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MIGRANTS AND HEALTH

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Talking about the universal in Universal Health Coverage

The cover of this edition of MTb is titled *Migrants and Health*. At the symposium *Care for newcomers* on the 9th of October one of the keynote speakers asked the audience what first comes to mind when talking about people newly arrived in the Netherlands. The audience was filled with global health professionals, health and welfare professionals working with asylum seekers and migrants, and so-called 'undocumented persons'. Responses to this question included 'migrants', 'vulnerable groups', 'forced displacement', 'access to care', 'language barriers', 'hope', and 'new neighbours'. None of them used the first synonym the thesaurus provides for newcomer: 'stranger'.

In trying to come up with a suitable title for this edition, we settled for *Migrants and Health*, although conscious of the fact that some of the articles do not officially belong to these categories. Though treatment and care – health and otherwise – for migrants is a hot topic in many of the current political and social debates in the Netherlands and beyond, strangely there is *no* universally accepted definition of the term migrant. Except perhaps for the definition provided by the UN Department of Economic and Social Affairs referring to international migrants as “any person who changes his or her country of usual residence”, and whereby “despite legal differences between countries, migrants and refugees are entitled to the same universal human rights and fundamental freedoms as anyone else”^[1,2]

And how does that entitlement work out in practice and in the daily lives of 'people on the move'? In this edition of MTb, you can read about the situation in refugee camps in Lebanon and Greece, and the role of NGOs in civil search and rescue operations at sea as a demonstration of such realities. We present the outcome of research among pregnant women in an asylum seeker centre in the Netherlands – many of them facing high fold risk of perinatal mortality as compared to their general counterparts in the area. In addition, we address the

health needs and limitations in accessing health services for people that do not belong to any of these groups, often falling between the cracks. These are persons who may consider themselves also on the move, in any case away from their country of usual residence. The question remains, where can the so-called undocumented persons (defined as someone residing in a country without legal residency status) go when in need of quality appropriate care? According to universal treaties, they are also entitled to this, under the same universal protection of human rights and fundamental freedoms.

The words of Hannah Arendt in her essay *We refugees* – written in 1943 shortly after she arrived in New York – still linger on: *“In the first place we don't like to be called refugees. We ourselves call each other “newcomers” or “immigrants” (...) A refugee would be a person driven to seek refuge because of some act committed or some political 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 opinion held. With us the meaning of the term “refugee” has changed. Now “refugees” are those of us who have been so unfortunate as to arrive in a new country without any means and have to be helped by refugee committees.”*^[3] Little seems to have changed, eighty years on.

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1. United nations General Assembly resolution 71/1 (2016). New York Declaration for Refugees and Migrants, paragraph 6. Available at : https://www.un.org/en/development/desa/population/migration/generalassembly/docs/globalcompact/A_RES_71_1.pdf
2. <https://www.who.int/news-room/fact-sheets/detail/refugee-and-migrant-health> [accessed 23 October 2024]
3. Hannah Arendt, “We Refugees,” *Menorah Journal* 31, no. 1 (January 1943): pp 69-77.

Provide undocumented individuals with access to health insurance

The paradoxical way healthcare is financed for undocumented individuals in the Netherlands is a burden on everyone.

A homeless man (30 years old) is experiencing severe abdominal pain. A volunteer visiting him notices that he looks unwell and takes him to the GP out-of-hours service (in Dutch: huisartsenpost). The patient himself is unsure if and how he can receive medical assistance. The receptionist of the GP out-of-hours service turns him away because he doesn't have insurance: he is undocumented (see Box 1). The next day, it turns out that he has a perforated appendix.*

In May 2024, the Lancet published *Universal Health Coverage for undocumented migrants in the WHO European Region: a long way to go*, stating that “undocumented migrants face some of the biggest challenges to accessing Universal Health Coverage (UHC) and are often left behind by systems that exclude and stigmatise them”.^[1] The Netherlands is no exception to this. Numerous studies, articles, and blogs have already been published on the subject: access to medical care for undocumented migrants in the Netherlands is downright inadequate. One important reason is that healthcare for undocumented individuals is not financed through regular channels. Switzerland shows this can be organised in a better way.

Box 1: Undocumented migrants

An undocumented person is someone residing in a country without legal residency status. In a recently published book, the undocumented population residing in the Netherlands is roughly divided into three broad categories: ‘asylum seekers’

(asylum seekers who have had their asylum claim rejected, often still with strong aspirations for legal status), ‘investors’ (labour migrants without work visas, who aim to earn money through work to support their families), and ‘adventurers’ (respondents who primarily left their homeland to explore the world, but who, over the years, often face a shrinking social network, sometimes homelessness and other social problems).^[2] There are also children born to undocumented parents, making them undocumented as well.

The exact composition of this group in the Netherlands is not well known but an estimated 23,000–58,000 undocumented individuals reside in the Netherlands.^[3]

A PARADOXICAL AND CONFUSING STRUCTURE

Since 1998, undocumented migrants in the Netherlands have been excluded from social services (such as benefits and allowances) through the *Koppelingswet* (Linkage Act) as part of a discouragement policy. This also means that undocumented individuals cannot take out health insurance. In principle, undocumented people must pay for medical care themselves. However, every person, according to the constitution and international treaties, has the right to ‘medically necessary care’. So this includes undocumented patients without sufficient funds.

What is ‘medically necessary care’ anyway? In 2007, the Klazinga Commission in the Netherlands elaborated on the concept of ‘medically necessary care’ on behalf of professional organisations and created guidelines. These guidelines state that healthcare providers must offer undocumented individuals ‘appropriate

and responsible care’. And appropriate and responsible care equates to nearly the same level of care as insured individuals and goes far beyond emergency care.^[4] This is more extensive than in many other countries.^[5] If an undocumented person cannot pay for this care, the CAK (Centraal Administratieve Kantoor = Central Administrative Office) reimburses nearly all healthcare that falls under the basic insurance package of the Health Insurance Act or the Long-Term Care Act, provided the healthcare provider deems the care ‘medically necessary’.

All of this, however, leads to a paradoxical and complex structure: undocumented people are not allowed to take out health insurance and cannot pay taxes, but they are entitled to appropriate and responsible care, almost equal to the basic healthcare package. They are required to pay for this care themselves, but if they cannot, there is a financing arrangement entirely funded by the government. Then why not simply allow them to take out insurance?

EVERYBODY LOSES

You might think that it makes sense that undocumented people cannot take out health insurance. After all, they are not Dutch citizens, and there is a financing arrangement in place. But this system actually makes no sense. In fact, everybody is a victim of this system. Allow me to introduce all the victims to you.

VICTIM 1: THE UNDOCUMENTED PERSON

Not being allowed to take out health insurance leads to poorer access to healthcare. This starts at the general practitioner (GP). In Amsterdam, 40%(!) of general practitioners sometimes refuse undocumented migrants, and 18% impose a maximum number for their practice.^[6] Reasons GPs give for refusing undocumented people are a lack of time and the medical problem not being perceived as urgent.^[7] Helping undocumented individuals takes up a lot of the GP's time and brings little financial return (see Victim 2). Many undocumented people therefore

have no GP and depend on volunteer organisations like Médecins du Monde or the Kruispost. But the problems do not end at the GP's office. When undocumented people are referred further along the healthcare chain, more problems arise. The paradoxical structure also creates confusion in hospitals, as the case at the beginning of this article illustrates. Stories continue to surface of receptionists or doctors in the emergency department who deny care to undocumented individuals, despite their legal rights.^[8] The system also puts up a barriers to outpatient hospital care. Undocumented people are regularly forced to make a down payment at the hospital,^[6] receive bills and reminder letters at home, and even have debt collectors sent to their door. Undocumented individuals find this frightening and humiliating, and therefore avoid seeking care.^[9] As a result, they only go to the doctor when the situation becomes critical, leading to more severe and harder-to-treat conditions.^[9]

VICTIM 2: THE HEALTHCARE PROVIDER

The financing arrangement via the CAK costs healthcare providers both time and money. For a single claim to the CAK, which must be submitted separately for each consultation or medical procedure, a healthcare provider can spend up to an hour filling out forms which are still entirely paper-based. In addition, claims are regularly denied by the CAK because of small mistakes or get lost, leading to more paperwork.^[7] GPs find this bureaucracy too time-consuming for a return of a few dozen euros.^[7] Of the GPs surveyed, 22% report not submitting claims to the CAK at all.^[6] Additionally, health care providers (with the exception of health care related to pregnancy and birth) only receive 80% reimbursement for the care they provide to undocumented individuals. Hospital financial departments also face a heavy workload. They have to make an effort first to recover costs from patients, before they can submit a claim to CAK.^[10] A peripheral hospital in a major Dutch city reports dedicating approximately one and a half days per week to handling CAK-declarations.

VICTIM 3: THE TAXPAYER

The costs of the CAK arrangement increase every year.^[7,10] In 2022, the costs amounted to 51 million euros,

although this increase can be largely attributed to inflation and the overall rise in costs observed in the health care sector.^[10] Additionally, the CAK-regulations have become better known in recent years.^[10] The costs are fully borne by the taxpayer since the undocumented person is legally unable to contribute to healthcare premiums.

But, you may wonder, wouldn't it be even more expensive if undocumented people had 'unhindered' access to healthcare? Probably not. Research, albeit limited, suggests the opposite: hindering access to care for undocumented individuals ultimately leads to higher costs, as delays in care result in costly hospital treatments instead of cheaper GP care.^[11,12]

UNIVERSAL HEALTH COVERAGE

In addition to all parties being a victim of the system, this system also fails to meet the Sustainable Development Goals (SDGs) to which the Netherlands, as a United Nations member state, is committed. One of these goals is achieving "Universal Health Coverage", which means that everyone worldwide should have access to quality healthcare services when and where needed, without facing financial hardship.^[1,13] One article aptly stated: "The WHO has declared that 'all roads lead to universal health coverage' (UHC), yet undocumented migrants do not travel those roads".^[14,15]

In short, it is time for a better system - one that truly guarantees access to care, places less burden on healthcare providers, reduces costs, and protects human rights. My proposed solution: access to health insurance.

SWITZERLAND

Let's travel to Switzerland where things are organised differently. Health insurance is mandatory for anyone residing in Switzerland for more than three months, regardless of residency status. This means that also undocumented individuals in Switzerland are required, or rather, entitled, to obtain health insurance. Health insurers cannot refuse anyone and are not allowed to share information with the government. Furthermore, when an asylum seeker's application is rejected (making them undocumented),

they retain their health insurance in many cantons.^[16] As a result, Switzerland ranks second on the Migrant Integration Policy Index (MIPEX) in the 'health' category - a much higher position than the Netherlands, which is in 17th place.^[17]

This Swiss mandatory health insurance system has been in place since 1994.^[18,19] Since 2000, the right to basic healthcare for everyone on Swiss territory has even been enshrined in the constitution, although this right already existed implicitly through several court rulings.^[18] A motion submitted in 2010 to deny undocumented people the right to health insurance was rejected by the Federal Council, which stated that "healthcare for the entire population represents enormous social progress that should not be restricted" and that "healthcare is a fundamental right."^[20]

The number of undocumented people in Switzerland does not explain this more liberal approach. In absolute and relative terms, there are more undocumented migrants in Switzerland than the Netherlands. Estimates suggest about 90,000 undocumented individuals (compared to 23,000-58,000 in the Netherlands), while Switzerland's population is less than half of the Netherlands.^[3,21]

There are, however, some caveats to the Swiss system. There are significant differences between cantons in outcomes. Basel is the most successful, where 80-90% of undocumented individuals have insurance, but nationwide, this figure may be less than half of that. Basel's success is due to the canton offering an easily accessible "health allowance" and an NGO dedicated to helping undocumented individuals obtain insurance.^[19] The reason that a small number of undocumented migrants remain uninsured is likely due to fear of authorities and financial uncertainty.^[18] A second caveat is that there is no backup plan for the remaining uninsured undocumented individuals, whose access to care is very poor. In other words, they have almost no access unless they pay for everything themselves or seek emergency care.^[10] But for those undocumented migrants with health insurance, access to care in Switzerland is smooth,

and there are no bureaucratic obstacles or instances of care denial, according to the NGO Anlaufstelle Basel.^[19]

APPLYING THIS TO THE NETHERLANDS

What can the Netherlands learn from this? Health insurance for undocumented individuals is possible, and would benefit all parties. Undocumented individuals would have less trouble registering with a GP, would no longer be unjustly turned away at emergency departments, and would not face debt collectors. Healthcare providers could deliver care without time-consuming forms and with full reimbursement. Having an insurance card would also clarify for the undocumented individual what they are entitled to, and the available evidence suggests that overall costs for society would decrease.

How can we apply this in the Netherlands? The “linkage principle” for medical care in the Koppelingswet (Linkage Act) needs to be reinterpreted. Medically necessary care should also be insurable for undocumented individuals. If an undocumented person cannot (fully) afford the premium, they could receive a healthcare allowance or subsidy. Additionally, asylum seekers should be able to retain their health insurance after their asylum application is rejected.

However, it is crucial that for those who remain uninsured, the current CAK arrangement remains in place. This backup plan is vital for those people in the most vulnerable situations who remain unable to take out health insurance (likely mainly asylum seekers and ‘adventurers’). Also, it is essential that data on undocumented individuals is never shared with authorities to facilitate deportations. This shockingly happened in the United Kingdom and has led to lasting mistrust of the NHS among undocumented individuals.^[22]

NOT SOLVABLE WITHOUT GOVERNMENT INTERVENTION

In 2023, a group of initiators from organisations such as Médecins Du Monde (Doctors of the World), the Protestant Diaconate of Amsterdam, and the Regenbooggroep (Rainbow group) initiated meetings with two health insurers that showed interest in making

health insurance possible for undocumented individuals. Unfortunately, these discussions did not lead to any practical results. The main stumbling block proved to be the financial risk for insurers, as ‘risk equalisation’ cannot be applied to this group. Normally, through the risk equalisation system, insurers are compensated by the government for patients expected to consume a lot of care, based on factors like age, gender, and income as well as care usage and hospital care. For undocumented individuals, such calculations based on these equalisation characteristics are not possible, meaning that insurers’ income would only come from premiums. Therefore, including undocumented migrants in the health insurance system would pose a larger financial risk to health insurance companies making them more than reluctant to do so. This demonstrates that government intervention is essential to make health insurance for undocumented individuals possible, for example by establishing a fund to compensate insurers and embedding the system in a national structure.

HEALTH CARE IS NOT A PULL FACTOR

The Linkage Act was initially introduced as part of the “discouragement policy aimed at discouraging undocumented migrants from residing in the Netherlands”^[23] Regardless of ethical concerns, does restricting access to healthcare actually discourage people from staying? In other words, if undocumented individuals no longer had to jump through bureaucratic hoops to access healthcare, would that lead to a significant increase in migration? There is no evidence that suggests this. Contrary to the claims of right-wing politicians, access to healthcare is not a major pull factor for migration. Work (48%), political, sexual, or religious orientation (19%), and family ties (14%) are the most common reasons for migration.^[24,25] Only 1.6% of undocumented migrants in the Netherlands cite healthcare as a reason for migration. This figure is similar to other EU countries, even those with different healthcare policies.^[25]

In conclusion, health insurance must be made available to undocumented migrants. Switzerland proves that it is possible and can work. Every person has the right to health and health care. And

this right cannot be exercised without health insurance. As doctors, we have taken an oath to promote health and care for the sick - all the sick, not just those with documents. The system must support this. Let’s pave the road to universal health coverage for all.

* This case is based on a true story

** For readability, undocumented migrants are referred to as ‘he’. However, it is estimated that 18-35% of undocumented migrants are female.^[26]

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How to practise what you preach: practical considerations for participatory global health research

Involving refugees in research about their own healthcare remains rare, despite growing calls for meaningful participation.^[1] While patient and community groups are increasingly involved in shaping their own health, refugees are often excluded and tokenised.^[2,3] A review of 53 WHO (World Health Organisation) European Region member states found that refugees and migrants are seldom co-producers of evidence regarding their health.^[4] Yet, their participation is critical, not just for the credibility and relevance of the research and for ensuring that healthcare systems address their unique needs, but also in fostering empowerment and agency.^[5,6]

Participatory Action Research (PAR) offers a solution to this gap. Rooted in anticolonial and emancipatory traditions, PAR actively involves those whose lives are the focus of research in the entire process of knowledge generation with the explicit aim of effecting positive social change.^[7] Rather than 'research on' refugees, PAR fosters 'research with' refugees, challenging the top-down approaches of traditional methodologies and dismantling harmful power dynamics that often mirror colonial hierarchies.^[8]

In the summer of 2023, our team embarked on a PAR project focused on the sexual and reproductive health of refugee women on Lesbos. Our research team included ten refugee co-researchers representing key ethnic groups from the refugee camp. Co-researchers typically had similar lived experiences and shared the same cultural and linguistic backgrounds as the research participants. They were recruited, trained and paid as collaborators and participated in every step of the research, from formulating the research questions and developing the data collection tools to recruitment, data collection, analysis and dissemination of the findings.

This collaborative process proved instrumental for the quantity and quality of our data. Moreover, it was transformative for everyone involved. For team members from western universities, it challenged preconceived notions about the refugee experience and prompted a re-evaluation of our approach to cross-cultural collaborations. Co-researchers acquired new technical skills and felt genuinely valued, which bolstered their confidence to pursue future opportunities. Meanwhile, for the refugee community, witnessing their fellow camp residents take on roles of responsibility instilled a sense of pride and reinforced the importance of their contributions. Additionally, the friendships and bonds formed



Photo by Zainab Satar.

throughout the project cultivated a strong sense of support and community that continues to thrive beyond the research.

Based on our experiences, we have compiled a list of practical considerations for researchers seeking to engage refugees meaningfully in healthcare research. While these insights stem from our particular project, we believe they hold broader relevance. We are not oblivious to the challenges that come with meaningful participation (e.g.: power dynamics, time constraints, elite involvement etc.), nor naïve to our own limitations, but remain passionate advocates of the approach. We offer these tips with humility, acknowledging that every research context is unique, and that flexibility, openness, and a commitment to continuous learning are essential to the success of PAR.

1. ESTABLISH EARLY COMMUNICATION

Create an informal network before fieldwork starts to initiate conversations and build relationships. This sets a

collaborative tone from the beginning. Three months prior to meeting each other for the first time, our team had been in touch via a WhatsApp group and was ready to dive into the challenges of the fieldwork. Now that our data collection is over, and we are dispersed over the world, we still remain in touch digitally.

2. TRUST COUNTERINTUITIVE ADVICE

During consultations with the refugee community prior to recruitment, we were advised to include a male co-researcher in the team, despite our focus on women's health. Initially, we dismissed this suggestion, but after having it reiterated from others, we decided to trust their judgement. It proved invaluable and was crucial advice, actually enhancing access to this particular community.

3. CO-CREATE A WORKING AGREEMENT

Discuss expectations, hopes, and fears at the onset. This ensures alignment and clarity on roles, responsibilities, and shared values. At the start of our

project, we spent considerable time co-creating our working agreement. This process helped us avoid misunderstandings later on and built a foundation of mutual respect and shared goals.

4. RESPECT REIMBURSEMENT DISCUSSIONS

Discuss compensation openly, considering hourly rates, net salary, and differences in involvement and workload. We openly deliberated on payment structures and revisited this once it became clear that some of the co-researchers were responsible for larger study samples than others. We then honoured the team's suggestion to recruit an extra member.

5. PRIORITISE RELATIONSHIPS

Spend time together outside formal research settings and invest in relationships. Personal moments—as simple as eating ice cream, celebrating birthdays, or visiting each other when sick—help build emotional connections and strengthen the team. Reflecting back on our field work, these

memories were by far the most valuable and instrumental in building trust.

6. PROVIDE TRANSPORTATION

Swallow your pride and do not get frustrated when you feel like a taxi-driver as opposed to a project lead. Flexibility in transport helps keep momentum when local infrastructure is unreliable. More importantly, driving the team to and from the refugee camp not only removed hierarchies but also created space for insightful conversations. For example, it was during such a trip that one of the co-researchers admitted that the day's training session on gender-based violence had made her lose trust in the project and that she considered resigning. This open feedback - which had not been shared at the debriefing - allowed us to address her concerns as well as those of the other team members the following day. We then co-created and implemented appropriate mitigation strategies.

7. ACT ON FEEDBACK

Continuously seek feedback and ensure that co-researchers have a real say in decision-making processes. This can help avoid tokenistic participation and foster a sense of ownership. In our project, we respected suggestions to the best of our abilities, whether related to content (which topics and questions are to be included in the questionnaire and in which order?), logistics (where and when should we conduct interviews?), reimbursement (should we financially compensate participants and if so, how much?), or dissemination (what are the main outcomes we want to present to the camp manager?).

8. SHARE RESOURCES AND RESPONSIBILITIES

Equip your team with the material they require to perform their work. Trust co-researchers with (sometimes expensive) devices, just like you would in any other context. In our project, the 'research bag' (including keys to our office and interview rooms, the communal research phone, and internet router) was not kept in the possession of the project lead alone, improving logistics and fostering accountability among co-researchers. Having said that, take concerns about safety seriously and provide lockers/safe places if this is deemed necessary. In our case,

for instance, some of the co-researchers were not comfortable keeping laptops in their tents due to the risk of theft.

9. HOLD YOUR TEAM TO THE SAME STANDARDS

Treat all team members equally, regardless of their background or circumstances. In our project, we ensured that everyone was held to the same professional standards and expectations, avoiding the risk of victimising or infantilising the co-researchers. By avoiding assumptions about their trauma or cultural background, we steered clear of patronising, romanticising, or stereotyping. This meant that co-researchers felt valued for the unique individuals they were and empowered in their professional roles.

10. AVOID ASSUMPTIONS ABOUT REFUGEES' TIME AND COMMITMENTS

Refugees lead complex and busy lives. Be respectful and sensitive to their time, particularly in camp environments with rigid schedules, such as food lines and asylum appointments. One of our co-researchers missed crucial food distribution slots due to the timing of training sessions, a misstep that made us realise we had not tried to fully understand the daily realities of our team. We quickly revised our schedule to ensure that no one's essential needs or other commitments were compromised.

11. BE SENSITIVE TO THE IMPACTS OF THE ASYLUM PROCESS

Camp life comes with many external stressors—like poor living conditions, legal uncertainty, and social isolation. One co-researcher was unexpectedly transferred to mainland Greece, while another was forcibly removed from her tent. A third had to suddenly share her accommodation with newcomers. These events placed significant strain on the individual co-researchers as well as the team and reminded us to remain agile and supportive.

12. ACKNOWLEDGE THE IMPORTANCE OF TANGIBLE TOKENS

In our project, we were initially sceptical about the team's request for visibility. However, we soon realised that co-researchers often faced access restrictions, whereas the team members with western passports could move freely in

and out of the camp. We addressed this by providing badges that clearly displayed their research roles, enhancing their authority and helping them navigate the system more effectively. It was a seemingly small but impactful solution that ensured they were respected in their roles.

13. AVOID RELYING ON CO-RESEARCHERS' PERSONAL RESOURCES

Do not expect co-researchers to use their own mobile data or rely on unreliable public WiFi. Initially, we tried to use the camp's WiFi for data entry, but it was slow and often non-functional. After noticing the frustration it caused, we invested in a mobile WiFi device.

14. EMBRACE CONFLICT

Conflict can be a powerful tool for growth. When disagreements arose, we viewed them as opportunities to better understand each other's perspectives. For example, a heated debate around how to approach gender-based violence led to a more thoughtful and respectful methodology. Addressing conflict head-on ultimately strengthened our collaboration.

15. INVEST IN TRAINING BEYOND RESEARCH TASKS

While technical training and skills development (such as data entry, interview techniques, research ethics, etc) are essential for ensuring high-quality research, investing in co-researchers beyond the scope of the project ensures that they benefit beyond the immediate research goals. By offering personal mentoring and CV building, we aimed to invest in individuals so they could not only contribute to the research but also navigate their own professional futures with a (renewed) sense of agency and purpose.

16. REMEMBER MENTAL HEALTH

The emotional toll of this work can be profound, particularly when confronted with accounts of discrimination, traumatic childbirths, drowned children, rape, physical assault, and the constant anxiety surrounding asylum procedures. Prioritising the team's mental well-being is essential to prevent burnout and sustain morale. In our project, we recognized the need for regular mental health support early on, implementing daily debriefs, routine check-ins,

and group therapy sessions to help the team process difficult experiences.

17. CONTINUE TO STAY IN TOUCH

Maintain the connections you have built among your research group and with external stakeholders, and use this as an opportunity to forge new initiatives and projects. In the case of our research project, we held two separate workshops in Athens and Lesbos in 2024 to co-create actionable solutions based on our research findings. Co-researchers who moved on from Lesbos to other parts of the world documented their daily lives and the impact it has on their health through photovoice, which we have exhibited at four conferences so far.

18. HONOUR FOLLOW-UP PLANS

Commit to the solutions you co-create. One of our co-researchers expressed disappointment that the actionable recommendations from our research had not been implemented fast enough. This experience reinforced the importance of staying dedicated to follow-up actions, ensuring that the work does not end when data collection does.

Finally, we advise you (tongue-in-cheek) to disregard the above considerations and encourage you and your team to craft your own set of guidelines. While theoretical training and learning from others are important, PAR thrives on democratic principles and requires forging new paths. To challenge entrenched power structures that marginalise communities, it is essential to experiment with innovative, creative approaches. Be bold — avoid falling back on protocols from the old guard — and remember that PAR was not meant to complement existing ways; it is a tool for disruption.

For more information:

<https://vu.nl/en/about-vu/research-institutes/athena-institute/more-about/venturing-beyond-emergency-care-participatory-action-research-on-the-sexual-and-reproductive-health-of-refugee-women-on-lesbos> (including the preliminary results of our research).



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Impediments to healthcare access for refugees: A case study of Lebanon

Lebanon has long served as a refuge for populations running from persecution in the Middle East, due to its historical role as a sanctuary for displaced persons, and, more recently, as a result of its proximity to regional conflicts that have forcefully displaced huge numbers. As of 2023, Lebanon hosts over 1.5 million Syrian refugees, alongside smaller populations from Palestine, Iraq, and other countries.^[1] Around one in every four people in Lebanon can be described as a refugee. Since the start of the war in Syria in 2011, the influx of refugees has weighed heavily on Lebanon's public resources, despite large-scale support from the international community. In the past years, as a result of political, social, economic, and conflict crises overlapping within its territory, the state's ability to shoulder the burden of a large refugee population has been greatly diminished. This article uses the case of Lebanon as a prism through which to examine the impediments to healthcare access that are typically associated with refugee populations living in countries which are themselves struggling with internal challenges.

HEALTHCARE SYSTEM OVERVIEW IN LEBANON

Lebanon's healthcare system operates on a dual model comprising both public and private sectors. While the private sector is well-developed and caters to a portion of the population, public healthcare services are often underfunded and overburdened.^[2] The influx of refugees has exacerbated these issues, leading to an increase in demand for services that the public system cannot adequately meet.^[3] For refugees, and other marginalised groups, the main access barrier to healthcare is not an issue of availability, but one of cost.



Photo by Kevin Charbel.

ECONOMIC REALITIES & NEGATIVE COPING STRATEGIES

Lebanon has been grappling with a profound financial crisis since 2019, characterised by hyperinflation, currency devaluation, and rising unemployment rates.^[4] This economic downturn has severely restricted the resources available for public health services, forcing the state to exclude refugees from coverage in many respects. Despite significant investment by the international community, mainly through United Nations High Commissioner for Refugees (UNHCR), 77% of refugee households still fall below the poverty line, with needs far exceeding available resources.^[4] Donor fatigue, competing needs (e.g. education, food, shelter), and increasingly hostile political dynamics have widened the gap between available resources and refugee needs.

The result is that refugees often face choices about which basic need to meet. When a family member falls ill, households may resort to negative coping strategies, such as cutting spending on food, heating, or clothing. Those with chronic or terminal illnesses may go without treatment due to other priorities. This is especially common in groups like female-headed households,

where the intersectionality of different vulnerabilities expands the risks associated with a lack of access to basic services, including healthcare.^[5]

LEGAL AND ADMINISTRATIVE BARRIERS

In Lebanon, many refugees lack official documentation, which significantly impedes their ability to seek healthcare services, as their undocumented status means they do not qualify for many forms of national or international support. Even if economics is no barrier, the *refoulement* policy (unilaterally returning refugees to Syria) enforced by the Lebanese state deters many unregistered refugees from pursuing treatment for fear of legal repercussions or deportation. Their caution is warranted, as the lack of a comprehensive legal framework that protects refugees' rights to health care, leaves them vulnerable and uncertain about their entitlements.^[6] Moreover, refugees often face bureaucratic hurdles when accessing healthcare, including lengthy paperwork, inconsistent service availability, and unfamiliarity with the system. These issues cause treatment delays, worsening health conditions and sometimes deterring people from seeking care, creating a cycle of untreated illness.

CONFLICT DYNAMICS

The internal and external conflicts Lebanon is facing have a detrimental impact on the wellbeing of vulnerable populations within its borders. For refugees, this impacts every aspect of their life as they are often disproportionately affected by the prevailing conflicts, exacerbating their already precarious living conditions. That is partly due to limited income generating opportunities and further marginalisation, caused by shifting public policy, often targeting the refugees as scapegoats. In Lebanon, this is characterised by campaigns to further pressure refugees to leave, implemented by adding administrative or economic burdens in order to access basic services.

The socio-economic challenges stemming from conflict dynamics also places immense pressure on host communities, which can lead to tensions between them and refugees. Competition for scarce resources such as jobs and housing often intensifies, contributing to social unrest and discrimination against refugees.^[7] This environment not only hampers refugees' ability to integrate but also perpetuates cycles of poverty and exclusion, increasing the likelihood that they will face challenges accessing healthcare.

PUBLIC HEALTH IMPLICATIONS OF REDUCED ACCESS TO HEALTHCARE

The impediments to healthcare access for refugees in Lebanon not only affect the individual well-being of displaced persons but also have broader public health implications. One of the most pressing public health concerns is the increased risk of communicable diseases. Refugees in Lebanon often live in overcrowded and unsanitary conditions, which can facilitate the transmission of infectious diseases; outbreaks of measles, cholera, and tuberculosis have been reported in refugee communities, posing risks to both refugees and the host population.^[8] Limited access to vaccinations and preventive healthcare exacerbates these risks, creating a potential public health crisis. The management of non-communicable diseases also presents a major challenge in the context of mass forced migration, especially in Middle Eastern countries like Lebanon where the incidence rate is much higher than the global average. The risk

of disruption of supply chain for chronic medication, and the limited continuity of care of chronic patients, caused by the loss of medical history, increases the likelihood of complications. These must be treated at a secondary level of care, generating a disproportionate economic burden on public health finances.

As the refugee population grows, so does the demand for healthcare services, placing additional strain on an already overburdened system. This strain can lead to reduced quality of care, longer wait times, and diminished availability of essential services for both refugees and Lebanese citizens. This reality is also compounded by the wave of emigration of qualified health care professionals, faced by Lebanon in the past years, affecting the healthcare sector particularly strongly.

The mental health implications of reduced healthcare access for refugees are also profound, as many refugees, by nature of their displacement, experience trauma related to conflict and loss, leading to high rates of anxiety, depression, and post-traumatic stress disorder (PTSD). The cost of mental healthcare remains completely out of reach for most refugees in Lebanon, thus excluding the vast majority of people in need of treatment, including for severe disorders, ultimately contributing to social instability and potentially increased healthcare costs in the longer-term.

Première Urgence Internationale (PUI) is a global humanitarian non-governmental organisation (NGO), with a focus on attempting to address the systemic and humanitarian issues in Lebanon's healthcare environment. PUI is one of the largest actors, working through around 30 healthcare clinics and 11 hospitals to ensure basic access to primary and secondary services, amounting to about 330,000 consultations per year, as well as now engaging in more direct interventions with regard to the emerging large scale conflict in the country.

CONCLUSION

Outside of a wider geo-political solution to forced migration in the region, effectively addressing the barriers to healthcare access for refugees in Lebanon requires a multi-faceted policy approach that

engages multiple stakeholders, including host communities, the Lebanese government and the international community. Strengthening healthcare infrastructure through increased investment in systemic improvements and resilience to crisis will inoculate both refugees and host communities from the perils of a lack of affordable, quality, healthcare. Streamlining legal processes and providing support can help refugees navigate the healthcare system more effectively. Public health campaigns should raise awareness about available services, while collaboration with NGOs can provide critical resources, especially in mental health. Importantly, investing in the political stability of Lebanon is crucial for creating a conducive environment for existing healthcare barriers to be broken down.



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‘When there is no regular care, people come when it’s too late’

An interview with Xander Meijs, dentist

Oral health is one of the many areas of health where certain population groups are unequally and unfairly at risk. Asylum seekers, refugees, migrant workers from Eastern Europe, undocumented people, and Dutch citizens with lower socio-economic status are, once again, the ones most at risk, both physically and financially.

Xander Meijs, dentist in a group clinic in Twente, is often confronted with the poor outcomes of oral health that certain people within the Netherlands endure. Besides his work in the clinic in Twente, he regularly participates in oral health care activities organised by the NGO Doctors of the World.^[1] “For me the reason to become involved in oral care for marginalised groups was the realisation that refugees who were placed in our municipality often had difficulty finding the proper routes for getting adequate oral health care. I became involved in volunteering for Doctors of the World in 2019, when the organisation launched a petition demanding inclusion of oral health care in basic health insurance.”^[2] Meijs now participates six times a year in the ‘Mondzorgkaravaan’, loosely translated the ‘Oral Care Convoy’, which consists of two mobile clinics: a fully instrumented dentist clinic and a prevention clinic.^[3] The mobile clinics tour the Netherlands and provide free oral health care and instructions to anybody who comes to the clinic. Besides his work with Doctors of the World, Meijs has several methods to integrate oral care for these groups in his own clinic.

ORAL CARE IN THE NETHERLANDS

“It is a weird phenomenon that oral health care in the Netherlands is not covered by basic health insurance,” says Meijs. Patients above 18 years old need additional insurance to be reimbursed for oral care and almost all (preventive) treatments, and then still for only part of the

costs.^[4] Meijs: “The costs of oral treatments and procedures and the costs of additional insurance have increased over the years, but the reimbursement that additional insurance offers has not kept pace.” Children until 17 years of age receive free oral health care, but orthodontist care is excluded from this. Refugees, i.e. people who have been granted asylum, are in the same category as Dutch citizens in that they are obliged to have health insurance and therefore the same reimbursement (or



rather lack thereof) regulations apply to them. Asylum seekers only have access to limited acute dental care with a maximum cost of 350 euros per year.^[5] Theoretically, migrant workers have their own health insurance from their country of origin.

VULNERABLE GROUPS

Meijs again: “Refugees and asylum seekers are often not used to the Dutch system of oral care. Regular check-ups every half year is something that many refugees or asylum seekers have never had access to in their lives. Also basic oral hygiene practices such as regular tooth brushing were often not part of their daily routine. This is the reason why these

groups have more complications, needing expensive treatment. “Untreated cavities, sometimes up to the gums, is what I mostly see. Sometimes the tooth cannot be saved and needs to be removed to prevent further infection. Sometimes an expensive root canal treatment is necessary. Prevention would have been much more cost-effective, as the oral health problems presented by them require more expensive treatment.” In addition to high costs, access to Dutch oral healthcare is often hindered by language barriers which, for example, make getting an appointment and getting there at the right place and time more difficult.

Meijs points out another vulnerable group he often encounters: young adults recently turned 18 who often have received extensive support and guidance through youth care, and now have to organise everything themselves. Around this age, wisdom teeth often start being a problem, and these young adults are all of a sudden faced with high dental costs in addition to their deductible when they go to the dental surgeon. “This might be an added reason why some of them are pushed towards debt at a young age.”

Homeless people and undocumented people “who sometimes have been in the Netherlands for years already,” are other groups Meijs often encounters with less access to adequate oral care and therefore more complications. Also seasonal migrant workers, the people who pick our vegetables for low wages, are at risk: “Nothing is organised for them. One of my assistants has a family member who has some migrant workers from Romania working for him. Every year some of them come with acute dental problems. I just do the treatment for free then.”

INITIATIVES FOR IMPROVING ACCESS

“A buddy system, in which a refugee or asylum seeker is taken along by someone else to an oral health care appointment, is



a possible solution to increase their access to adequate oral care.” This ‘someone else’ might be a former asylum seeker. “In this way they can be guided through making appointments and dealing with invoices, and can become used to the Dutch system of planning ahead for regular check-ups.”

Meijs also participates in the “Compassie Netwerk”, an initiative by Doctors of the World in which participating oral health clinics provide minimally 10 treatments per year free of charge to people who have trouble paying the costs.^[6] “Unfortunately, dentists’ involvement in the care for these groups is low in the Netherlands. Interestingly, Dutch dentists who themselves have a multicultural background are more often involved.” Unfortunately, the aforementioned petition has not yet brought about any significant political change, while it has already been signed more than 300,000 times. Meijs sees an important role for the Dutch patient foundation, the ‘Nederlandse Patiënten Consumenten Federatie’ (NPCF). “They should be standing up for adequate access to quality oral care.”

TOWARDS EQUITABLE ORAL CARE FOR ALL

People new to the Netherlands, be they asylum seekers, refugees, migrant workers, or undocumented people, often deal with worse oral health conditions resulting in higher costs. The current system of limited reimbursement increases the already existing health inequities within a high-income country such as the Netherlands. Oral care should be included in basic health insurance, and should be accessible to all people in the Netherlands, regardless of legal status.



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Counting every life: the role of data invisibility in migration-related health inequities

In 2023, official statistics reported 164,487 live births in the Netherlands.^[1] However, these figures exclude children whose parents are not listed in the Dutch Personal Records Database (BRP), such as undocumented migrants and recent asylum seekers. Without registration in the BRP, these individuals lack not only a social security number (BSN) and the associated access to essential services in the Netherlands, but also the fundamental right to be counted. This phenomenon, known as data invisibility, both conceals and perpetuates migration-related health inequities worldwide and in the Netherlands.^[2,3]

UNCOUNTED BIRTHS

Data invisibility arises when marginalised migrant populations remain unaccounted for in research, public health monitoring, or national health and population statistics. This often affects those with a precarious legal status who may avoid healthcare, face restricted access, or whose health data are not retraceable. In the previous example of the Netherlands, asylum seekers are generally added to the BRP and receive a BSN after six months of residence (although this process has faced major delays in recent years), while undocumented individuals, such as asylum seekers whose applications have been rejected, are excluded from the BRP entirely.^[4] When these unregistered parents have children, their newborns may receive a birth certificate from the municipality, but their births are not formally registered by Statistics Netherlands (CBS), which only counts official residents. Consequently, these children are omitted from official Dutch birth statistics, leaving their existence bureaucratically invisible.

UNCOUNTED LIVES, UNCOUNTED DEATHS

Recent research demonstrates that data invisibility obscures not only the lives, but also the deaths of affected migrant

populations. In a nationwide registry study, we aimed to examine perinatal mortality and other adverse pregnancy outcomes in asylum seekers and refugees with a residence permit (“forced migrants”) in the Netherlands.^[5] Previous studies had revealed alarming findings, with one Dutch study reporting mortality rates up to seven times higher among asylum seekers at the Ter Apel reception centre compared to the general population.^[6] In our registry-based study, we linked data from a migration database managed by CBS to the Dutch perinatal registry (Perined), creating a cohort of more than 16,000 births among forced migrants between 2014 and 2019.^[7]

Our study confirmed elevated risks of adverse pregnancy outcomes, including perinatal mortality, among forced migrants compared to Dutch women without a migration background (relative risk 1.50 [95 % CI 1.20–1.88]). However, as women without a BSN -those who recently arrived or were undocumented - could not be included for data linkage, their births were excluded from our study. As this subpopulation may be at the highest risk of adverse outcomes, this manifestation of data invisibility may explain why the differences found in our study were less extreme than those reported in Ter Apel.^[2]

While data invisibility obscures, it also exacerbates the inequities that affect marginalised migrant populations, since alarming trends and urgent health needs are not reflected in research that can inform policy and resource allocation.^[3] This issue was tragically illustrated by a maternal death that was reported to the authors only after the study had concluded that no maternal mortality had been registered in the study period. The case involved an asylum-seeking woman who had arrived late in her pregnancy and died before receiving a BSN.

RECOMMENDATIONS

The process of forced migration often inherently disrupts access to healthcare

and the corresponding data collection. As highlighted by recent research, migration-related data across Europe is often fragmented, incomplete, and of poor quality, despite the available knowledge and technology to address this issue. Political factors at local, national, and European levels continue to hinder the systematic collection of migration-related health data.^[3,8] However, to prevent data invisibility once people arrive in the Netherlands, a number of changes are possible and necessary, including:

1. Every child born in the Netherlands must be counted in official statistics.
2. Asylum seekers and undocumented migrants should be registered in the BRP and receive a BSN urgently, or an alternative identification number usable for data linkage must be expedited, especially for populations in potentially vulnerable health situations, like pregnant women.
3. To disaggregate health data based on migration status, health information systems in hospitals, and databases such as the Dutch national perinatal registry (Perined) need to incorporate migration indicators such as country of birth, length of residence and legal status. Recent recommendations in the Lancet Regional Health also highlight the necessity and ethical use of such indicators to capture and monitor the health needs of different migrant groups.^[3]
4. Health data from actors involved in the migration sector, such as Gezondheidszorg Asielzoekers (GZA) in the Dutch asylum reception centres and non-governmental organisations such as Doctors of the World, should be as accessible as possible for research and monitoring purposes. The Ministry of Health needs to ensure that the quality of healthcare, data registration, and access are managed

with the same standards and transparency applied across the broader Dutch healthcare system.

CONCLUSION

Addressing data invisibility is vital to reducing health inequities among migrant populations in the Netherlands. Failure to include undocumented and recent asylum-seeking populations in national health registries leaves the most disadvantaged groups unaccounted for, thereby perpetuating their marginalisation and obscuring the true extent of health inequities. To remedy this, equitable registration and the ethical use and integration of health and migration data are needed to create a more complete and accurate picture of the health needs of underserved populations. This strategy would also align with the mission of the Dutch Ministry of Health's "Solid Start" (Kansrijke Start) programme to facilitate the best possible start of life for every child born in the Netherlands. Ultimately, achieving health equity depends on the right to be counted.



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Sevenfold perinatal mortality risk for asylum seekers in Ter Apel

Interview with Dr. Anouk Verschuuren

“We expected there would be a difference, but none of us expected the difference to be this big,” says Anouk Verschuuren when talking about the results of her PhD on *Maternity care for refugees and asylum seekers in the Netherlands*.^[1] Verschuuren is a medical doctor, currently working in dermatology and former researcher at the University of Groningen. Over the last years, Verschuuren and her team conducted several studies concerning pregnant asylum seekers, including those in the large asylum seeking centre in Ter Apel in the north of the Netherlands. These studies were initiated following an appeal for help from local midwives who felt that, despite their enormous efforts, this specific group of pregnant women was still not receiving adequate care. Looking for a solution, it was decided that it was important to first assess the extent of the problem. “Once it was clear that the pregnancy risks for asylum seeking women were so much higher than expected, our research team started thinking about the possible causes and, subsequently, what could be done about it,” says Verschuuren.

PERINATAL RISKS AND THEIR CAUSES

Verschuuren and her team collected data from all births of asylum seeking women between 2012 and 2016, utilizing records from both the midwifery practice and the hospital providing care to the asylum seekers’ centre in Ter Apel.^[2] This included a total of 344 asylum seeking women, who were compared to a group of 2323 Dutch women from the same region in the north-east of Groningen. The most shocking result was the ominously higher risk of perinatal mortality in the asylum seeking group compared to the local Dutch population (3.2 versus 0.6%). After



Dr. Anouk Verschuuren

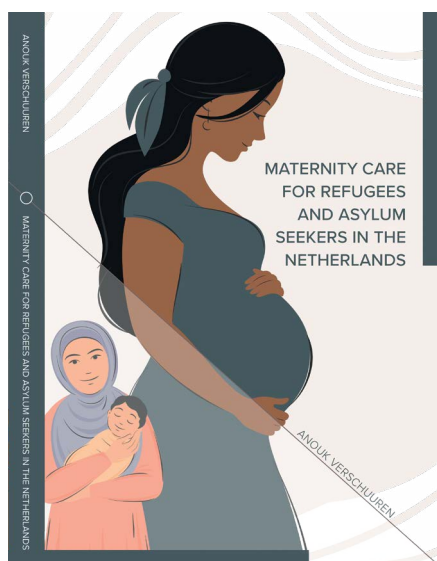
adjusting for birth weight, gestational age, and parity, the relative risk of a perinatal death was 7.21 times higher for asylum seeking women. Also, female asylum seekers often had lower birth weights, longer postpartum hospital stays, and higher rates of opioid use. Drawing conclusions about the lower birth weight is challenging, as this was assessed using Dutch standards of average birth weight which may be less applicable to other ethnicities. However, the increased risk of perinatal mortality was shockingly evident.

This increased risk of perinatal mortality among asylum seekers did not have a single, identifiable cause, but rather a combination of factors. The most significant factors consistently identified were language barriers, the lack of knowledge of the Dutch healthcare system, frequent relocations to other asylum seeking centres, and delay in seeking care. Additionally, the handover of information and teamwork between different healthcare providers was not always seamless. “It is important to note that the latter is not solely a healthcare issue but is also influenced by political decisions, such as the design of the asylum procedure,” according to Verschuuren. These and other suboptimal factors that influenced health seeking behaviour, access to care, and the quality of care were identified by looking at different real-life cases from

perinatal audits.^[3] During this part of the study, sorrowful and often preventable situations came to light. “One of the women who lost her child was already experiencing loss of green fluid and decreased foetal movements at the beginning of the weekend. Uncertain about who to contact and whether she was allowed to call during the weekend, she reported to the midwife’s office on Monday. A severe infection was discovered, and sadly the baby had already passed away.”

INTERPRETATION AND (POLITICAL) CHALLENGES

According to Verschuuren, interpreting the results was particularly challenging. “The asylum seeker population in Ter Apel is incredibly diverse. Within the population there are significant differences in education level, language proficiency, and health literacy. This makes it difficult to draw general conclusions about all asylum seekers.” In addition to the differences within the asylum seeking population in this particular centre, comparing these studies to data of other countries is challenging. Even within Western Europe, there are significant differences in the refugee population. This makes cross-national comparisons difficult. For instance, the Netherlands receives a relatively large number of Syrian refugees (13,030 in 2023), compared to a significantly smaller number in France (2,690 refugees).^[4] Furthermore, there are differences between how countries politically manage asylum seekers and how their procedures work. But according to Verschuuren, comparing with other countries is not the only challenge. “Because our pregnancy outcome study was conducted in Ter Apel, it is questionable how representative our own study groups were. For example, due to the location of the study the Dutch control group probably included a relatively large proportion of women with a lower socioeconomic status. This raises questions about how comparable this group is to the rest of the



Front cover PhD thesis Anouk Verschuuren.

Dutch population. Theoretically, it could therefore be the case that the differences between the pregnancy outcomes of asylum seekers and the Dutch population are even greater,” explains Verschuuren.

On the other hand, the group of asylum seekers in Ter Apel is also a complex group, with potentially a higher risk than other asylum seekers in the Netherlands. Ter Apel is a unique asylum seekers’ centre because it serves as a registration centre for the asylum procedure. This means that the people who report here have only been in the Netherlands for a short time, sometimes only a few days. Because of their journey women might not have received medical care for an extended period of time. The purpose of this centre is to transfer asylum seekers within 3 to 10 days to other asylum seekers centres for a longer-term stay. These more permanent centres often have a doctor on site and access to healthcare is better organised. However, in practice, the scarcity of these more permanent asylum places often necessitates the use of temporary accommodations.^[5] This results in frequent relocation of large groups of vulnerable people, with limited knowledge of the Dutch healthcare system.

To advocate change, a shift in mindset is essential, argues Verschuuren. “The way our society looks at migrants needs to change if we truly want to achieve something. Migrants are often eager to work hard and become part of our society. So, if

we were to give them those opportunities, migration could be a win-win in which both migrants and society benefit greatly.”

However, with the current political climate and the Dutch government’s move to declare an ‘asylum crisis’ and attempts to bypass European asylum rules, it seems unlikely that this situation will improve soon.^[6] Nevertheless, Verschuuren remains hopeful: “The current political climate is challenging, but it gives me hope to see how much attention our research has received. I am not alone in wanting change, and that’s encouraging.”

PRACTICAL TIPS

Healthcare providers can also implement smaller-scale changes themselves, like familiarising themselves with culturally sensitive care. One of Verschuuren’s most practical tips is to make use of an interpreter service. This may seem obvious, but in practice it happens less often than recommended.^[3] Verschuuren: “I work in healthcare myself; I know it can be difficult due to time pressure, but it’s been proven that a child or a partner as translator is not a good option as an interpreter. We know that too much information is lost in that case.” Verschuuren also emphasises the importance of paying attention to the mental health issues refugees and asylum seekers often are dealing with. “It is important to realise that many women have had a difficult time and often still experience a great deal of stress related to the asylum process. For many women, this makes pregnancy a low priority.”

Given the alarming results from Ter Apel, a collaborating research group in Rotterdam decided to repeat the analysis but with the inclusion of national data in the EGALITE project.^[7] This project included newly registered asylum-seekers as well as women who were granted official refugee status during the time of the study. The perinatal mortality rate in this study was still higher compared to Dutch women without a migration background (1.4 times the Dutch rate). However, the difference was much less pronounced than in the study by Verschuuren *et al.* What is important to note is that women without a social security number at the time of delivery and who did not receive a legal refugee status afterwards were not included in the national data and therefore not included in the outcomes of the EGALITE project. Given that 31-75% of asylum applications were rejected over the last five years, a significant proportion of these women may not be included in the national database.^[8] This problem is also known as ‘data invisibility’. Julia Tankink, researcher on the EGALITE project, describes this problem in more detail in the article on page 14-15.

The numbers speak for themselves: the perinatal mortality rate among asylum-seeking women in Ter Apel is unacceptably high. There are several underlying causes resulting in less access to adequate care for these women. Addressing this problem necessitates a twofold approach: smallscale changes and a fundamental shift in policy.



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Bridging the gap: The role of Search and Rescue organisations in medical care and dignity for those rescued at sea

The Central Mediterranean has become the focal point of a prolonged migration crisis, where thousands risk everything on the deadliest migration route in the world in search of safety in Europe. Many depart from Libya and Tunisia, facing the grim reality of overcrowded, unseaworthy vessels as they traverse hundreds of miles across the sea. This perilous journey often endangers lives, especially as European state-sponsored rescue efforts have diminished and funding has shifted to Libyan and Tunisian coastguards, leading to more dangerous push-backs. As a result, civil Search and Rescue (SAR) operations have become even more essential for providing immediate, lifesaving assistance; over 14,000 people were rescued by SAR non-governmental organisations (NGOs) in 2023 alone.^[1] Leading these efforts is SOS Méditerranée, founded in 2015, which operates the Ocean Viking—a vessel dedicated to saving lives in life-threatening situations at sea.^[2]

In 2023, the migration crisis saw 157,651 migrants to Italy comprising 62 different nationalities, predominantly from Guinea, Tunisia, and Côte d'Ivoire. Among those rescued, 72% were male, 12% were unaccompanied children, 10% were women, and 5% were accompanied children.^[3] Each demographic group faces distinct vulnerabilities in addition to the widespread physical and sexual violence experienced along the migration pathway; unaccompanied minors are particularly at risk of exploitation, women often encounter gender-based violence, and accompanied children endure the trauma of potential family separation. Men, too, face significant challenges, including exploitation, mental health issues stemming from trauma and isolation, and increased



Treating a leg wound. Picture by Tara Lambourne.

risks of violence and legal uncertainties during their migration journey.^[4-6]

HEALTH NEEDS

The physical health needs of these individuals are often diverse and can be urgent. Common conditions include dehydration, hypothermia, heat-related illnesses, seasickness, and skin infections. Many also suffer from untreated chronic diseases such as diabetes and hypertension, complicating their care. Acute injuries—from trauma and burns to violence-inflicted wounds—underscore the harsh realities of their journeys. In 2023 alone, the Ocean Viking conducted over 1,250 individual medical consultations, with 276 survivors referred for further medical care on land.^[7]

Many individuals arrive with unmet healthcare needs due to a lack of access during their journeys. Women commonly present with gynaecological issues related to sexual violence or exacerbated untreated conditions, and maternal healthcare is provided onboard due to the frequent inaccessibility of care along migration pathways and in countries of origin. Pregnant women often face

emergencies onboard due to minimal antenatal care before embarkation as well as the extra stressors added to an already delicate physiological balance. Children require basic healthcare and can show signs of emotional distress but often thrive when cared for by compassionate individuals. Child well-being checks are vital for infants born along migratory pathways, as they are particularly vulnerable to health complications due to denial of access to necessary care.

Primary health needs are prevalent across all demographics, including untreated skin conditions that have escalated in the harsh realities of detention centres and generalised body pain resulting from the physical toll of their journeys. Each encounter reaffirms the importance of providing not only medical care but also the kindness and empathy that aim to restore dignity and hope—qualities often stripped away from those rescued at sea.

One case highlights the critical and varied nature of our work: a young man requested help from the rescue team, initially reluctant to draw attention to

himself during the ongoing rescue. While he originally appeared to have burns from fuel exposure, further assessments revealed a much graver situation: he had escaped captivity in Libya by jumping from an upper-floor window, resulting in a fractured spine and severe burns after landing in a fire. While this case is extreme, it reflects a broader reality. Typically, individuals present with an array of minor conditions that have worsened due to prolonged neglect, but medical teams must be prepared to respond to extreme physical and psychological injuries stemming from the cruelty inflicted by other humans or from desperate attempts to flee such violence. A key role in these moments, in addition to providing essential medical care, is to rebuild trust not only in medical professionals but also in strangers, reassuring those rescued that compassion still exists, especially after significant trauma. Recovery involves addressing the immediate physical health needs while also providing psychological first aid, a vital aspect of humanitarian efforts. Survivors additionally often draw strength and support from one another, forming bonds of solidarity that help them navigate their shared experiences.

MEDICAL RESOURCES

Medical resources on SAR vessels are essential for effective operations. While each ship has a unique team structure, the Ocean Viking is staffed by four medics: a medical doctor, a nurse, a midwife, and a medical team leader, whose clinical profile can be any of the previous three. The rescue ship is equipped with medications for both emergency and primary healthcare, along with resuscitation and stabilisation supplies, allowing them to serve as ‘ambulances of the sea’. As operations have evolved, provisions have been incorporated for longer-term medical treatment, particularly for chronic conditions exacerbated by delays in safe port assignments or extended transits.

Medical professionals play a crucial role not only in managing the influx of patients in this resource-limited environment through care provision, but also in the training of the wider crew to assist them when needed. All crew members receive training in basic life support and emergency protocols, which are vital



Examining a patient. Picture by Johanna de Tessieres.

when faced with overwhelming needs such as happened in March 2024, when a boat was encountered carrying individuals who had been at sea for over seven days. Many had already lost their lives, while the remaining survivors arrived in critical condition, with an extreme combination of exhaustion, dehydration, and hypothermia, necessitating a ship-wide mass casualty response.

Upon rescue, standard operating procedures are implemented for assessing and triaging survivors. Initial evaluations determine whether individuals can walk and talk, and if there are any obvious emergent medical conditions.

In exceptional mass casualty scenarios, a modified triage scale is employed to ensure that those in greatest need receive prompt care.^[8,9] Infection control is also particularly important, given the heightened risk of disease in the overcrowded and unsanitary conditions many have been exposed to before being rescued.

Following rescues, medical teams begin to address the numerous health conditions present in survivors through a combination of in-depth clinical consultations and health promotion, along with expedited assessments conducted on deck. Logistically, providing care in a confined, moving environment presents



Picture by Jérémie Lusseau.



The Ocean Viking. Picture by Claire Juchat.

significant challenges. Factors such as exposure to the elements, seasickness, and limited resources can exacerbate the vulnerabilities of those rescued. Advanced medical care is often constrained, and evacuation protocols for serious cases depend on national vessels or helicopters, heavily influenced by weather conditions and proximity to land, complicating timely assistance. Each operation highlights the critical need for adaptability as teams strive to meet the diverse health needs of those rescued.

DISCUSSION

Since 2014, over 30,396 people have tragically died while attempting to cross the Central Mediterranean—a number likely to be a grave underestimation due to significant gaps in data regarding departures.^[10] This ongoing crisis is compounded by escalating violence against people seeking safety within North Africa and Europe, where individuals are increasingly viewed not as humans but as mere ‘numbers’ or ‘problems’.^[11] Such dehumanisation undermines the fundamental rights of people on the move, who often face horrific conditions and treatment throughout their journeys. The humanitarian work of organisations like SOS Méditerranée and others operating in the Central Mediterranean goes beyond their legal obligation under international maritime law to save lives at sea and the fundamental human right to access healthcare. It seeks to restore

dignity and recognise the humanity of those we serve whilst attempting to fill the critical gap in protection and assistance within the region.^[11]

Each rescue mission emphasises the urgent need for a collective global response to ensure the well-being of the most vulnerable populations. SAR operations play a crucial role, focused primarily on saving lives, irrespective of an individual’s reasons for migrating. The medical and psychological needs of survivors are urgent and multifaceted, ranging from acute injuries and untreated chronic diseases to mental health challenges exacerbated by trauma and social isolation. Many survivors need to utilise an established mechanism for continuity of care via referral through Uffici di Sanità Marittima Aerea e di Frontiera (USMAF) when reaching land due to increased risk of morbidities.^[5,12]

SAFEGUARDING THE RIGHTS OF ALL INDIVIDUALS

The work on SAR vessels, staffed by dedicated healthcare and rescue professionals, is vital in addressing these varied health needs and fulfils a devastating gap left in the Central Mediterranean. These missions reinforce the importance of adaptability and resilience in the face of complex challenges. Each encounter with a survivor reveals their stories of resilience and strength, deepening our commitment to delivering effective

healthcare amidst the chaos of migration and conflict. Ultimately, these experiences highlight the critical role we play in the lives of those seeking refuge and inspire a broader call for humanity to unite in safeguarding the rights, well-being, and access to care of all individuals, regardless of their circumstances.



Rebecca Marcussen-Lewis, Medical Team Leader and Midwife, SOS Méditerranée.

Dominika Wanczyk, Head of Post Rescue, SOS Méditerranée.

<https://www.sosmediterranee.org/contact-us/>

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Care for children of migrant workers

Interview with Elza Zijlstra - youth health care physician in training

Elza's path to youth health care is rooted in service to vulnerable populations. She began her studies in international development at Wageningen University before continuing her education at medical school in Nijmegen. Her work experience in adult psychiatry eventually led her to work at the Centre for Sexual Violence in Gelderland Zuid-Midden and currently at GGD Limburg Noord as youth health care physician in training, where she works closely with migrant families.

Her involvement with migrant workers began during the COVID-19 pandemic. The pandemic shone a light on the vulnerabilities of migrant workers in the Netherlands, particularly those working in the meat processing and agriculture sectors. Elza also highlights the poor living and travel conditions many face every day, compounded by challenges in accessing healthcare due to incorrect registration details. "We saw homeless camps along the Maas River", she recalls, stressing the severe conditions faced by many. Following this, Zijlstra questioned the conditions in which children of migrant workers were being raised.

CHALLENGES FACING MIGRANT CHILDREN

In the Netherlands, approximately 800,000 migrant workers are officially registered in the Personal Records Database, though the actual number of migrant workers is likely higher. Of these, 92,000 children are registered, with some municipalities in Limburg Noord, with Venlo and Venray ranking highest in the country in terms of concentration.^[1] "At our centre, we sometimes see an average of two migrant children per consultation day", Elza notes.

While many children appear to be doing well at initial consultations, some significant challenges remain. In Venlo, for instance, Elza sees many single mothers struggling to balance work with child-care responsibilities. "They have trouble negotiating their work conditions and, as a result, don't get the time to take their children to and from school", she explains. "We do see that the Polish community is becoming more organised, but Bulgarian migrants remain a particularly vulnerable group", says Elza. The 2022 report by the "Aanjaagteam Roemer", a task force for the protection of migrant workers, highlighted the issue of rogue employment agencies, and called for stricter oversight. These agencies often recruit Bulgarian, Polish or Hungarian

workers, mainly exploiting them by providing sub-standard working and living conditions. This adds to the precarious nature of their lives in the Netherlands.

Language barriers are another major hurdle for accessing services, with few migrant parents speaking Dutch, leaving them with limited social support. For help, some families have to rely on relatives, such as grandmothers from Poland, but social isolation remains a widespread issue. "What we noticed is that migrant families are hesitant to engage with local services such as the GGD or municipal organisations." Elza attributes this to a lack of trust. "In countries like Poland, there are no equivalents to the GGD, and public services are often associated with



out-of-home placements of children.” As a result, many migrant families shy away from seeking help. Additionally, despite access to early childhood education, language issues are common amongst children due to these circumstances.

The socio-economic background of these families also leads to other health concerns. Obesity is prevalent, not only among migrant children but also in other disadvantaged groups. Reports are frequently made to Veilig Thuis (a Dutch domestic violence hotline) and youth welfare services, and cases of domestic violence and contentious divorces among parents add to the strain. “However, there are also some families that provide excellent examples for their children”, Elza emphasises. It also depends on whether families move to the Netherlands mainly to do seasonal work or whether they move to raise their family here. But many, particularly those from socio-economically disadvantaged backgrounds, face heightened stress and poor housing conditions, contributing to developmental and behavioural issues in young children. Schools have reported delays in potty training and language development, especially in Bulgarian children, since they do not have to attend school till the age of 7 in Bulgaria.

THE ROLE OF YOUTH HEALTH CARE

Once registered, children aged 0-4 are referred to the GGD for a home visit within a few weeks. For school-aged children (4-18), attending school, the GGD conducts regular screenings. However, migrant children often fall through the cracks due to their frequent travel to their home countries, also for doctor visits, making it difficult for health services to maintain consistent care. “We don’t know what we’re missing”, Elza admits, pointing out that many children disappear from the system altogether. In Utrecht, for example, a significant group of Bulgarian children were not registered and did not attend school, leaving teenage girls particularly vulnerable, since they do not receive any sexual education, making them at risk for teenage pregnancies.^[2]

In Limburg-Noord, Elza and her colleagues are establishing a care working group to target migrants, refugees, and

low-literate populations. Simultaneously, they are creating a network of “key figures” who can bridge language barriers and establish trust within these groups. These key figures, such as those from organisations like Pharos, have proven invaluable for the care of migrant groups in regions like Utrecht.^[2]

RECOMMENDATIONS FOR THE FUTURE

Elza stresses the importance of staying connected with schools to ensure migrant children remain visible in the system. Establishing national data on “invisible” children and improving communication with municipalities to flag concerns are essential steps forward.

Moreover, the recommendations from the Roemer report on improving working conditions should be implemented, as better circumstances for parents directly benefit their children.

The establishment of a national working group on care for migrant workers, consisting of members of the Community Medicine organisation (KAMG), the Dutch organisation for Insurance Medicine (NVVG), and the Dutch Society for Occupational Safety and Health (NVAB) has already begun to yield results, with the goal of developing a multidisciplinary guide for healthcare providers, including occupational health physicians. Elza believes that more outreach and communication being available in multiple languages are key to being accessible to migrant families. “We can also learn from the way migrant families raise their children”, she adds, emphasising the need for mutual understanding.

As Elza continues her work, she remains inspired by figures like Steven van der Vijver from the HealthMove organisation, which provides a platform containing the medical information of people on the move. She also advocates for healthcare professionals to speak up about the issues they witness. “We could embrace a more activist role, since doctors are the eyes and ears of the society”, she suggests, aiming for a future where the health and welfare of migrant families are better protected.



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Dementia among older people with a migration background

The importance of tailor-made interventions to support family caregivers

The proportion of the population aged 65 and older worldwide has never been so high and is expected to double over the next three decades.^[1] At the same time, the number of older people living outside their country of origin is growing. Against this background, the prevalence of dementia is projected to increase from about 50 million cases in 2018 to 152 million by 2050.^[2] This increase is expected to be even sharper in certain ethnic and migrant communities due to the higher prevalence of comorbidities such as diabetes and hypertension as well as the influence of social determinants of health. These unprecedented demographic changes require structural adjustments within health systems to develop and implement inclusive strategies to promote health among ageing and increasingly diverse populations. All of this is taking place in societies with waves of anti-migration rhetoric in which the complexity of migration narratives is reduced to a security issue and in which diversity is considered a threat to society.

DEMENTIA EDUCATION PROGRAMMES

Dementia is an umbrella term that refers to a number of cognitive disorders, characterised by a wide variety of symptoms. Symptoms can include memory and language problems and difficulty with planning and executing tasks as well as problems with orientation and behavioural changes. The progression and intensity of the symptoms vary, affecting the daily life of those diagnosed to different extents. It impacts not only the life of the patients but the entire support system around them. As health professionals, we

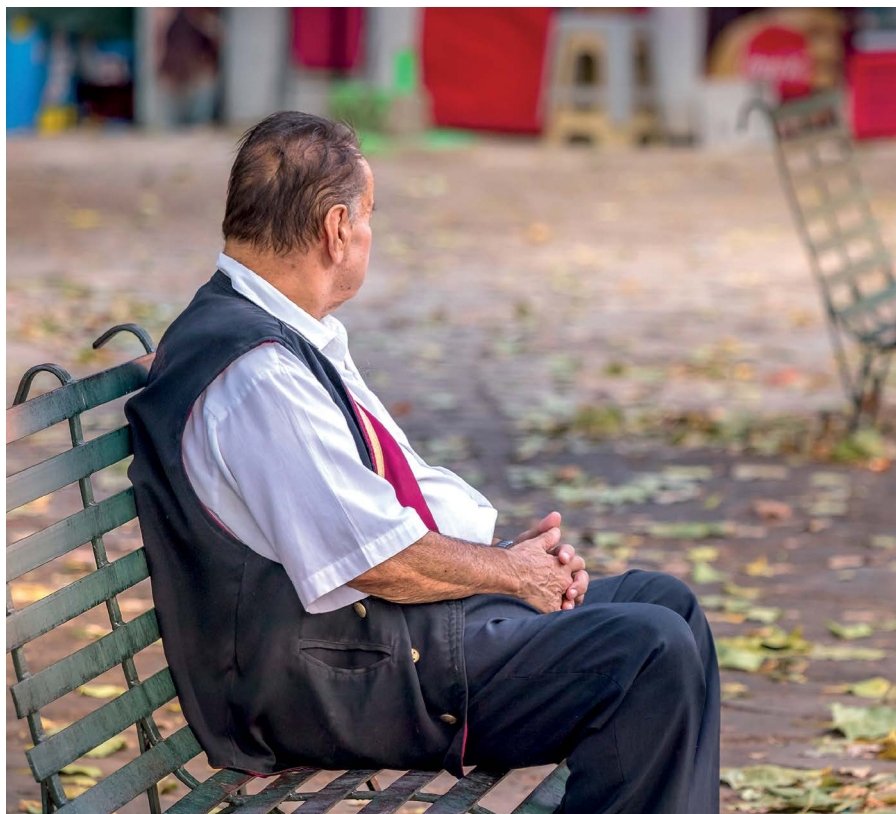


Photo Ruben M. Ramos, Shutterstock

are familiar with this description. Ideally, every individual should be equipped with the knowledge to recognise potential signs of dementia and seek timely medical attention: dementia knowledge helps prevent delays in diagnosis and empowers caregivers to manage their daily responsibilities more effectively.^[3]

Over the past decades, researchers and practitioners have developed numerous dementia education programmes. Yet, these are usually tailored for the wider population and may not reach minority groups nor address their specific needs adequately.

Studies conducted within migrant communities, mainly in high-income countries, reveal that older people with a migration background are diagnosed with

dementia later than their native peers and at a more advanced stage of the disease, suggesting the need for targeted interventions within these communities, where informal caregivers frequently bear primary responsibility for managing care.^[4,5]

BARRIERS TO CARE AND DELAY IN DIAGNOSIS

The concept of “older migrants” is a simplification, referring to a highly diverse group encompassing many ethnicities, languages, and cultural beliefs. Nonetheless, despite differences, there are common challenges that affect access to care for those ageing outside their countries of origin, including communication, financial, and systemic barriers.^[6]

Communication barriers arise not only from language differences but also from

different health beliefs, which influence symptom interpretation and help-seeking behaviours. For instance, dementia symptoms may be interpreted as a normal part of ageing, delaying diagnosis and exposing family caregivers to a higher risk of burnout. Furthermore, health literacy - which includes the ability to navigate health systems and understand medical information - is often lower among older migrants as they are more likely to have received fewer years of formal education compared to native-born populations.^[7]

Regarding financial barriers, older migrants are at greater risk of financial hardship due, for example, to obstacles in accessing pension systems, which can in turn limit access to social and health services.^[8]

Additional barriers are “built-in” within health systems that fail to develop and promote culturally sensitive strategies, ranging from culturally validated screening tools and access to interpreters to spiritual and religious support, as well as tailored educational resources for both patients and their caregivers.^[9-11]

PROMOTING DEMENTIA KNOWLEDGE WITHIN MIGRANT COMMUNITIES

The literature describes various interventions to promote dementia knowledge among informal caregivers of individuals with dementia from migrant backgrounds. These include in-person educational programmes led by experts, peer-support sessions, and websites providing information in multiple languages.

For example, Van Wezel et al. describe a peer-support group intervention for Turkish and Moroccan caregivers living in the Netherlands held at local mosques and community centres.^[12] The authors found that the educational sessions significantly improved participants’ knowledge of dementia ($p < 0.001$) and were associated with a higher acceptance of support from home-care staff ($p < 0.05$). Morano and Bravo reported that a 20-hour, face-to-face support programme conducted over five consecutive days among Spanish speaking communities in the US, enhanced caregivers’ knowledge and ability to manage dementia-related challenges ($p < 0.05$).^[13] This intervention provided

both theoretical knowledge and practical guidance on personal care techniques and strategies for managing behavioural and psychological symptoms. The authors emphasised the programme’s focus on the needs of culturally diverse caregivers and their provision of free respite care and transportation to participants to enhance participation. Additionally, several online platforms offer culturally tailored educational resources, often co-produced through interviews and focus groups with informal caregivers from minority communities.^[14, 15]

RECOMMENDATIONS FROM THE LITERATURE

A look at the literature teaches us that culturally tailored interventions are generally effective in improving dementia knowledge and caregiving practices. In turn, dementia knowledge encourages caregivers to seek formal support from home care staff. This increased acceptance of external help contributes to reducing the risk of caregiver burnout.

Factors contributing to the success of interventions are co-creation and engagement of community leaders. The feeling of social isolation is often described by informal caregivers, and peer support, when available, is effective in reducing this, providing emotional relief.

However, the literature also shows that important barriers persist. Misconceptions and stigma around dementia in both caregivers and individuals from migrant backgrounds with dementia are consistently reported, often creating hesitation and reluctance to seek formal support.^[16]

Addressing these persistent challenges - such as stigma, language barriers, and access to formal services - requires social and health systems to work collaboratively alongside communities. Involving caregivers in designing educational and supportive interventions, creating peer support networks, and engaging community leaders are essential steps to make care more inclusive and accessible. By prioritising cultural sensitivity and addressing systemic barriers, we can improve the lives of caregivers and, ultimately, those they care for.



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Reflections on what lies beyond a migration crisis

At the time of writing my review of Hein de Haas' study on migration ^[1], I found myself in Bangladesh working on an interuniversity programme on climate change and green skills education and training. It was an interesting context for reviewing de Haas' account on migration, as Bangladesh ranks as the sixth-largest migrant population worldwide, and is one of the largest remittance-receiving countries.^[2]

Working on the production of this edition of MTb on Migrants and Health and the symposium Care for Newcomers ^[3] inspired me to read de Haas' book in the first place. The presentations and discussions at the symposium made it more than clear to me that, in order to define and respond to health needs of migrants, it is good to clarify who we are talking about as well as the many misconceptions that surround migrants and migration matters in the current debate and public understanding.^[4]

POLITICAL SUICIDE

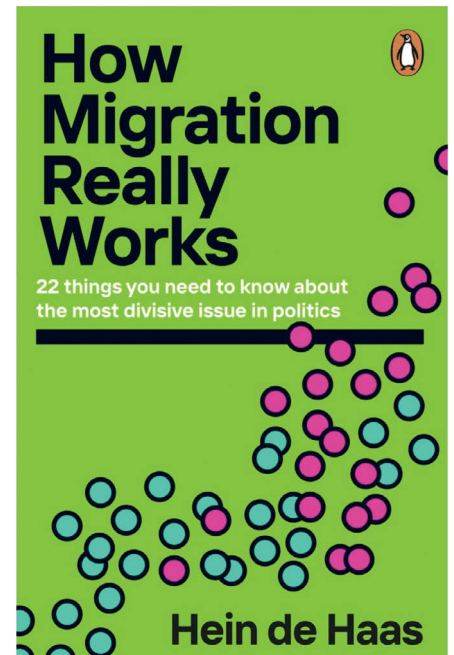
The book *How migration really works, 22 things you need to know about the most divisive issue in politics* delivers on its promise in many ways. Thirty years of social science research on migration is skilfully presented in this impressive book on trends and patterns of global human migration. In his quest to dispel persistent left- and right-wing migration myths, de Haas presents an overwhelming amount of data, facts, figures and essential information to discuss the current myths surrounding the migration debate. He wrote the book with a great sense of urgency as, despite the many lectures he delivered and the many debates he participated in, he realised that *speaking truth to power* was simply not enough to improve the tone and quality of the debate. Often, high-ranking policymakers complimented him on the fantastic

presentation he gave, but reassured him that putting his advice into practices *would of course be political suicide*.

He wrote the book to give the general reader tools to engage in a more informed debate and to challenge the visions of (Western) politicians on the migration problem. The book does not pretend to give an ideological perspective on migration, as de Haas mentions "if it was a solvable problem – or the contrary – a solution to a problem". Rather, migration is here; it is an intrinsic and inseparable part of the broader social, economic and cultural changes in societies and in the world in general – changes that will have an impact, sometimes for the good and sometimes downright detrimental – but inevitable changes that cannot be ignored or wished away. We had better take an informed look at the nature and causes of this phenomenon and change the framing of the debate.

SOME STATISTICS

Two easy to memorise facts stand out. First, migration is as old as mankind, and secondly, international migration has remained stable at around 3% of the world's population. This means that *97% live in their country of origin*. A remarkable figure, so sees De Haan, given the enormous inequality in the world. Roughly around one tenth of all migrants are considered refugees, and most of them find shelter in a neighbouring country. Since the 1950s, the percentage of refugees has fluctuated between 0.1 and 0.35 of the world's population. Also, statistics show that while *migration patterns* have changed over the years, the overall numbers have not dramatically increased. Obviously, what did change were people's motivations to migrate, such as during the heydays of the trans-Atlantic migration when millions of Europeans left the 'Old World' to embark on a new adventure in The United States, Canada, Brazil, and Australia. Or the waves of mass-migration in the period when European imperialism reigned and many European soldiers, colonists, missionaries, administrators and business



Hein de Haas
How Migration Really Works
22 things you need to know about
the most divisive issue in politics

English
Paperback
9780241998779
08 August 2024
464 pages

people settled in the colonies. Or the insatiable quest for a labour force driven by European imperialism and industrialisation. The book carefully compiles these statistics and presents each of the myths in a similar way: first introducing the misconceptions, such as *Illegal migration is getting out of hand* (Myth 2) – followed by a section on How it really works.

SO HOW DOES IT WORK IN THE CASE OF BANGLADESH?

Migration as a desperate flight from misery: the sixth myth that Hein de Haas challenges in his book. Could that be the case for the many Bangladeshis who 'flee' their home country for greener pastures elsewhere? At first glance, in view of the public image that people may have of Bangladesh (poor, unstable, high

inequality, high levels of corruption), one could believe that this indeed is the drive of many. On the other hand – as with the other myths that de Haas carefully dismantles with a wealth of data, statistics and analysis – first glances are often misleading. According to World Bank data, the country was able to reach a lower-middle income status while coming from being one of the poorest nations on earth after gaining its independence in 1971, and was also able to vastly improve its human development indicators.^[5]

“The picture that politicians and journalists paint of migration from poor countries is often steeped in stereotypes about poverty and misery in ‘the third world’. However, the data belie the stereotypical view that migration from developing countries is based on irrational dreams about life abroad. Although many migrants face hardships, are often exploited and get disappointed at times, the majority still believe that leaving is a better option than staying. The money that migrants send home is an important source of income for families and communities in countries of origin”. More than often, as he continues, it is the result of people’s rational decision to simply want to better their (and their family’s) living conditions, the family income, or young people’s interest in education and career opportunities abroad. Seen from this angle, migration can become a gamechanger at the individual and societal level – and even more effective than development aid. Figures also underlie this, as in 2020 global remittances surpassed the level of development aid (\$193 billion) by some 2.6 times.^[6] For Bangladesh this amounts to almost \$22.1 billion (2021), making it the seventh highest recipient of remittances in the world, and the third highest recipient of remittances in South Asia.^[7] As such, remittances are a more stable factor in the development of a nation than relying on international development aid. This is food for thought given the trend of cutting rigorously in Western spending on development aid, like in the Netherlands where recent government plans involve high cuts in development aid.^[8]

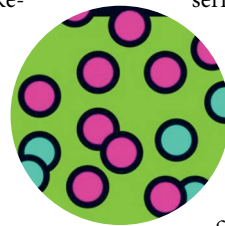


In more than one way, Bangladesh is an interesting case for reflections on migration. While many Bangladeshis leave the country (roughly 4.4% of the total population of 170 million population is residing overseas), at the same time, the country is experiencing rapid urbanisation and internal migration, and is hosting one of the *largest* refugee populations in the world: the approximately one million Rohingya from Myanmar in makeshift settlements around Cox’s Bazar.^[9] The vast majority of migrants from Bangladesh are so-called ‘regular’ labour migrants to countries in the Gulf (a popular destination since the 1970s oil boom), and to Malaysia, Indonesia, and Australia, and only in more recent years to Europe and North America.^[10] In spite of what politicians want us to believe. (see the chapter on Myth number seven: *We do not need labour migrants*), many of these labour migrants are more than welcome in the recipient countries. Making *the demand for labour* one of the major drivers for international migration. Migrants often fill the 3-D vacancies that are hard to fill these days: the dirty, dangerous and demeaning jobs. They may not be wanted but are by default, indispensable and serve as the oil in the neo-liberal system.

BACK TO MIGRATION AND HEALTH, MOVING FORWARDS

Meanwhile, back in the Netherlands, the Dutch government continues to look for ways to frame the migrant situation in the country as a national crisis. In fact, we still see all the myths that are debunked in the book continue to feature as ‘truth’ in the media and in the policy intentions of the politicians. The book provides sufficient ammunition to counter all of this.

But what should and can we do, and how? These are also questions which de Haas addresses in his final chapter. As far as he is concerned, the answer depends on the kind of society we want to live in. Unfortunately, this debate is difficult to hold with icy political winds blowing (read: anti migration winds), in a highly polarised context, and not only in the Netherlands.



In a way, de Haas concludes with hope. Rather than focusing on what went wrong and where policies have failed, we should acknowledge the progress that has been made and the reality we are in. Like it or not, de facto we have accepted that we have become immigration countries. And while many European countries are working on a stricter migration policy, the Spanish government recently presented a series of reforms to their migration policy, wanting to make it easier for migrants to come and work in Spain – not only because of humanitarian reasons, but mainly for economic and demographic reasons.^[11] They clearly accepted what De Haas refers to as the elephant in the room in the migration debate – our persistent demand for labour. Meanwhile Denmark has also taken a different path and is revisiting its migration policies. They too realised the counterproductive results of their highly restrictive migration policies, as not only unwanted foreigners failed to come but also the wanted ones (i.e. the much-needed labour migrants and students). A U-turn was needed.^[12]

Let these U-turns be an inspiration. And in the meantime, countries are held to fulfil their obligations on respecting ‘the right to health’ and ‘universal access to health for all’, without exceptions, including the newcomers, the not so recent newcomers, and people without proper legal documents. The symposium Care for Newcomers in the Netherlands was a valuable step towards making this happen. To be continued.

Also available in Dutch: Hoe migratie echt werkt. Het ware verhaal over migratie aan de hand van 22 mythen. Nederlands, Paperback, 9789000386857. 21 september 2023, 520 pagina’s

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- 12.

Uncommon manifestation of nodular fasciitis in a young malawian male: a case report

Nodular fasciitis is a benign soft tissue disease. Patients usually present with a rapidly growing soft tissue mass typically up to two centimetres in diameter. In this case report, an unusual presentation of nodular fasciitis will be discussed.

CASE REPORT

In May 2022, a 24-year-old, otherwise healthy man, presented to the Outpatient Department at Mulanje Mission Hospital, Malawi, with a mass in the left axillary region. The mass had been growing for the past two years. The size reduced the range of motion of the patient's left upper extremity. The swelling was non-tender and there was no reported history of infection, trauma or other soft tissue masses. On examination, a firm and mobile soft tissue mass, measuring 15 by 15 cm was present on the left side of the trunk, just below the axilla. No skin lesions, erythema, calor or fluctuance were present. The differential diagnosis included a benign mass such as lipoma, fibroma, and epidermoid cyst. However, the size of the mass, the firm consistency, and the relatively rapid growth raised clinical suspicion of a malignant lesion, such as a sarcoma or neurofibroma. An ultrasound scan was performed and showed a firm mass, sonographically suggestive of a lipoma. A biopsy was taken and analysed at a private laboratory in Blantyre.

The findings upon histopathological examination were as follows. Sections showed proliferation of fibroblastic tissue forming storiform to solid patterns. The neoplastic cells showed a tissue culture pattern and extravasated red blood cells. No malignant cells were found. Findings were in line with the characteristics of nodular fasciitis.

The histological findings were discussed with the tertiary surgical service in Blantyre. We were advised to excise and perform histopathological analysis of the mass. The mass was completely resected under general anaesthesia and a surgical drain was placed. 48 hours after resection, dark serous fluid was drained from the wound suspect for secondary wound infection. The incision was reopened, cloxacillin started, and the wound was dressed daily. After ten days, the infection had subsided. Following secondary skin closure, the patient was discharged home. Histopathological analysis of the resected mass was not performed due to financial constraints of the patient.

Upon a 3-month follow-up visit, the wound was found to have healed well without recurrence of a mass. The patient has not presented to the hospital since.



CASE REPORT

DISCUSSION

Nodular fasciitis is a benign mesenchymal tumour. Other terms, such as infiltrative fasciitis, proliferative fasciitis, and pseudosarcomatous fasciitis, have been used synonymously.^[1-4]

CLINICAL CHARACTERISTICS

Nodular fasciitis is most often observed in young adults (20 to 40 years of age).^[1] Men and women are equally affected, but in childhood the mass is observed predominantly in boys. Most patients present with a rapidly growing, painless, solitary soft tissue mass. The consistency ranges from solid to nodular, rubbery or firm.^[3] After a period of rapid growth, usually less than one month, the lesion tends to plateau in size and typically measures less than two to three centimetres.^[4] However, masses with a size up to 10 to 15 centimetres exist as seen in this case. In atypical presentations, it is important to confirm the diagnosis of nodular fasciitis, as the clinical features share similarities with some forms of fibrosarcoma, which require a more aggressive treatment.^[2] The most common site of presentation is the upper extremity, especially the forearm, followed by the chest wall, back, head and neck, with the latter presenting most often in infants and children.^[3] The condition has also been reported on the hand, intra-oral, intra-neural, and intra-articular.^[6-7]

When evaluating a mass like this, especially in remote settings, it is of great importance to differentiate between benign and malignant causes. Ideally, non-invasive diagnostic methods should be performed before any surgical resection is done. Imaging using MRI, CT, ultrasound, or PET-scan have all been used to describe the nature of such a lesion.^[2-7] However, such diagnostic tools lack the capacity to definitely exclude malignancy and are often not available in small hospitals or those in low resource settings. Therefore, a biopsy is the recommended approach to obtain a preoperative diagnosis of a soft tissue mass when the nature is unclear. When a preoperative biopsy is performed, a postoperative histological analysis is of little added value. The preoperative approach is more cost-effective and this is of great importance in settings with limited resources.

The treatment of choice is surgical excision, although partial excision may be sufficient in nodular fasciitis as residuals may subsequently regress by scarring.^[1,2] The lesions do not metastasize and rarely reoccur. Reoccurrence of a lesion should lead to a critical review of the original diagnosis.^[2,3]

CONCLUSION

Nodular fasciitis is a rapidly growing, benign, soft tissue tumour which must

be considered in the differential diagnosis of soft tissue masses. The preferred method of treatment is curative surgical excision with histopathological analysis to confirm the diagnosis.



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Figure 1. Showing the mass in the left axillar region from posterior angle.

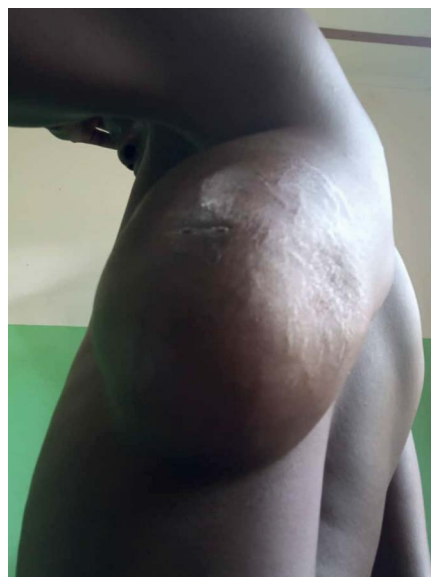
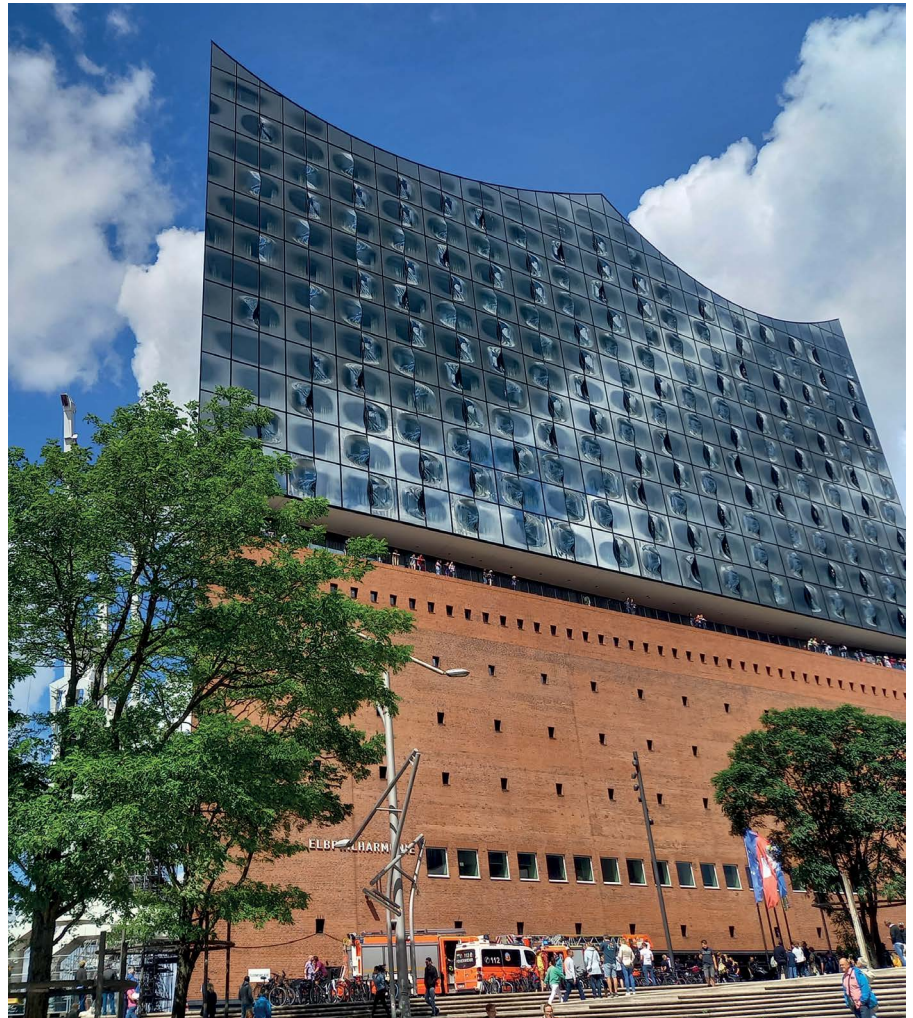


Figure 2. Showing the mass in the left axillar region from oblique angle.

‘Better health for all in a changing world’: the 14th European Congress on TMIH in 2025 in Hamburg

After 30 years, the European Congress on Tropical Medicine and International Health (ECTMIH) is returning to Hamburg. In September 2025, the Bernhard Nocht Institute for Tropical Medicine (BNITM) and its partners will host the 14th edition of this European congress. The overarching theme will be ‘Better health for all in a changing world’, which is also the vision of the European Global Health Strategy. The main themes will be under the umbrella of One Health, merging the ongoing planetary health challenges with human and animal health, climate change, and disrupted ecosystems, and looking for proposed solutions.

The congress intends to offer a platform for the dissemination of new insights and for presenting interdisciplinary approaches to global health (GH) problems. We invite researchers from all parts of the globe to present their latest research in all domains of GH, including infectious and tropical diseases, migrations, and right to health, to name just a few (see Box 2). We encourage participants to address the underlying social, cultural and economic dimensions of health, and to build on the principles of universal access to health, equity, and on climate justice. We will adopt a cross-cutting and interdisciplinary perspective to tackling health problems in the 21st century. The congress is planned for Monday to Thursday, 29 September to 2 October 2025, and will be held at the modern and attractive Congress Centre Hamburg (CCH).



BOX 1: FROM TROPICAL MEDICINE TO PLANETARY HEALTH

The Hamburg congress in 1995 was focused on the main pillars of clinical tropical medicine (TM) and took the first steps towards international health. The ECTMIH 25 would like to offer a reflection not just on the changing of names and terminology, but on a paradigm shift of the lens from TM challenges, which by the way still hold, towards planetary health challenges. This transition was first reflected in the 2007 Amsterdam Partnership and Innovation in Global Health edition. This trend of widening the focus was also seen in the congresses that followed – such as the inclusion of an equity and human rights lens, and addressing the consequences of migration on health, among others in the congresses in Verona (2009), Barcelona (2011), and Bergen (2021). The 13th edition in Utrecht 2023 ‘Shaping the future of equitable and sustainable planetary health’ catalysed the transition and change we need for equitable, just, and sustainable societies to ensure that all populations – and especially those in low(er) resource settings – have optimal chances of health and wellbeing.

BOX 2: PROGRAMME FOCUS AND TRACKS

The focus of the ECTMIH Congress in Hamburg 2025 will be on advancing scientific collaboration, knowledge sharing, and global action to address pressing health challenges. The congress will explore a wide range of topics across its seven carefully curated tracks, each aiming to tackle critical aspects of global health (GH), particularly for populations in low-resource settings. With an overarching commitment to equity, innovation, and sustainable solutions, ECTMIH 2025 will provide an inclusive platform for experts and stakeholders to collaborate and shape the future of healthcare. The tracks will be:

1. Interfaces: Immunology and Interaction
2. Emerging Infections: Pandemics and Control
3. Tropical Medicine: Diseases and Care
4. One Health: Approaches and Solutions
5. International Health: Travel and Migration
6. Vulnerable Populations: Poverty and Neglect
7. Non-infectious Diseases: Challenges and Society.

Cross cutting topics include: equity in health, climate change, and implementation. These cross-cutting themes will enrich the discussions within each track, ensuring a comprehensive approach to tackling the most pressing GH issues of our time.

BOX 3: DELEGATE PROFILES

We encourage the active participation of researchers, global thinkers, and policy and decision makers in the programme, and the inclusion of debates on the role of cooperation agencies and scientific institutes in the field of GH. Although ECTMIH is a European congress, GH challenges do not have borders, and delegates from all over the world, in particular from LMICs, are invited to contribute and/or to participate. We would welcome and facilitate a large participation by young scientists, i.e. the future generation for taking on GH challenges.

A disparate mix of international health professionals and researchers from the various branches active in GH, both in the North global health and South, will meet at this congress:

Academia: researchers and undergraduate, graduate and post-doctoral students

Professionals in the healthcare system: health specialists, physicians, nurses and other health workers, global health experts

Professionals from governmental agencies such as health ministries, regulatory bodies, and health departments as well as from non-governmental organisations

Representatives from private research & development organisations

BOX 4: ORGANISING PARTIES

The congress is organised by the European and German Societies for Tropical Medicine and Global Health (FESTMIH, www.festmih.eu; DTG, www.dtg.org), the Bernhard Nocht Institute for Tropical Medicine (BNITM, www.bnitm.de) and the University Medical Centre Hamburg-Eppendorf (UKE, www.uke.de).

INVITATION TO PARTICIPATE

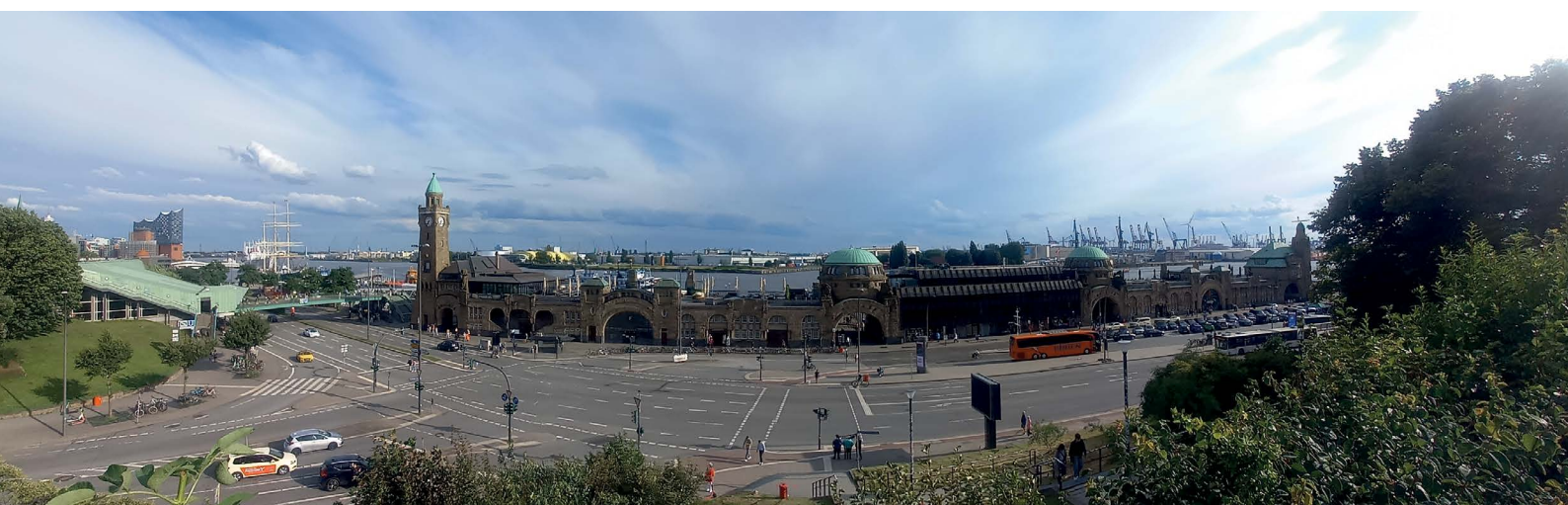
We invite all stakeholders, academic institutions, and TM and GH scientific societies interested in global health and in tropical medicine to mark the date and engage with us over the next months in the shaping of the congress. The call for proposals for organised sessions in any of the seven tracks is open from October 2024, and the call for proposals to submit abstracts will open sometime in December. On our website (www.ectmih-2025.de), you will find regular updates on the programme, enabling you to become part of the global and planetary health network.



Prof. Juergen May, President of ECTMIH 2025 (BNITM)

Prof. Marco Albonico, President Federation of European Societies for Tropical Medicine and International Health (FESTMIH)

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The naked don't fear the water: an underground journey with Afghan refugees

Matthieu Aikins
Harper, 02-2022
ISBN-10 978-0063058583

The exact meaning of the Dari proverb “The Naked Don’t Fear the Water” eludes me, but I imagine it means something along the lines of “There’s Nothing Left to Lose”, a phrase which has the air of desperation. The life of the Afghan Omar, the main character of the book, was “coeval with the war on terror”. Omar was born in a refugee camp in Pakistan and grew up as a refugee in Iran. After the invasion of Afghanistan by the Americans, he, his family and thousands of other Afghans had returned to Kabul “eager to take part in the promised era of peace and reconstruction.” However, the older generations were wary of the international forces, as they had “once watched the Soviets with the same hooded look”. What a bitter feeling that must have given, watching the Americans leave in chaos a mere 20 years later, closely followed by the return of the Taliban. However, four years before this retreat even happened, Omar (again along with thousands of other Afghans like him) was again forced onto the smugglers’ road in a desperate attempt to find a better life in other parts of the world.

The Naked Don’t Fear the Water is the gripping, intimate, fly-on-the-wall account of the journey, and the decisions leading to this journey of a refugee from Afghanistan. The book weaves personal struggles faced by refugees such as Omar together with chillingly distant but immensely influential political

affairs, such as the closing of the EU border in 2015, into an inseparable mess.

The strength of the book lies in the fact that it is mostly a first-hand account. The author Matthieu Aikins, whose physical appearance resembles that of a Hazara, an ethnic minority in Afghanistan, undertakes the smugglers’ road as an

applications, and the powerlessness when stopped and humiliated by border guards. However, the reader stays permanently, soothingly, aware of the possible exit. Hamid, Aikins’ alias, is just one phone call away from reclaiming his “Aikins identity” and saying goodbye to being a refugee. For Omar this is not an option. Maybe the absence of this option, of the

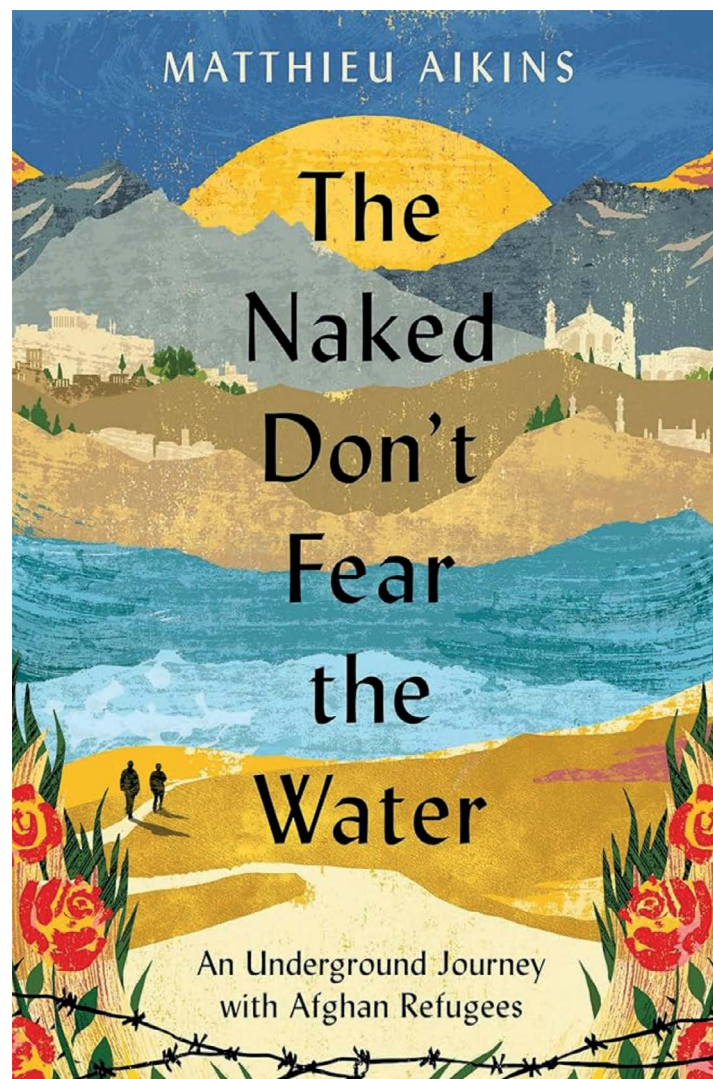
possibility to escape from the present situation, is the most distinguishing part of being a refugee. The impossibility of going back to one’s previous life and the gloomy uncertainty of the life ahead is what Aikins, and with him readers such as myself, will never fully understand.

Aikins’ quote at the beginning of the book when describing his interaction with Afghans is also quite fitting in this setting: “There was a gulf between us, but I thought we could bridge it in our encounter as humans.” Can the gulf between refugees in Europe, the “newcomers”, on the one hand, and European citizens on the other, be completely bridged in our encounter as humans? Whatever the answer, the moral obligation to try remains.

©

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undercover journalist. He ditches his passports, becomes undocumented, and joins his friend Omar as a fellow refugee. As a reader you feel the weight of the decision to leave your home country, the uncertainty of the smugglers’ promises, the boredom of endless waiting for



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