A safe and healthy future? Epidemiological studies on the health of asylum seekers and refugees in the Netherlands
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Citation for published version (APA):
CHAPTER 1

INTRODUCTION
Box 1.1.1 Definition of asylum seeker and refugee

Asylum seeker
An asylum seeker is a person who has left his or her country of origin, has applied for recognition as a refugee in another country, and is awaiting a decision on his or her application.

Refugee
The official definition of a refugee is any person who is outside their country of origin and unable or unwilling to return there or to avail themselves of its protection, on account of a well-founded fear of persecution for reasons of race, religion, nationality, membership of a particular group, or political opinion.

In this thesis, the term refugees refers to persons who have been given refugee status in the host country, independent of whether the person has a permanent or a temporary residence permit.


1.1 BACKGROUND

Asylum seekers and refugees in the Netherlands

Asylum seekers have fled their country of origin and applied for protection as a refugee in another country (definitions in Box 1.1.1). During their asylum procedure they must demonstrate that they have a well-founded fear of persecution for reasons of race, religion, nationality, political opinion, or membership in a particular social group.

The number of asylum requests lodged in the Netherlands is subject to change. Whereas the number of requests was 43,900 in the year 2000, it was only 9,730 in 2007, and then increased again to 17,190 in 2013 (Figure 1.1.1).

![Figure 1.1.1 Number of asylum requests per year in the Netherlands, 2000-2008 (first and subsequent requests combined)](image)

Beyond the shared hope of being recognized as a refugee, asylum seekers are very diverse. This diversity becomes visible during any visit to an asylum-seeker centre. It can also be visualised by thinking about the geographical distribution of the wars and conflicts that have caused important refugee movements over the last decades, for example, in Afghanistan, the former Yugoslavia, Iraq, Iran, Rwanda, Somalia, and Syria. In figure 1.1.1 the number of asylum requests for persons from Afghanistan, Iraq, and Somalia are shown, as these countries have been on ‘the top five’ for more than ten years. The group ‘other countries’ contains approximately two thirds of the total number of asylum seekers in the years presented.
The asylum-seeking population is very young compared with the population of the Netherlands. Nearly half of the asylum seekers who arrived between 2000 and 2008 were younger than 20 years of age at the time of arrival, whereas only less than a quarter of the population of the Netherlands is younger than 20. The proportion of asylum seekers aged 40 or over was 11% compared with 52% in the population of the Netherlands.\textsuperscript{6} Male asylum seekers constituted nearly two thirds of the asylum seekers who arrived between 2000 and 2008.

Asylum seekers are housed at asylum-seeker centres managed by the Central Agency for the Reception of Asylum Seekers (COA). These centres include former cloisters or barracks, and, sometimes, caravans or semi-permanent housing units throughout the Netherlands. An average asylum-seeker centre houses about 400 occupants from some 40 nationalities. Asylum seekers look after themselves as much as possible. They usually live in housing units in groups of between five and eight persons. Each housing unit has a number of bedrooms and a shared living room, kitchen, and sanitary facilities. The COA gives asylum seekers weekly pocket money for food and clothing. The COA gives a one-off allowance for household goods and, as necessary, occasional allowances for purposes such as travelling expenses or buying baby clothes. Asylum seekers are allowed to work up to 24 weeks per year.\textsuperscript{a}

Asylum seekers stay at an asylum-seeker centre until the Dutch Immigration and Naturalisation Service or if they lodge an appeal, the court reaches a decision on their request for asylum. When asylum seekers are granted a residence permit, the search starts for a place there they can live on their own. Municipalities have an obligation to provide housing to a certain number of refugees per year. The COA allocates a residence permit holder to a particular municipality, which then sets to work finding suitable accommodation based on the profile of the asylum seeker. Municipalities do so by allocating social housing owned by housing associations. Residence permit holders can also find a place to live themselves.\textsuperscript{b}

Due to the use of different definitions, estimates of the total number of refugees living in the Netherlands vary between data sources. According to CBS Statistics Netherlands, on 1 January 2010, 69,620 persons had arrived in the Netherlands as asylum seekers and were living in the Netherlands with a permanent or temporary residence permit.\textsuperscript{8} According to the Netherlands Institute for Social Research SCP there were around 38,000 people of Afghan origin, 52,000 people originating from Iraq, 31,000 from Iran and 27,000 from Somalia living in the Netherlands in 2010.\textsuperscript{9} Figure 1.1.2 shows the trend in the number of first- and second-generation persons from Afghanistan, Iraq, and Somalia.
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**Health care for asylum seekers and refugees**

For asylum seekers in the Netherlands, entitlement to healthcare is similar to that for residents of the Netherlands. The current organisation of health services for asylum seekers dates from 1 January 2009. The studies in this thesis are based on data for the period between 2000 and 2008, and therefore we describe below the organisation of the health systems during these years.

Starting in 2000, the COA contracted local GGDs and a health care insurer to provide health services for all asylum seekers in the Netherlands.10 For administrative reasons the local GGDs set up the MOAs, which are separate foundations. The main responsibility of the MOA was to provide regular public health services to asylum seekers (such as health education, preventive child health care (JGZ), infectious diseases control, testing for tuberculosis (TB), hygiene and safety inspections, and epidemiology).

In addition to the regular tasks of public health services, nurse practitioners from the MOA were the first point of health care contact for asylum seekers. The nurse practitioners worked in close collaboration with family physicians contracted by the health care insurer. The health care insurer also contracted other standard health care providers, such as pharmacists, dentists, midwives, hospitals, mental health care providers and home care services.
As of 2009, the public health services for asylum seekers have been an integral part of local GGDs and the Asylum Seekers Health Centre (GC A) is responsible for the provision of primary care.\(^{11}\)

As soon as asylum seekers get a residence permit and move to a municipality, they are obliged to get a health insurance, and will have access to health services accordingly. The GGD of the municipality in which they settle is responsible for the public health services.

### 1.2 THE HEALTH STATUS OF ASYLUM SEEKERS AND REFUGEES

With television and newspaper images of the situation of refugees in places like Afghanistan, Somalia, and Syria in mind, it is not difficult to imagine that asylum seekers and refugees are a vulnerable group with respect to their health. Factors that may affect the health of asylum seekers and refugees are exposure to war and violence, food shortages and limited access to health care. The health of asylum seekers and refugees will also be influenced by the context in which asylum seekers live during their asylum procedure such as the uncertainty of the asylum procedure, the living conditions in asylum-seeker centres, the limited possibilities for participation (e.g. work, education), and limited financial means.\(^{12}\) Once a residence permit has been granted, the circumstances will be better but adversities (such as the consequences of limited language skills, discrimination, and unemployment) may still place the health of refugees at risk.\(^9\)

The available evidence shows that due to the accumulation of their experiences in the past and in the host country, asylum seekers and refugees are indeed a vulnerable group with respect to their health.\(^{4,12,13}\) However, to know whether special policies and interventions are needed, it is essential to have more detailed insight in the health problems and the risk factors that affect the health of asylum seekers and refugees.\(^{4,13}\)

In this chapter, an overview of the epidemiological studies with respect to mental health, diseases and conditions and sexual and reproductive health in asylum seekers and refugees in Western host countries published before 2009 is given. More recent literature will be addressed in the discussion in chapter 4.

**Mental health**

A relatively large proportion of the literature on asylum seekers and refugees addressed mental health problems and post-traumatic stress disorder (PTSD) in particular. The studies among adults show large variations in the prevalence rates of mental health
problems. For PTSD, depression, and anxiety, the prevalence rates range from a few percent to more than 70%. A systematic review of large clinical studies reported that 9% of the refugees had been diagnosed with PTSD and 5% had a major depression. The review observed a wide range of rates for both conditions. The systematic review attributes this variation to differences in the composition of the study population and measurement instruments used.

In the Netherlands two medical record studies that covered the years 1982-1988 report prevalence rates of diagnosed PTSD among Latin American and Middle Eastern refugees of 6% and 11% respectively. A study among Iraqi asylum seekers in the Netherlands reports prevalence rates of 37% for PTSD, 35% for depressive disorder, and 22% for anxiety disorder. The study ‘Gevlucht-Gezond?’ reports symptoms of PTSD in 28% of the asylum seekers and 11% of the refugees from Afghanistan, Iran, and Somalia. The study reports symptoms of anxiety or depression for 68% of the asylum seekers and 39% of the refugees.

In 1998-1999, compared with the general population, the suicide mortality among asylum seekers in the Netherlands was 2.8 times higher (95% confidence interval (CI) 1.5-4.1) for male and 1.5 times higher (95% CI 0.0-3.6) for female asylum seekers. A study in Denmark shows a rate of suicidal behaviour that is 3.8 times higher compared with the general population.

For the children of asylum seekers and refugees, studies in different countries also report a wide range of prevalence rates: from 19% to 54% for PTSD and from 3% to 30% for depression. A study based on strengths and difficulties questionnaires filled out by teachers reports an elevated score for 25% of the young (<11 years) and 20% of the adolescent asylum-seeking children in the Netherlands. The mental health of unaccompanied minor asylum seekers (UMAs) was analysed in a large study in the Netherlands. Fifty percent of the UMAs had severe and chronic mental distress.

Several studies show that the mental health of adults and children is associated with the exposure to traumatic events in the country of origin and the conditions in the host country. Several studies report on the effect of lengthy asylum procedures and relocations on the mental health of asylum seekers; these studies, however, share the limitations of the use of cross-sectional data. A longitudinal study in Sweden concludes that for many refugee children, the circumstances in the host country were of equal or greater importance than previous exposure to organised violence in the country of origin or experiences during the flight.
Diseases and conditions

With respect to infectious diseases, studies in the Netherlands and other Western host countries report higher prevalence rates for infectious diseases in subgroups of asylum seekers and refugees compared with the host population (for TB, hepatitis B, HIV and intestinal parasites, amongst others).\textsuperscript{16,31-36} TB prevalence among asylum seekers at entry to the Netherlands was 222 per 100,000 asylum seekers in the years 1994-1997, while TB incidence in the general population was lower than 10 per 100,000.\textsuperscript{31} In 1992, the percentage of hepatitis B carriers among asylum seekers was reported to be 11\% to 16\% compared with 0.2 to 2 \% in the general population.\textsuperscript{37} In a cause-of-death study among asylum seekers in the Netherlands in 1998-1999, infectious disease mortality was four times higher among male asylum seekers and eight times higher among female asylum seekers compared with the general population.\textsuperscript{19}

With respect to noncommunicable diseases, only a few studies among asylum seekers and refugees were published before 2009. Primary-care-based studies show that low back pain, other musculoskeletal conditions, dermatological problems and anaemia are common health problems among asylum seekers and refugees.\textsuperscript{16,34,38,39} However, the study populations of the available studies are too small to give insight into the prevalence of specific health problems such as diabetes and cardiovascular diseases. For the same reason, few studies provide data that have been disaggregated by country or region of origin.\textsuperscript{34,38,39}

Only a few studies were found that report on somatic health problems in asylum-seeking and refugee children. In a study in Denmark the most frequently reported physical health problems were dental problems, skin problems and enuresis.\textsuperscript{40} Studies in the Netherlands and the USA show high rates of growth and nutritional disorders, such as caries, iron deficiency, stunting, and obesity.\textsuperscript{41-44}

Sexual and reproductive health

Already before 2009, sexual and reproductive health was recognized as an important aspect of the health of refugees.\textsuperscript{45,46} War-affected populations are considered to be disproportionately at risk for sexually transmitted infections including HIV, sexual and gender-based violence, female genital mutilation, and unmet contraceptive needs.\textsuperscript{45-48} However, to our knowledge, no epidemiological data on the reproductive health status of asylum seekers and refugees in Western host countries had been published before 2009.\textsuperscript{49}
The need for more information

The epidemiological data available before 2009 show the vulnerability of asylum seekers and refugees in Western host countries with respect to various health aspects. However, the available evidence was scarce, and while it was clear that asylum seekers and refugees are not a homogeneous group with respect to their health problems and needs, there was scarcely any disaggregated data available. To inform policies and practices, more information was needed with respect to:

- Which diseases and conditions are more prevalent among asylum seekers and refugees compared with the general population in the Netherlands?
- Which subgroups of asylum seekers and refugees are particularly at risk of certain diseases or conditions?
- What are the specific risk factors for the health of asylum seekers and refugees?

The topics for the studies in this thesis were chosen so as to address each of these three questions. Moreover, we took into account the information needs expressed by policymakers as well as research topics suggested by health professionals.

1.3 AIMS OF THIS THESIS

The main aim of this thesis is to describe the distribution of diseases and conditions among asylum seekers in the Netherlands and to analyse a number of risk factors that affect their health. Based on this knowledge and the scientific literature, we will explore the implications for policies and practices aimed at the promotion of the health of asylum seekers and refugees.

The studies in this thesis are presented in two chapters. Chapter 2 contains five studies that aim to analyse for which diseases and conditions asylum seekers are at increased risk compared with the general population in the Netherlands and whether risk differences exist within the asylum-seeking population. The first study addresses mortality and causes of death, the second suicide and suicidal behaviour, and the third, diabetes. The last two studies in this chapter address two topics with respect to the sexual and reproductive health of asylum-seeking women: induced abortions and teenage pregnancies, and HIV prevalence among pregnant asylum seekers.

Chapter 3 contains three studies aimed at gaining insight into risk factors for the health of asylum seekers. The first study in this chapter analyses whether relocations between asylum-seeker centres are associated with mental distress in asylum-seeking children.
The second study analyses whether maternal violence exposure and maternal mental health problems are associated with the risk of newly diagnosed physical child abuse. The last study explores the association between PTSD and the prevalence of diabetes.

1.4 DATA SOURCES

The studies in this thesis are based on two data sources, both of which are based on data from the MOA.

The first data source consists of the notification forms that were filled out nationwide by health professionals of the MOA. Under a national protocol, public health doctors and nurses of the MOA were instructed to complete a standard form for every case of death (general death notification form) and suicidal behaviour. The health professionals submitted the forms to their regional managers, who sent the forms to GGD Nederland. For the study on induced abortions and teenage pregnancies, a temporary notification form was used. The COA provided the denominator data for these studies.

The second data source is an electronic database that contains medical data from the MOA and family physicians as well as demographic data from the COA. This database, which is referred to as ‘the MOA database’ contains data on all asylum seekers in the Netherlands between 2000 and 2008.

Nationwide the health professionals of the MOA and the family physicians recorded health and psychosocial data (based on their findings during preventive and curative consultations) in paper medical records. They used the ‘problem-oriented records’ (POR) method. Main and chronic health problems were recorded on the problem list along with the International Classification of Primary Care (ICPC) code, date of diagnosis, and a short open field description. Health professionals from the MOA entered the problem list data into a dedicated medical section of the COA’s electronic information system. After the implementation of changes to the health system in 2009, the electronic medical data and the relevant demographic and reception data for the years 2000-2008 were transferred into the MOA database with the aim of using them in epidemiological studies.

The reference data that have been used for comparison with the population of the Netherlands differ between studies; details are described in Chapters 2 and 3.

Table 1.1.1 shows for each study the data source(s) used, the study population, the outcome variables, and the risk factors that were studied.
### Table 1.1.1 Overview of the studies in this thesis

<table>
<thead>
<tr>
<th>Section</th>
<th>Theme and study title</th>
<th>Data source</th>
<th>Population</th>
<th>Outcome variable</th>
<th>Asylum-specific variables</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Chapter 2. Diseases and conditions</strong></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>2.1</td>
<td>Mortality and causes of death among asylum seekers in the Netherlands</td>
<td>Notifications</td>
<td>222,217 person years, all ages, 2002-2005</td>
<td>– Mortality</td>
<td>– Causes of death</td>
</tr>
<tr>
<td>2.2</td>
<td>Suicide death and hospital-treated suicidal behaviour in asylum seekers in the Netherlands</td>
<td>Notifications</td>
<td>179,942 person years, age group &gt;= 15 years, 2002-2007</td>
<td>– Suicide</td>
<td>– Suicidal behaviour</td>
</tr>
<tr>
<td>2.3</td>
<td>High diabetes risk among asylum seekers in the Netherlands</td>
<td>MOA database</td>
<td>59,380 persons, age group 20 – 79 years, 2000-2008</td>
<td>– Diabetes</td>
<td>– Length of stay</td>
</tr>
<tr>
<td>2.4</td>
<td>Induced abortions and teenage births among asylum seekers in The Netherlands</td>
<td>Notifications &amp; MOA database</td>
<td>9,218 women, age group 15 – 49 years, 2004-2005</td>
<td>– Induces abortions</td>
<td>– Teenage pregnancies</td>
</tr>
<tr>
<td>2.5</td>
<td>HIV prevalence among pregnant asylum seekers in the Netherlands</td>
<td>MOA database</td>
<td>4,854 women who delivered in reception, 2000-2008</td>
<td>– HIV</td>
<td>– Length of stay</td>
</tr>
<tr>
<td><strong>Chapter 3. Risk factors for the health of asylum seekers</strong></td>
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</tr>
<tr>
<td>3.1</td>
<td>Frequent relocations between asylum-seeker centres are associated with mental distress in asylum-seeking children</td>
<td>MOA database</td>
<td>8,047 children, age group 4 – 18 years, 2000-2008</td>
<td>– Mental distress</td>
<td>– Relocations</td>
</tr>
<tr>
<td>3.2</td>
<td>Increased risk of physical child abuse in asylum-seeking families in which the mother suffers from mental health problems</td>
<td>MOA database</td>
<td>17,780 children, age group 0 – 18 years, 2000-2008</td>
<td>– Physical child abuse</td>
<td>– Maternal PTSD and depression</td>
</tr>
<tr>
<td>3.3</td>
<td>Relationship between PTSD and diabetes among 105,180 asylum seekers in the Netherlands</td>
<td>MOA database</td>
<td>105,180 persons, age group &gt;= 18 years, 1998-2008</td>
<td>– Diabetes</td>
<td>– PTSD</td>
</tr>
</tbody>
</table>

*Database of the Community Health Services for Asylum Seekers (MOA).*

In line with Dutch legislation, the privacy statement of the MOA included a statement on the anonymous use of data for epidemiological purposes. Because only data collected for health care purposes were used, the medical ethics review committee of the Academic Medical Center at the University of Amsterdam stated that the approval of the
medical ethics review committee was not required for the studies based on the MOA database (letter W12-276#12.17.0315).
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