

Nº 4, Fourth Quarter 2018



THE LANCET



WELCOME

to the Humanitarian Health Digest—a quarterly bibliography of published peer-reviewed journal articles on humanitarian health. The Digest is compiled by the Johns Hopkins Center for Humanitarian Health and The Lancet. It includes one or two new commentaries on peer-reviewed articles cited in the Digest.

The objective of the Digest is to provide links to peer-reviewed articles on humanitarian health from a wide variety of journals in one place for ease of reference. Peer-reviewed articles will be searched systematically using the PubMed and Global Health (OVID) databases. Articles will mostly include primary research and systematic reviews. Humanitarian health will be divided into three broad categories: 1. Conflict and Forced Displacement; 2. Natural Disasters; and 3. Technological Disasters. The articles will be further divided into low- and middle-income countries and high-income countries.

Under each of these two subcategories, articles will be subdivided into the following public health-related categories:

- I. COMMUNICABLE DISEASE
- II. NON-COMMUNICABLE DISEASE
- III. REPRODUCTIVE, MATERNAL, NEWBORN, CHILD AND ADOLESCENT HEALTH
- IV. NUTRITION AND FOOD SECURITY
- V. WATER, SANITATION AND HYGIENE (WASH)
- VI. MENTAL HEALTH, PSYCHOSOCIAL ISSUES, AND SUBSTANCE ABUSE
- VII. HEALTH SYSTEMS
- VIII. MULTI-CATEGORY

All featured articles from the Lancet family of journals will be free to read with registration on TheLancet.com. It is the Center for Humanitarian Health's goal that other journals will follow suit to allow all peer-reviewed articles to be free to read so that humanitarian workers worldwide can learn from and apply lessons learned and conclusions immediately in the field to benefit persons affected by conflict, natural disasters and technological disasters.

We hope that you will learn and benefit from the articles presented in the Humanitarian Health Digest.

Paul Spiegel MD, MPH Director of the Center for Humanitarian Health

Richard Horton FRCP, FMedSci Editor-in-Chief of *The Lancet*

COMMENT I.

A need to understand implications of immigration detention

by Divya Mishra, MD-PhD Candidate, Department of International Health, Johns Hopkins Bloomberg School of Public Health



▲ Detention center fencing, Christmas Island, Australia (David Stanley/CC BY 2.0).

In light of the routinized detention of asylum seekers and refugees in many countries, the United Nations High Commissioner for Refugees published a strategy to end the practice in 2014,1 emphasizing the ineffectiveness of detention as a deterrent to migration, and the fact that it contradicts international law. However, given the surge in migration into Europe in subsequent years, rates of immigration detention remain high. In 2017, there were 25,810 immigration detainees in Greece, 31,908 in the UK, and 46,800 in France.^{2,3} In the US, Immigration and Customs Enforcement (ICE) detained 323,591 irregular immigrants in 2017,3 and a record high of 42,000 immigrants each day on average in 2018.4

This quarter's *Digest* includes the first systematic review of immigration detention's mental health impact since 2009, by von Werthern and colleagues.⁵ Given the scarcity of data from immigration detention centers, the authors used an inclusive search strategy that did not restrict studies based on immigrants' country of origin or country of detention, or their age. Included studies concerned detention facilities in the US, UK, Australia, Canada, Israel, Japan, and Switzerland.

Among adult detainees, the authors found that greater trauma exposure

prior to detention was associated with higher rates of depression, anxiety, and post-traumatic stress disorder (PTSD) symptoms. Multiple studies found that over 70% of detainees suffered from one of these mental health disorders. All studies comparing symptom scores of common mental health disorders between detained and non-detained asylum seekers, controlling for immigration status and past exposure to trauma, found higher symptom scores among detained populations.

The effects of immigration detention on children went beyond those seen among detained adults. Studies based on clinical assessments found that all children exhibited at least one common mental health disorder, as well as rates of eating and sleeping problems, some as high as 100%. Among children under 5 years, developmental problems were common, such as language regression, attachment problems, and enuresis. Over 90% of adolescents exhibited symptoms of very severe PTSD, and more than half continued to meet criteria for PTSD after their release from detention.

Given rising numbers of unaccompanied minors, the effects of immigration detention on children have important implications for many countries where it is an ongoing practice, including the US,³ as well as countries where unaccompanied children are accommodated in detention-like conditions, such as Greece.⁶

The studies included in the von Werthen review come from highincome destination countries. However, many migrants today pass through one or more transit countries where they may also be detained. In 2017, Mexico detained over 90,000 South and Central American migrants, including those en route to the US.³ Turkey, which currently hosts the greatest number of refugees, administratively detains irregular migrants who apply for asylum within its borders, as well as those who are intercepted on their way to Europe.⁷

Although detention facilities may not be directly accessible to the humanitarian community, the mental health consequences of immigration detention are likely to affect many populations we serve. The review by von Werthen and colleagues is an important step towards understanding these consequences. Further research is needed to understand the lasting effects of detention and develop strategies to address them, both in destination countries and transit countries, where the use of detention may be even more routine.

COMMENT II.

Debunking fallacies around migration in the face of the political schism

by Marianne Guenot, MSc, PhD, Senior Editor, The Lancet

This quarter's Digest features the paper Global patterns of mortality in international migrants: a systematic review and meta-analysis by Aldridge and colleagues, published online on Dec 5, 2018 as part of the UCL-Lancet commission on migration and health.¹ It investigates whether available data supports the so-called "healthy migrant" hypothesis-the observation that migrants seem to have a mortality advantage over the majority population in host countries. The scarcity of data, unfortunately, prevents the authors from assessing whether this hypothesis holds up to scrutiny in marginalised populations such as forced migrants and migrants living in low- and middle-income countries. However, the findings of this metanalysis suggest that in highincome destination countries overall, international migrants' mortality was lower than that of the general population.

This observation may seem counterintuitive. As stated in the paper's accompanying Comment by Borhade and Dey: "In host populations, popular rhetoric and media coverage often portray migrants to be in poor health and a burden on health systems."² The research suggests a different reality. This could be because healthier migrants might be more likely to choose to migrate, might benefit more from the decision to migrate, or may be more likely to successfully migrate. The so-called "salmon bias" also posits that migrants might chose to return to their country of origin when they are in poor health and near death, thus alleviating that public health burden from the host country.

The importance of building a strong evidence base to challenge the assumption that migration is a burden on the host country becomes evident when examining current data. An estimated 244 million people are on the move globally, a number that is set to increase with climate change and conflict. Although most will remain in the country where they were born, an increasing number are now migrating to other countries. It therefore seems misguided to think that building walls, be it metaphorical or literal, will effectively keep migrants at a country's doorstep. Moreover, evidence such as that gathered by the UCL-Lancet commission indicates that "migrants contribute positively to the economies of host countries and, in wealthy countries such as the UK and the US, migrants constitute a large proportion of the health workforce", according to lead author Ibrahim Abubakar.1

Yet, the possibility of global, concerted, policy-making-desperately needed to potentiate migration towards a mutually-beneficial situationseems drastically compromised by the schism that exists around migration policy. As stated by Hungary Prime Minister Viktor Orbán, who was commending the Rome-Warsaw axis (a staunchly anti-immigration alliance formed by the Italian and Polish governments ahead of the upcoming European Parliament elections), "party structures, traditionally left or right, are being taken over by a different dimension-those for migration and against immigration".3

Perhaps it is time to accept a new era for the planet, one where a mobile population is seen as a value to a country's health and economy, not a threat. But until the misperceptions around migration—the fear of the dreaded "other" utilised by populist leaders to garner political cloutare alleviated, progress will almost certainly be slower than need be to transform migration into an asset for all. By providing the objectivity of scientific analysis to shed light on the realities of migration, researchers such as Aldridge and colleagues can help advance this debate.



Syrian migrants barred from Keleti railway station, Budapest, Hungary (Freedom House).

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³ Global Detention Project. Americas. 2019. https://www.globaldetentionproject.org/ regions-subregions/americas.

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⁵ von Werthern M, et al. The impact of immigration detention on mental health: a systematic review. *BMC Psychiatry* 2018; **18**: 382.

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² Borhade A and Dey S. Do migrants have a mortality advantage? *Lancet* 2018; **392**: 2517–18.

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³ For more on Viktor Orbán's statement see https://www.theguardian.com/world/2019/ jan/10/viktor-orban-calls-anti-migration-politics-take-over-eu-matteo-salvini.

For more information about migrants and health see *Report on the health of refugees and migrants in the WHO European Region*. http://www.euro.who.int/en/publications/ abstracts/report-on-the-health-of-refugees-and-migrants-in-the-who-european-region-no-public-health-without-refugee-and-migrant-health-2018.

Conflict and Forced Displacement

I. COMMUNICABLE DISEASE

LOW- AND MIDDLE-INCOME COUNTRIES

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II. NON-COMMUNICABLE DISEASE

LOW- AND MIDDLE-INCOME COUNTRIES

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III. REPRODUCTIVE, MATERNAL, NEWBORN, CHILD, AND ADOLESCENT HEALTH

LOW- AND MIDDLE-INCOME COUNTRIES

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IV. NUTRITION AND FOOD SECURITY

LOW- AND MIDDLE-INCOME COUNTRIES

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V. WATER, SANITATION, AND HYGIENE (WASH)

N/A.

VI. MENTAL HEALTH, PSYCHOSOCIAL ISSUES, AND SUBSTANCE ABUSE

LOW- AND MIDDLE-INCOME COUNTRIES

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HIGH-INCOME COUNTRIES

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VII. HEALTH SYSTEMS

LOW- AND MIDDLE-INCOME COUNTRIES

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HIGH-INCOME COUNTRIES

N/A.

VIII. MULTI-CATEGORY

LOW- AND MIDDLE-INCOME COUNTRIES

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HIGH-INCOME COUNTRIES

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Natural Disasters

I. COMMUNICABLE DISEASE

LOW- AND MIDDLE-INCOME COUNTRIES

Kodish SR, Rohner F, Beauliere JM, et al. Implications of the Ebola virus disease outbreak in Guinea: Qualitative findings to inform future health and nutrition-related responses. *PLoS One* 2018; **13**: e0202468. doi:10.1371/journal.pone.0202468. https://www.ncbi.nlm.nih.gov/pubmed/30138407

HIGH-INCOME COUNTRIES N/A.

II. NON-COMMUNICABLE DISEASE

LOW- AND MIDDLE-INCOME COUNTRIES N/A.

HIGH-INCOME COUNTRIES

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III. REPRODUCTIVE, MATERNAL, NEWBORN, CHILD, AND ADOLESCENT HEALTH

LOW- AND MIDDLE-INCOME COUNTRIES

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HIGH-INCOME COUNTRIES

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IV. NUTRITION AND FOOD SECURITY

N/A.

V. WATER, SANITATION, AND HYGIENE (WASH)

N/A.

VI. MENTAL HEALTH, PSYCHOSOCIAL ISSUES, AND SUBSTANCE ABUSE

LOW- AND MIDDLE-INCOME COUNTRIES

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HIGH-INCOME COUNTRIES

Ozaki A, Horiuchi S, Kobayashi Y, et al. Beneficial roles of social support for mental health vary in the Japanese population depending on disaster experience: a nationwide cross-sectional study. *Tohoku J Exp Med* 2018; **246:** 213–23. doi:10.1620/tjem.246.213. https://www.ncbi.nlm.nih.gov/pubmed/30542048

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VII. HEALTH SYSTEMS

LOW- AND MIDDLE-INCOME COUNTRIES

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HIGH-INCOME COUNTRIES

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VIII. MULTI-CATEGORY

LOW- AND MIDDLE-INCOME COUNTRIES

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HIGH-INCOME COUNTRIES

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Technological Disasters

I. COMMUNICABLE DISEASE

LOW- AND MIDDLE-INCOME COUNTRIES N/A.

HIGH-INCOME COUNTRIES

Kwon EH, Reisler RB, Cardile AP, et al. Distinguishing respiratory features of category A/B potential bioterrorism agents from community-acquired pneumonia. *Health Secur* 2018; **16**: 224–38. doi:10.1089/hs.2018.001.

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II. NON-COMMUNICABLE DISEASE

III. REPRODUCTIVE, MATERNAL, NEWBORN, CHILD, AND ADOLESCENT HEALTH

IV. NUTRITION AND FOOD SECURITY

V. WATER, SANITATION, AND HYGIENE (WASH)

II.-V, N/A.

VI. MENTAL HEALTH, PSYCHOSOCIAL ISSUES, AND SUBSTANCE ABUSE

LOW- AND MIDDLE-INCOME COUNTRIES

Loganovsky KN, Bomko MO, Abramenko IV, et al. Neuropsychobiological mechanisms of affective and cognitive disorders in the Chornobyl clean-up workers taking into account the specific gene polymorphisms. *Probl Radiac Med Radiobiol* 2018; **23:** 373–409. doi:10.33145/2304-8336-2018-23-373-409.

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HIGH-INCOME COUNTRIES

Ito S, Sasaki M, Okabe S, Konno N, Goto A. Depressive symptoms and associated factors in female students in Fukushima four years after the Fukushima nuclear power plant disaster. *Int J Environ Res Public Health* 2018; **15**. doi:10.3390/ijerph15112411. https://www.ncbi.nlm.nih.gov/pubmed/30380803

Murakami M, Hirosaki M, Suzuki Y, et al. Reduction of radiation-related anxiety promoted wellbeing after the 2011 disaster: 'Fukushima Health Management Survey'. *J Radiol Prot* 2018; **38:** 1428–40. doi:10.1088/1361-6498/aae65d.

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VII. HEALTH SYSTEMS

N/A.

VIII. MULTI-CATEGORY

LOW- AND MIDDLE-INCOME COUNTRIES

N/A.

HIGH-INCOME COUNTRIES

Takahashi A, Ohira T, Okazaki K, et al. Effects of lifestyle on hepatobiliary enzyme abnormalities following the Fukushima Daiichi nuclear power plant accident: the Fukushima health management survey. *Medicine (Baltimore)* 2018; **97:** e12890. doi:10.1097/md.00000000012890.







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