into the World campaign advocates for the importance of MDs in IHTM and the need for continuation of this specialization programme. The Into the World book bundles experiences and visions on their role in global health and includes interviews with experts from inside and outside the field, reflections, and facts & figures. The campaign is underway, a website will soon be launched, and several social media events are planned. The launch of the book will take place during the 110th anniversary year of the NVTG. We welcome your support for this initiative to ensure the sustainability of the IHTM programme in the field of global health. For more information, please contact us at: boek.AIGT@nvtg.org

Remco van Egmond,
Matthijs Botman

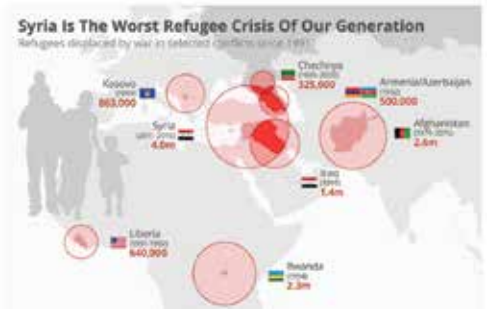


Mental Health on the Move

Short review on migration and mental health

The first studies on migration and mental health focused primarily on immigration in the Unites States in the beginning of the 20th century. Higher levels of mental health problems or "insanity" were observed among migrants as compared to host populations [1]. Selective migration of mentally ill people was understood to explain this difference. Although hypomanic traits such as impulsiveness, extraversion and risk seeking behaviour may seem to predispose individuals to emigrate, the so-called selective migration hypothesis has never been empirically supported [2, 3]. Furthermore, selective migration is a far less plausible explanation for the higher prevalence rates of psychopathology among individuals with a history of forced migration, such as internally displaced individuals and international refugees as well as stateless and undocumented immigrants [4].

Figure 1. Refugees displaced by war in selected conflicts since 1991 (Statista. 2015)



Currently, with conflicts and insecurity in different parts of the world, most attention is given to refugees who are forced to leave their homes as a result of war and violence. It is estimated that in 2015 around 244 million people fled their homes in search of security [5]. In 2015, the United Nations Higher Commissioner for Refugees (UNHCR) reported that the number of people fleeing Syria because of the war was more than 4 million, far more than the 2.3 million fleeing the Rwandan genocide in 1994 or the chronic conflict in Afghanistan since 1979 [6]. This makes Syria the worst refugee crisis of our generation (Figure 1). In the European Union, almost 1.5 million refugees applied for asylum in 2015 (Figure 2). Refugees typically face multiple challenges during different stages of their migration process, with each stage having a specific impact on their mental health [7].

PRE-MIGRATION MENTAL HEALTH

Push and Pull factors have been described to explain migration from rural to urban areas as well as international migration. Adverse local conditions will push populations in case of war and violence. In such cases, specific attention should be given to traumas that refugees experience before departure, such as loss of family and friends, physical and sexual violence, and detention and torture. There is, moreover, a loss of social, personal and material resources. Political, societal, educational and/or religious institutions will fail to function, and people will therefore be less able to retain and regain resources. This loss of resources causes loss of social capital of individuals and can traumatize communities. One such resource is the local health care system, the failure of which is reflected in refugees' pre-departure health status [8].

TRANSIT MENTAL HEALTH

The mental health of refugees is often affected during transit from the country of origin to the country of destination. Multiple modes of transport may be used and are often not safe. Accidents on roads or at sea may result in traumatic experiences as well as forced loss or separation from family. Uncertainty about the route and borders, cultural and language differences, and hostile reception in the transit countries may cause stress and anxiety symptoms.

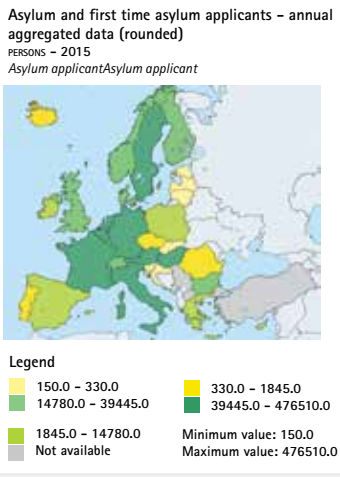
Victims of human trafficking are often exposed to criminal acts in transit, varying from illegal border crossing and forced commitment of illegal acts to physical and sexual violence [4]. Older persons and children form specifically vulnerable groups in transit.

POST-MIGRATION MENTAL HEALTH

Upon arrival, an initial period of restored hope and peace may be found. However, the post-migration mental health of refugees will eventually depend on a host of different factors. Family problems, poor socioeconomic conditions, lack of opportunities for employment, language problems, uncertain asylum procedures, and discrimination are described as the major stressors experienced by asylum-seekers [9]. Longer asylum procedures were associated with higher levels of mental health problems as well as family and work problems. Prevalence of mental disorders in asylum seekers in the Netherlands was found to be 42% upon arrival. This number increases to 66% at 2 years following arrival, with depression and anxiety being more prevalent. About one-third of the asylum seeker population was found to have posttraumatic stress disorder [9].

For many refugees, resettlement in a new country may ignite a process of "cultural bereavement" [10], a state of grief due to a permanent loss of previously familiar social structures and cultural institutions. The process of adapting to a new culture may also lead to acculturation stress if previously successful coping strategies are no longer available or effective. Moreover, loss of social and economic status and the experience of discrimination and exclusion may have a significant negative impact on the mental health of refugees. The presence of a supportive social network in the host country and a hybrid form of identity, norms and values, consisting of elements of both the "original" as well as the "new" culture [11], are thought to be most beneficial for mental health.

Figure 2. Asylum applicants in the European Union 2015 (Eurostat. 2016)



REPATRIATION MENTAL HEALTH

Many refugees that fled their country of origin because of war and violence will continue to feel a state of "permanent transit" and alienation, missing their loved ones and culture left behind. Repatriation is always in their mind, even during ongoing conflict in the country of origin. Few data are available on repatriated refugees. In a retrospective German study of refugees that participated in a state-sponsored repatriation programme, increased levels of psychopathology were found after return. Living and working conditions were mostly unstable [12].

CONCLUSION

The mental health of refugees is affected by a host of social and cultural factors that may be at play before, during, and following migration [7], as can

be seen in Figure 2. Adequate assessment and management of psychiatric problems among refugees should, ideally, incorporate the many ways in which refugees' social and cultural contexts during each stage of migration may have affected their current experience. This requires a fundamental departure from the purely symptom-oriented approach to mental health assessment and treatment, in favour of an ecological perspective. On the political and social levels, consistent efforts are required to fight discrimination and exclusion, to ensure early participation of refugees in the host communities, and to create employment opportunities during and after the asylum procedure.

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Mr.C.

was born in the capital of Syria in 1986 as part of a well-off family with 7 children. After finishing secondary school, he worked as a barber for several years in Syria as well as in Abu Dhabi. In 2012 and 2013, he was arrested for political reasons and held in detention for 3 and 7 months respectively. He was tortured numerous times with a variety of methods. In 2014, he fled to Lebanon were he later heard his father had been killed. He visited psychiatric services on a regular basis in Lebanon for sleeping problems and depressive moods, having been medicated. He decided to look for safety in Europe and fled to the Netherlands via Turkey and Greece. The boat he travelled in capsized in the Mediterranean Sea, but he managed to survive the trip. Once he got to the Netherlands, in September 2015, Mr. C. applied for asylum. He then stayed in different asylum centres in the country until June 2016, when he got an apartment. During the period of applying for asylum, he sought help for psychological complaints several times. He was seen by a general practitioner (GP) and got medication but was not referred to mental health services. Once Mr. C. was able to move to his apartment, he sought help with a new GP and was immediately referred to a specialised mental health institution.

Upon intake, Mr. C. presented with severe psychological suffering. We diagnosed a posttraumatic stress disorder, a depressive episode, and a nicotine addiction. Anxiety and stress had caused severe underweight symptoms (BMI 16.4). He had been previously medicated with a cocktail of tranquilizer, opiates, antidepressants and antipsychotics. His low BMI combined with his medication also caused him equilibrium problems. Severe dental problems and torture-induced scars were found on physical examination. Financial debts were an additional stress factor. After intake, Mr. C. was hospitalized for specialized psychiatric treatment.

Ms.B.

was born in a small village in Sierra Leone in 1989, having lost her mother at the age of 6. During her adolescence, she became aware of her homosexual orientation which put her in danger in the local community. At the age of 20, Ms. B. had to leave school to stay with an uncle following her father's death. While living with her uncle, she was psychologically and physically abused. She was "sold" to a 75 year-old man as a 3rd bride and became a victim of sexual violence. The threat of a second female circumcision (she underwent the first at the age of 11) made her flee to the capital. Trying to survive without family or other resources, she became the victim of human trafficking until she reached the Netherlands and was forced to work as a sex worker in 2012. Her asylum claim was denied because her story was not considered consistent. Therefore, during her outpatient treatment in a specialized mental health service for traumatized victims of human trafficking, she was undocumented and trying to survive with the help of a local religious organization. After 4 years of juridical procedures, she was recently granted asylum and is currently under psychotherapeutic treatment, trying to deal with the multiple traumatic events she has gone through.

Protection against vaccine-preventable diseases in adult asylum seekers in the Netherlands

Recent measles outbreaks among refugees in Germany and France as well as serological studies among asylum seekers in Germany showed that immunity against measles and other vaccine-preventable diseases may be suboptimal. In the Netherlands, vaccinations included in the National Immunisation Programme (NIP) are offered to asylum seeker children up to 19 years of age, if considered necessary. To assess the level of protection in adult asylum seekers, we conducted a serosurvey in three asylum seeker centres between July and August 2016. The results can serve as a basis to guide Dutch vaccination policies. In this article, we describe the first phases of the study, which is expected to be completed in 2017.

BACKGROUND

The number of people applying for asylum in the Netherlands increased sharply in 2015. At the end of 2015, the Central Agency for the Reception of Asylum Seekers (COA) housed almost 50,000 people in asylum seeker centres. In 2016, the influx has started to decline, and as of the first of July 2016 some 37,000 people were living in asylum seeker centres. About 40% of those asylum seekers are from Syria, followed by Iraq, Afghanistan, Eritrea and Iran. Harsh living conditions and poor hygiene during their journey and overcrowding in asylum seeker centres make asylum seekers a vulnerable group for contraction of infectious diseases.

As part of the infectious disease control policy in the Netherlands, asylum seekers are routinely screened for tuberculosis upon entry into the country. Local public health services address outbreaks of, for example, scabies, varicella and hepatitis A. Overall, the risks from infectious diseases among asylum seekers seem limited and manageable[1]. However, recent measles outbreaks in asylum seeker centres in Germany and France show that the levels of immunity against measles infection among asylum seekers may not be sufficiently high to ensure herd immunity[2,3]. Likewise, a serological study among asylum seekers in Germany found relatively low levels of seroprotection against measles infection (79.9%), whereas, ideally, the herd immunity threshold should be at least 94%[2]. Insight in the seroprotection of adult asylum seekers in the Netherlands against vaccine preventable diseases is lacking.

The European Centre for Disease Prevention and Control (ECDC) recommends assessing the immunisation status of all asylum seekers and offering immunisation according to the national immunisation programme[4]. In the Netherlands, currently only the vaccination status of asylum seeker children up to 19 years of age is assessed, and a vaccination plan is made if vaccinations are needed[5]. Adult asylum seekers are not assessed and are not offered immunisations.

This study aims to assess the seroprotection levels against a range of vaccine-preventable diseases (diphtheria, tetanus, polio, measles, mumps, rubella, varicella and hepatitis A) in adult asylum seekers, and to collect essential information on demographics and vaccination history by means of a questionnaire. For that purpose, the National Institute for Public Health and the Environment (RIVM), in collaboration with Radboudumc, set up a serosurvey, whose results can serve as a basis to guide vaccination policy.

STUDY DESIGN

The research population consisted of adult asylum seekers aged 18 to 45 years who originate from Ethiopia, Eritrea, Iraq, Iran, Afghanistan and Syria. The rationale behind the choice of this age range was that asylum seeker children below the age of 19 already receive vaccinations if deemed necessary. Persons above the age of 45 likely experienced prior natural infection in their country of origin and therefore already have protective antibody levels, as was described by Toikkanen and colleagues[2].

In this study, participants were divided into three groups with respect to country of origin: 1) Syria, 2) Iran, Iraq and Afghanistan and 3) Eritrea and Ethiopia. Based on power calculations, the aim was to include 300 participants in each group. Likewise, within each country group, participants were also assigned to the following age groups: 18-25 years, 26-35 years and 36-45 years. Per age and country group we strived to include 100 participants, i.e. 900 in total.

In consultation with the COA, the refugee centres in Dronten, Luttelgeest and Almere were selected as study sites. These relatively large centres appeared to be the most suitable with respect to numbers of asylum seekers originating from the countries included in this study. All study materials, such as the invitation letter, questionnaire and consent form, were translated into languages most commonly spoken by asylum seekers who were invited to participate in the study (Arabic, Farsi, Tigrinya and Amharic – besides Dutch and English). We also included a flyer with icons describing the study graphically to reach illiterate asylum seekers. In addition, we put up posters at the study sites, which displayed sampling days and general information on the study. Interpreters, who were trained prior to the beginning of the study, facilitated communication with study participants.

Serological tests will be performed in fall 2016, using assays as described in the PIENTER study, which has a comparable study setup and is periodically conducted in the general Dutch population.

Table 1. Overview of number of participants per country of origin (divided into three groups) and age group

Country of origin	Age group in years			
	18-25	26-35	36-45	Total
Syria (group 1)	92	117	79	288
Iran (group 2)	32	54	25	111
Iraq (group 2)	26	43	13	82
Afghanistan (group 2)	35	26	10	71
Total group 2	93	123	48	264
Eritrea* (group 3)	13	25	15	53
Total	198 (33%)	265 (44%)	142 (23%)	605

*of these, one participant was born in Ethiopia

DATA COLLECTION

It is obligatory for asylum seekers to report to the foreign police and their refugee centre on a weekly or bi-weekly basis. In Dronten and Almere, invitation letters were distributed on this reporting day one week ahead of the study. The invitation letter included information on the sampling days and hours during which asylum seekers who were interested in participating in the study

were expected. In Luttelgeest, housing counsellors visited the refugees personally to inform them about the study and to distribute invitation letters.

On the sampling days, interpreters explained the study aim and procedure to participants, either in a group or on an individual basis. Following the general explanation, interpreters assisted with filling in the informed consent form and short questionnaire. Female medical personnel subsequently collected one tube of blood. To ensure privacy during blood collection and lower cultural barriers that might have hindered female asylum seekers from participating, we set up folding screens. Participants received 10 euros as compensation for their cooperation.

Between 11 July and 10 August 2016 – distributed over nine sampling days – 633 asylum seekers participated in the study. Based on the questionnaires, we found that a number of these were born in countries other than specified in the inclusion criteria. In some instances, information on the age of participants was missing. Hence, the results of the preliminary analyses were based on 605 participants. Of these, 80% were male and the mean age was 29 years. The high percentage of males was expected, as recent figures released by COA show that 72% of persons living in refugee centres who are between 18 and 39 years of age are male. Table 1 shows the number of participants according to country of origin and age group.

According to figures provided by COA, a large group of asylum seekers had the Ethiopian nationality. However, during the data collection, we found that hardly any asylum seekers from Ethiopia who spoke Amharic lived in refugee centres. The likely explanation for this is that Eritrean asylum seekers often have Ethiopian nationality, due to the complex political situation since the 1993 referendum on Eritrean independence. Hence, translation of the study material into Amharic (language commonly spoken in Ethiopia) would have been dispensable.

In general, the number of participants originating from Eritrea was considerably lower compared to other countries (Table 1). The reason for the lower participation was likely a different socio-cultural perception of research of that kind. Interpreters reported that – despite explanation of the study procedure – some Eritreans refused to participate, as they worried that laboratory results could negatively influence their asylum application. As the response rate of Eritreans in all refugee centres was lower than expected, we assumed that the response in other refugee centres would be similarly low. Therefore, we refrained from expanding the study and accepted that the precision of seroprevalence estimates for the group of Eritreans would be lower than for participants from other countries of origin. For the latter countries (Syria, Iran, Iraq and Afghanistan), the total number of recruited participants was satisfactory (n = 552).

FUTURE

Serological tests will be performed in the fall of 2016. Additional analyses and reporting will follow in 2017. Among other analyses, we will compare the seroprevalence findings in asylum seekers with seroprevalence findings in the Dutch population tested in the course of the PIENTER study. The results can ultimately serve as a basis to guide vaccination policy for adult asylum seekers.

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Note

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Gender bias in Humanitarian Aid – What about the Men?

STEREOTYPING

In the media, male refugees are often portrayed as aggressive (young) men, perpetrators of (sexual) violence, homophobes, a threat to "our own women and daughters" etc. This is a rather negative, false or limited picture which is contributing to a climate of "us versus them". Women, on the contrary, are often portrayed as innocent, vulnerable, victims of sexual violence. Without negating women's suffering in crises, this limited picture of women may easily get in the way and prevent us from also seeing them as strong, resilient agents of change.

Gender stereotyping is part of daily life. When reference is made to gender, the concept is often mistaken as referring to women only, ignoring the fact that it is a relational concept. We come across such biases even with development partners and in humanitarian aid. The 2015 edition of UNFPA's World Population Report focuses exclusively on a transformative agenda for women and girls in a crisis-prone world. An inventory among humanitarian aid organisations conducted by Rutgers also showed a lack of focus on men in SRHR and GBV interventions [1]. At the recently held World Humanitarian Summit in Istanbul, a strong plea for safe, healthy and dignified lives for women and girls was heard. The sexual and reproductive health needs of men and their role in combating gender-based violence was overlooked, as if they are immune to gender-based problems.

UNTYING GENDER STEREOTYPES

How can we explain this predominant focus on women and girls? It may well be part of a sincere concern for the well-being of women and children, who generally suffer the most in crises. A global study by IFRC [2] indicates that women and children are 14 times more likely than men to die in disasters. Prevailing vulnerabilities, patterns of inequality and discrimination tend to deepen in situations of crisis.

Asking for attention for the needs of men in humanitarian crises is difficult. Firstly, fundraising for victims of violence with often dreadful experiences is certainly easier. But there is more. People may fear that programmes for men interfere with attending to women's needs. Advocating for involving men and addressing their needs can create tension, as staff from non-governmental organisations or international organisations may also not be free from gender bias. 'I know for a fact that the people behind the report insisted the definition of rape be restricted to women', according to Dolan, director of Refugee Legal Project of Makarere University. There is also a taboo among men themselves. Being vulnerable in a patriarchal culture is rather problematic. 'Part of the activism around women's rights is about "Let's prove that women are as good as men". But the other side is you should look at the fact that men can be weak and vulnerable as well', says Dolan [3]. Men are supposed to be masculine and strong, being able to provide income for their families. If they can't do so, frustration and humiliation may occur. In the case of sexual violence, disclosure is even more problematic, as men who have experienced this will not be considered real men anymore. Feelings of failed masculinity, humiliation and a loss of personal value can even prevent sexually or otherwise abused men from accessing the services they need.

WHY INVOLVE BOYS AND MEN IN SRHR?

Men's and boys' sexual and reproductive health needs are often embedded in a context of severe gender inequality. Knowledge of their own sexual health may be distorted, especially when the information they have is from dubious sources or based on male-dominant (pornographic) information. Sexual consent may be a particularly troubling area, in which inequitable attitudes lead to sexual violence. Women's ability to negotiate contraception is often very limited, and their attempts to do so may be perceived as disrespectful, provoking further violence. In combination with a lack of open communication and traditional gender roles, these situations can escalate into forced sex or violence. Changing rigid norms and patterns must start with engaging boys and men in SRHR, with sexuality education, paying attention to gender equality, and provision of SRH information and services, also within humanitarian aid. According to Benoit Ruratotoye, psychologist of Living Peace Institute in Goma, DRC: 'We have to develop a positive masculinity. It starts with boys. If they are not taught human rights, respect for women, and equality, these children will grow into young men who think they are better than women and who will become violent men who rape'. [4]

ENGAGING MEN IN DEALING WITH TRAUMA

Although women suffer a higher proportion of sexual and gender based violence, it is important to acknowledge male victims too. Organized rape of men in war can be considered as a political act of 'unmanning' and humiliation during war. Where men have witnessed or suffered violence themselves, it is likely to lead to violent behaviours on their own part. If men do not get a chance to recover, their unhealed trauma may fuel the next epidemic of domestic violence. Healing programmes are urgently needed in order to break the circle of violence. In her paper on working with men to increase stability,

Henny Slegh refers to interesting experiences with Living Peace, a psycho-socio community therapy in DRC: 'In promoting positive masculinity, men are helped to develop alternative coping strategies that are gender transformative and constructive in dealing with problems' [5]. Let's be clear: rape and sexual violence are a tragic human rights abuse, too often accompanied by impunity. Poverty or frustration of failed manhood can never be an excuse for any form of violence. Perpetrators must be prosecuted, for which a security and legal system, resources and capacity are needed. But this will not be enough. Adequate GBV and gender transformative policies and programming for women and men are essential in general and in disaster and conflict affected areas in particular.

MEN AS CARING PARTNERS AND FATHERS

Failing to engage men as caring partners and fathers is a missed opportunity. Even in more stable circumstances, few health facilities are prepared with trained health staff to engage men in such roles. Growing evidence is showing the positive health and social impacts of engaged fatherhood – for women and children, and for men themselves (State of World's Fathers) [6]. MenCare+, a three year programme of Rutgers, resulted in improved communication, better health, engaged fatherhood and a reduction of domestic violence by engaging men in gender transformative programming [7]. Part of the programme addressed the attitude of health providers. They were trained to be sensitive to the needs of fathers that attended the clinics, to look beyond traditional patterns, and to see the man in front of them as a person who cares about his children.

How to engage boys and men in a positive way?

- Create a safe space for boys and men and listen to their stories.
- Use a group therapeutic approach that critically questions and challenges harmful concepts of masculinity.
- Identify current coping mechanisms, strengthen positive ones, and reshape negative ones (those reliant on violence, alcohol or isolation).
- Approach men as diverse and complex actors – not only recognising them as perpetrators, but also as victims and witnesses of violence, as agents of change, partners, fathers and clients.
- Acknowledge that man are not born violent and that learned violent behaviour can be unlearned.
- When conducting programming to end sexual and gender-based violence, include information and training on SRHR, consent contraception, pregnancy, antenatal care etc.
- Use an ecological model to support individual-level change with community and structural support, encouraging the healing of trauma and the restoration of the individual to the family and to the community.
- Encourage a locally owned and driven approach by building capacity within local organizations, as well as by training trainers and facilitators from within the community

Without a doubt, we must continue providing support to women and girls who are severely affected by poor SRHR and GBV during conflict and disaster. But in order to make tangible changes, we must pay attention to the root causes of GBV, poor SRHR, and gender inequality. Engaging boys and (young) men offers an opportunity to unpack patriarchal structures and transform harmful social norms into positive notions of manhood and respect for girls and women. In order to tackle persistent gender stereotyping, also within the framework of humanitarian aid, it is helpful to start questioning the gender biases in our own minds, in policies and interventions. A good starting point is taking note of the (SRH) needs of men, and seeing them as potential for change instead of as the sole problem.

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