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World Medical Journal

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Official Journal of The World Medical Association

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Doctor in the World and Medicines

In the modern world, pharmaceutical business is an honorary second runner-up among the most profiteering businesses, right after trafficking in humans and in drugs. With the recent shipping of refugees to Europe, the winner and the first runner-up have merged into one. The pharmaceutical business mostly is a quite legal, transparent and straight one, except for counterfeit medicines which take up 10–15% of the market. For a medical doctor, global information available in 2015 is interesting due to the following patterns:
(I) clinical research is becoming increasingly costly, new drugs are getting discovered less, generics are taking up higher proportion and even prevail in the market. Countries and regions happen to overlook the letter and spirit of the Helsinki Declaration, particularly in respect of the work of the Ethics Committees;
(II) the pharmaceutical industry is losing interest in small-size markets, production costs are increasing due to quality control requirements, whereas compensation systems in the countries fail to evolve together with the changing market. The pharmaceutical business is facing new challenges, which are shortages of production capacities and limited availability of raw materials;
(III) the accessibility of medicines and counterfeit drugs is becoming a global problem as a result of internet pharmacies chains, re-export with the purpose of price arbitrage and parallel import;
(IV) refugee crisis in Europe (also the flows of refugees in Asia, Australia, the Republic of South Africa and some countries in Latin America) involve uncertainties about the immigrants' state of health, infectious and parasitic diseases, vaccination against dangerous diseases, e.g. poliomyelitis. With some countries failing financially (e.g. Greece is unable to settle its payments for the delivered medicines for quite a while), selected segments of the drugs market start panicking, and a tendency emerges to stock up some medicines, instead of placing them on the market;
(V) there is not enough research as to the dosages for senior patients and children: it is still believed that patients, though dissimilar as to age, gender or physical capacities, should get prescribed medicines in equal dosages;
(VI) most of clinical trials are shifted to developing countries, which leads to a mistrust in the trial results in developed countries;
(VII) resistance to drugs is increasing, and not exclusively to antibiotics. The body cells tend to develop biochemical dependency on medicines, and dosages need to be raised;
(VIII) polypragmasia as a medical problem in industrial and developed economies. Both in Europe and America, the population in the age group beyond 50 are taking more than six different drugs daily, plus a number of food supplements and over-the-counter medicines. For the time being, no proper research has been done, and there is a lack of understanding how much food supplements and other chemically active substances are being consumed along with medicines (e.g. illegal psychoactive substances, sports drinks and powders etc.). Advertising promotes unreasonable consumption of medicines and food supplements, especially among senior citizens;
(IX) biomedicines – medicines of the future – and their biological equals appear in the market without adequate knowledge and understanding on the part of doctors and pharmacists, they are scarcely used due to the high price;
(X) medicines launched to the market at an early stage and having heightened vigilance, which have been subject to less trials and who may have more side effects, especially when taken with other medicines. Individualised medicines are being released to the market as well;
(XI) non-cooperating patients. 25–40% of patients are non-cooperating when receiving treatment: they are neither willing nor motivated to get well again. 10–20% of population prefer to be treated by charlatans, healers and witchdoctors, or by psychologists or psychotherapists without any medical education etc.. Alongside with the drugs prescribed by the doctor, nature therapy, Ayurveda medicines and other chemically active substances are used;
(XII) medicines are continuously being discarded in open environment and may end up into food; in most cases the non-used medicines still do not get destroyed.

This list could be compiled in a different order and complemented with other items. In global medicine, the influence of the pharmaceutical industry is increasing, people are ageing, funds from governments or insurance are not sufficient to pay for medicines.

The World Medical Association has to analyse the developments in the medicines market all over again.

Dr. Pēteris Apinis
President of the Latvian Medical Association

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Interview with Dr. Xavier Deau, President of the World Medical Association

By Dr. Peteris Apinis. September, 2015

Xavier Deau

Q. Global warming and emission gases are among the world's most essential public health problems. What initiatives can we expect from the WMA for the forthcoming Paris conference as to fighting global warming?

The WMA will be present in Paris at the COP21, channelling the serious concerns of physicians regarding the impact of climate change on health. The health of the planet is our health. This is the message that I would like to bring forward. The WMA has joined the Campaign "Our Climate, Our Health". It is a new campaign created to mobilise the health profession in the lead up to the 2015 climate change negotiations in Paris. The Campaign is led by the World Health Organization in collaboration with the Global Climate and Health Alliance. It aims to reach out to all parts of the health sector, communicating the links between health and climate change, demanding a stronger international deal, and building support around a common declaration – to be presented to negotiators in Paris this December. We will participate in the Climate and Health Summit which is scheduled to take place on the 5th of December in Paris in the framework of this Campaign.

Q. Clean air, clean water and harmless food are the most important health preconditions for global population. Right now, when the global oceans and seas are being polluted with plastics and chemical products, it has an impact on each single inhabitant on the Earth. We can even call the polluting of the world with chemicals a chemical war. What could the WMA do in order to reduce the global pollution with chemicals? Shouldn't the WMA take a more radical position against the use of heavy metals (mercury, bismuth), against pesticides, herbicides, mineral substances and other substances which inhibit the development of hormonal system?

The WMA's policies in the area of environment have been developing over the last years with the expertise of its members. We have a clear position on climate change, mercury products, chemicals, and more recently on air pollution. We have also set up the environment caucus to promote exchange of good practices and experiences between the members. We could certainly work further on our policies. But most important, the challenge now is to make sure that our voice is finally heard, that strong commitments and actions are finally taken by decision-makers. This is a matter of urgency. Our planet is ill and we are all accountable. Mobilisation of all is what is needed today.

Q. Shouldn't the WMA develop its own strategy for fighting global warming and use a variety of instruments, such as strong criticism of global polluters, or create a WMA award in recognition of the most successful pollution treatment and ecological projects?

The WMA has been increasingly active in the area of climate change nationally and globally through various means: the UN process, the promotion of regular platforms for discussion between NMAs and also through partnerships with the WHO and non-governmental organisations, active in the area of health and environment. I do not believe that another award will bring significant changes. Today we need concrete actions nationally and locally, we need to raise awareness amongst the health professionals, the public, the decision-makers. I nourish great hopes that the young generation will continue carrying that torch. As a matter of fact, the Junior Doctors Network is extremely active in putting health at the centre of the climate negotiations, and I am proud that the WMA embraces this new generation of physicians.

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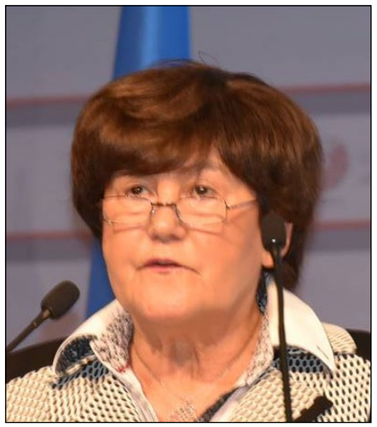
Interview with Dr. Zsuzsanna Jakab, WHO Regional Director for Europe

By Dr. Peteris Apinis. September, 2015



Zsuzsanna Jakab

"Better Health for Europe: More Equitable and Sustainable – That is What We Work for"

Q. The WHO Regional Office is a European leader in public health area. Could you please update us on the progresses, concerns and main goals of the Region?

During the past few years, the WHO European Region made good progress in many areas, but we must do more and we must do better.

On key health indicators, such as life expectancy, Europeans are living longer and the differences between countries in health outcomes are shrinking: a clear sign that inequalities are declining and Health 2020 – the WHO European policy framework developed and adopted by all our 53 Member States – works. However, the gap between the countries with the highest and lowest life expectancy is still 11 years.

The Region is on track towards reducing premature mortality due to decline in cardio-vascular diseases (CVDs), and Europeans are reducing their health risk behaviours. But people in Europe still smoke and drink more than anywhere else in the world, and are among the most obese.

We are making progress in improving women's health, but wide inequities between and within countries remain. The use of modern, effective methods of contraception is alarmingly low in many countries. Some countries have the highest abortion rates in the world. Effective perinatal care resulted in the decrease in the major killer of mothers – the severe obstetrical bleeding. Now is the time to focus on pre-existing medical conditions – such as diabetes, obesity, CVD and mental diseases – that are exacerbated by pregnancy. More needs to be done on sexual and reproductive health and rights.

Transforming health services to match the needs of the 21st century is the strategic priority in our Region. Coordinated, integrated health-service delivery towards people-centred care is the way forward. The Region is scaling up efforts on strengthening health systems and public health capacity in order to improve health outcomes in an equitable manner, ensuring financial protection, responsiveness and efficiency.

We are addressing health-systems barriers for specific diseases and conditions, including communicable diseases and NCDs, which are then translated into policy decisions and actions. We are now broadening the focus to include environmentally sustainable health systems.

An extensive area of work in the Region relates to tackling public health emergencies and crisis situations. Our aim is to ensure that our Member States are adequately prepared to effectively detect and respond, whenever and wherever an emergency with health consequences strikes. The recent Ebola outbreak in West Africa demonstrated that the international community is not sufficiently prepared to manage major health hazards. This is a defining moment for change. We are fully committed to taking all necessary action. This is a global objective. In the Regional Office, we take an integrated, generic, all-hazards and multisectoral approach to preparedness for both humanitarian and public health emergencies.

Let me stress: real improvements in health, including the areas I just outlined, can be achieved if we work across government. All sectors, especially with those responsible for social and fiscal policies, need to work in partnership for better health for all.

Intersectoral action for health requires political commitment. It should focus on key public health priorities and upstream interventions by addressing the determinants of health and health equity, and strive for maximum impact by creating win–win partnerships.

Development is impossible without better health. Health is a precondition for alleviating poverty, and an indicator and outcome of progress towards a sustainable society.

More decision-makers are making coherent and interconnected government policies, with a strong intersectoral component, and using Health 2020 as the way forward. From 2010 to 2013, the proportion of countries with national health policies aligned with Health 2020 almost doubled: from 38% to 70%. And this is a great achievement so far. This progress demonstrates what we can do if we are committed and work together, but it also shows that we have many challenges ahead, confirming that the key strategic directions of Health 2020 remain more relevant than ever before.

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Only the governments that put health and well-being high on their social, economic and development agenda will be able to overcome these challenges. Health is a political choice. In essence, Health 2020 supports making the right political choices for health. Our key role is to protect health as a universal value and to promote it as a social and political goal for government and society as a whole.

The economic case for investment in health is strong. Investing in health generates cost-effective health outcomes and economic, social and environmental benefits. The health sector's call on government to invest in health will make this change happen. We need to give this message loudly.

For example, current evidence suggests that investment in reproductive, maternal and child health has a potential return of more than US$ 20 for every dollar spent. The argument for investing in the best-buy interventions is equally clear for addressing noncommunicable diseases (NCDs).

Current investments in health and public health are not sufficient. We need to invest more. It is alarming to see that, between 2007 and 2011, the health share of public spending fell in 24 countries in Europe. By tapping into new sources, improving efficiencies and giving high priority to health, all countries can find ways to raise sufficient funds for health.

Also, many countries are applying the life-course approach in developing their national policies or improving collaboration between sectors, which is a key strategic direction of Health 2020.

On 25 September, world leaders gathered at the United Nations summit to adopt the Agenda for Sustainable Development, to end poverty by 2030. The Agenda has universal goals that will apply to every nation – not just to developing countries. Among the 17 Sustainable Development Goals, the one for health is central. It aims to "ensure healthy lives and promote well-being for all at all ages". There is increasing acceptance that the new health goal must also aim to achieve universal health coverage in every community, in every country of the world.

The formulation of the health goal is fully aligned with Health 2020.

Focusing solely on the health goal would be a missed opportunity. All the Sustainable Development Goals will influence health, because they all address the determinants of health. The 2030 Agenda will link different dimensions of development – including health – to the environment, to prosperity and to all actions and policies that people need.

Now we have a historic political responsibility to pursue the integration of health and well-being into each and every goal. We have the opportunity to put into practice the whole-of-government and whole-of-society approaches to which we subscribed through Health 2020.

Better health for Europe: more equitable and sustainable – that is what we work for.

Q. At present, there is an opposition to vaccination in Latvia. The situation is pretty similar in other European countries. What can the WHO Regional Office do in order to promote immunization?

Vaccination is one of the most cost-effective health interventions available, saving millions of people from illness, disability and death each year. Vaccines protect against more than 20 serious diseases.

Although the WHO European Region has made good progress in protecting more people, vaccine-preventable diseases still challenge Europe's public health and continue to burden our Member States. The loss of a child from diphtheria, the deaths of children from measles complications, alongside thousands of cases of measles, represent solemn reminders of unfinished business. Accepting the status quo is not an option.

Our goal is to reach and maintain high levels of immunization, particularly in vulnerable groups, at the appropriate ages and recommended doses. To achieve this goal, WHO/Europe works with Member States, international organizations and bilateral agencies to help countries strengthen their programmes for the control of infectious diseases. Current major initiatives include: supporting communication capacity of national immunization programmes; introducing new and underused vaccines; eliminating measles and rubella and maintaining the poliomyelitis-free status of the European Region.

In adopting the European Vaccine Action Plan, our Member States committed themselves to eliminating measles and rubella by 2015.

While many countries are on track to do this by the end of this year, the regional goal continues to elude us, owing to the lack of steadfast political commitment in some countries. We need public health leaders to stand by your commitments to eliminate measles and rubella.

There is no stronger reminder of the need for vigilance than the return of polio. The report of two cases in Ukraine, in August this year, is alarming, particularly given the large pockets of susceptible populations who could be exposed to this crippling, deadly disease. It is imperative that Ukraine and all European countries continue to mitigate the risks posed by polio by maintaining high immunization coverage and surveillance.

In the 21st century, every child has the right to live free from vaccine-preventable diseases. Strengthening immunization is vital.

WHO/Europe leads and coordinates European Immunization Week (EIW). Since its establishment 10 years ago, EIW has served as a flexible platform for Member States in the European Region to mobilize support for immunization. From its humble beginning in 2005 with eight pilot countries, EIW expanded each year to become a truly Region-wide campaign encompassing all 53 Member States. Together with Immunization Week in the Americas, EIW was a forerunner of World Immunization Week, established in 2012.

Regional and national partners, including the United Nations Children's Fund (UNICEF) and the European Centre for Disease Prevention and Control (ECDC), support implementation. EIW also benefits from high-level support at the national level, including ministers, ambassadors, first ladies and other distinguished supporters. At the regional level, the initiative has the support of Her Royal Highness Crown Princess of Denmark, who is WHO/Europe's patron. In April this year, we celebrated the tenth anniversary of the EIW initiative throughout the Region.

There is still a lot to be done in this area – our vision is a European Region free of vaccine-preventable diseases. We need Latvia's full support and commitment in reaching this goal.

Q. In the past two years, Latvia has made good progress in adopting a range of tobacco control regulatory legal acts. In Latvia smoking is absolutely prohibited in public facilities, premises of central and local government institutions, work places, and elsewhere where it can harm other people's health. How would you evaluate our achievement and how could we attain this in entire Europe?

You are right: Latvia is doing well in tobacco control. The country ratified the WHO FCTC in 2005 and took a number of legally binding obligations in tobacco control, from smoke-free public places, high taxes on tobacco products, banning tobacco advertising to eliminating illicit trade in tobacco products. Latvia is among only 33 countries in the world that have sufficiently high tax rates on tobacco, which are among the most effective tools in reducing consumption.

However, a lot more needs to be done. Although the smoking among the adult population has gone down in recent years, 30% of Latvian adults smoke and this is slightly higher than in the WHO European Region in average (28%). Over 17% of female and 45% of male adult population smokes in Latvia.

More needs to be done in stopping young people to become addicted to tobacco and start the use of tobacco at an early age. Data on the current situation is grim: 70% of the boys in Latvia initiated smoking at the age of 15 years or younger (in comparison, in UK and Ireland, it is around 30%); up to 72% of the girls in Latvia started smoking at the age of 15 years or younger (in comparison, in UK and Ireland, it is around 40%).

The Region as a whole is striving towards making tobacco a thing of the past. Last week, WHO Regional Committee for Europe – Region's governing body – adopted a roadmap for tobacco control, setting an ambitious goal of full implementation of the FCTC and the voluntary global target to reduce tobacco use by 30% by 2025. We are grateful to Latvia for its support in adopting this roadmap and count on its support in its implementation in the coming years.

Tobacco smoking among adults continues to decline in the Region. Nevertheless, we remain the region with the highest overall rate of adult smoking.

In the year 2000, 250 million adult people in Europe smoked, in 2015, 200 million and it is projected that in 10 years' time, in 2025, 180 million will continue to smoke. As of 2015, Europe has the highest number of its people smoking, 28%, in the world. Globally, being born male has been the highest predictor of smoking. However, European women are smoking alarmingly more than any other women around the globe.

19% of European adult women smoke and this number will continue to rise in the coming years while smoking among men is stabilizing or going down. As a consequence of women smoking like men in some countries, the breast cancer is not any more the biggest killer but the lung cancer is. The change in the rates of incidence and mortality for lung cancer can be attributed to smoking prevalence amongst females.

As a result of high levels of smoking, 16% of Europeans die as a result of a tobacco related disease while the global average is lower, 12%.

Against this background, it is clear that Europe could and should do more to save health and life of Europeans. We know what works; we have an international health treaty – the WHO Framework Convention on Tobacco Control (FCTC), which is celebrating a decade of action. At present, 50 countries out of 53 in the WHO European Region have taken the political commitment by ratifying this Treaty but the actual implementation should be scaled up. Since last year, four additional countries in our Region have become parties to the Protocol to Eliminate Illicit Trade in Tobacco Products. This is a great achievement and we call on others to join.

Several countries in Europe are already moving towards becoming tobacco-free: such as Ireland by 2025, Finland by 2040, UK Scotland by 2034. Tobacco free country is defined by less than 5% of adult population smokes. I am proud that our countries are taking global leadership in plain packaging for tobacco products.

The generation growing up now cannot comprehend that people used to smoke on airplanes, buses, in restaurants or in offices. The achievements of the past 20 years show that the dream of a Europe where tobacco control has succeeded is not unrealistic. The gains will be huge if tobacco control succeeds, but there is hard work ahead. Governments must fully implement the measures in the WHO Framework Convention on Tobacco Control and work toward the implementation of a common goal: a Europe where tobacco is not a social norm.

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Interview with Dr. Jacques de Haller, Vice President, President Elect 2016–2018 (Switzerland) of CPME

By Dr. Peteris Apinis. September, 2015

Jacques de Haller

Q. Right now, there is quite an opposition to vaccination in Latvia. The situation is pretty similar in other European countries. There are excellent lecturers, nice-looking books and YouTube files discouraging people from vaccination and explaining about the dangers of vaccination. What could the European physician do in order to present the information on the need of immunization in an equally attractive manner from the visual and informative aspect?

You are addressing a real problem indeed. In our European countries, many seem to have forgotten how life and death was before vaccination and, disregarding the immense progress medicine has brought to all of us, and particularly to our children, they show something like a "spoiled child" attitude towards vaccination.

I don't think that this is only a question of nice booklets and lively internet pages – the WHO for instance has produced an abundance of both, and although it does offer an important support, it is obviously not enough of what is needed. I think that the question relates much more to culture and societal trends: as a reaction to the difficulties of our industrial world and to the threats on health and the environment, people see nature, "natural" medicines and the rejection of "chemistry" as the way to a "safer health".

So what we have to do, as Doctors, and that's something I see as an ethical obligation for Doctors, is to convince, convince and convince, without losing any opportunity to discuss this with the patients, with all the parents we see at our consultation. We don't have the right to give up!

Q. Maybe it is the time to have a single immunization calendar in Europe? This issue is becoming more and more topical due to the increasing labour mobility in Europe. Children are moving along with their parents. For example, a child is born in Latvia, three months later it is taken to his or her father to Ireland, and a year later the parents come to Brussels to work there. Each single country in Europe has its own vaccination calendar, which is the reason why many children do not get adequate vaccination and immunization. To start with, perhaps we could declare as mandatory such vaccinations as against diphtheria, poliomyelitis, tetanus and some more and these to be administered according to strictly defined time schedule all across Europe, whereas the rest (rotavirus, German measles, pneumococci) could be left at the national level?

I understand the idea behind your question very well, but I am not sure I completely share your point of view.

We live in a time when the European Union is a concept questioned by quite a few people in all our countries, and it's obviously not a good time to go for mandatory uniformity; I'd suggest to concentrate on the results – request a good immunisation coverage of the children at the end of school, for instance, and leave the "how", the decisions on the means to achieve this goal, in the hands of the Member States.

Q. Isn't it high time that we have a mandatory requirement to vaccinate all immigrants from third countries, because their earlier vaccination is unreliable? We are aware that many countries in Africa are short of vaccines, and people often have fake vaccination documents.

I definitely think that it is an absolute necessity, and in fact a question of ethics and dignity for all our European countries, to offer proper healthcare to the refugees and immigrants now arriving in Europe.

I don't think though that we should make any treatment mandatory in medicine, except in very critical situations of health emergencies, like epidemics for instance. In all other circumstances, medical treatment (and vaccination is one!) should be done with the consent of the patient: patients, irrespective of their situation at the given moment, are partners of the health professionals for their own health!

Q. In Latvia, we conducted a survey among medical doctors about vaccination. The question we asked was: do you immunize and are you active in prescribing immunization against the flu for infants, pregnant women, patients with immunodeficiency, and the answer was "yes". Another question was: have you immunized your own grandchildren, your daughter or daughter-in-law who is expecting, in most cases the answer was "no". Still another question to doctors was: have you immunized yourself against the flu, and the answers were evasive – "a couple of times", "once". The trust in vaccination programmes has decreased in the doctors' community. What can be done to recover the prestige of vaccination among medical professionals?

This is a terribly difficult question! We have the same situation in Switzerland, and not only for immunization: some surgical procedures show the same pattern, for instance.

I find it very positive that Doctors are in close contact with society, share its concerns, and are not isolated in an ivory tower, but at the same time Doctors should definitely remain in close contact with the academic world (permanent medical education is the point, here!), and be more willing and able to believe in what they learned. "Do what I say and not what I do" is not an option for us, Doctors!

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From Zoonosis to Pandemic

A.D.M.E. Osterhaus

The human-animal interface has developed from ancient times till today into an arena with a complex pattern of interactions, strongly affected by the constantly evolving impact that humans have on their local and global environments. Consequently, many human pathogens have evolved in the Neolithic revolution by crossing the animal-human species barrier and subsequent adaptation to the newly invaded species. These include mumps virus (of the Paramyxoviridae family), smallpox virus, Corynebacterium diphtheriae, and Bordetella pertussis [1]. The respective animal hosts of origin of these pathogens, being domesticated, commensal, or wild, have largely remained elusive. While the phylogenetically closest species of measles virus and smallpox virus are rinderpest virus (infecting cattle), and camelpox or gerbilpox viruses, respectively, it is unknown whether these animal host species were sources or recipients of these human pathogens. A recent pandemic infectious disease outbreak fuelled by a complex mix of predisposing factors in our modern society was caused by the emergence of HIV/AIDS in Africa some 30 years ago. Today, the virus claims more than one million lives each year, with more than 20 million deadly victims in total since its emergence.

Fortunately, the ever-increasing range of infectious diseases is largely paralleled by the implementation of an almost equally complex mix of intervention strategies. The latter includes the coordinated and timely use of the achievements of medical, molecular, mathematical, social, and other sciences. In the past decade, this has resulted in the timely identification of the SARS coronavirus, allowing concerted public health efforts to successfully control the emerging epidemic before the newly introduced pathogen could cause a full blown pandemic. Although this will prove much more difficult for more transmissible pathogens, as was the case for the latest influenza pandemic of 2009, the SARS episode is unique in our recorded history.

Among other most successful achievements of modern medicine is the eradication of two long-time plagues: smallpox and rinderpest that have devastated human and animal populations for many centuries. In both cases, a combination of well coordinated mass vaccination campaigns, intensive surveillance, and case containment, successfully brought these pathogens to extinction, with last identified cases in 1977 and 2001, respectively [2]. Stimulated by these successes, concerted public health efforts for the eradication of measles and polio are currently ongoing, which in principle should be considered feasible in the near future, however, with major obstacles rather being of political nature than related to technical feasibility.

Although these successful eradications may represent victories over infectious diseases, the dynamic nature of infectious pathogens, in particular due to their epidemiological and evolutionary flexibility and adaptability, call for caution. With the eradication of pathogens and the waning of immunity that had characterized animal and human populations for millennia, we are facing new challenges by creating niches for colonization by related pathogens lurking in the animal world. Monkeypox virus may be considered a looming threat at the global human-animal interface, which one day could fully adapt to more efficient human-to-human transmission and fill the niche left empty by the eradicated smallpox virus. Similar threats to animals and humans may come from

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animal morbilliviruses after the eradication of rinderpest or the future eradication of measles [3].

Unexpected virus threats continue to emerge, as is painfully demonstrated by the increasing number of human MERS coronavirus (MERS-CoV) infections, partly due to increase in nosocomial transmission, but also because of ongoing transmission from dromedary camels to humans. The most prominent mode of camel-to-human transmission is probably through human contacts with respiratory excreta although transmission via milk or urine cannot be ruled out. An important breakthrough was the identification of the receptor of the virus in humans and animals, which already proved helpful in identifying animal species susceptible to MERS-CoV infection and may further help in identifying intervention strategies. An attractive option would be to develop a vaccine for dromedary camels and tackle the problem at the source.

Our new era characterized by a real explosion of novel molecular technology leads to the discovery of an avalanche of hitherto unknown human and animal pathogens, some of which are candidates to fill newly emerging niches at the modern human–animal interface. For instance, in 2013, we examined sick harbour seals that had developed neurological signs. The seals were suffering from meningo-encephalitis of an unknown cause. After thorough examination, a novel parvovirus was discovered that resembles the human B19 parvovirus which among other manifestations has been associated with neurological disease in children. The human B19 parvovirus had also been associated with meningo-encephalitis, but it was never demonstrated before that the virus can indeed enter the brain tissue. By showing that the newly discovered seal B19-like parvovirus is indeed present in brain tissue and directly linked with neurological disease, we provide evidence that infection with this group of viruses may cause meningo-encephalitis in animals and most probably also in humans F [4].

Another group of infectious agents that continues to cross animal-human species barriers consists of influenza A viruses. In the framework of several US and EU funded projects, the minimal determinants of H5N1 transmission through air were identified: only a handful of amino acid substitutions suffice for avian H5N1 virus to become airborne in mammals, and these are associated with three traits: efficient binding to human type receptors, increased stability of the hemagglutinin, and increased polymerase activity in mammalian cells. In line with the H5N1 research, similar experiments were conducted with avian H7N9 virus, which emerged in spring 2013. This virus was found to already display certain traits of airborne H5N1. The wild type H7N9, without any experimental modifications, is indeed already airborne transmissible in ferrets, though not very efficiently [5]. It is suspected that it lacks sufficient hemagglutinin stability to be efficiently transmissible, and needs to reduce binding to avian receptors.

In conclusion, rather than investing in trying to influence the complex mix of predisposing factors of emergence at the human–animal interface, which are largely related to human behavioural issues, investment in newly emerging technologies and intervention strategies may provide us with the tools to prevent or limit disasters caused by emerging infections. This will not only allow us to win major battles, but also to limit the impact of the apparently never ending war between mankind and its relentlessly emerging microbial foes. We should do this in a multidisciplinary One Health approach. After all, emerging and re-emerging infectious diseases clearly demonstrate that human, animal and ecosystem health are inextricably linked. It is therefore good to see that new One Health initiatives are taken, and in this context I would like to highlight the newly founded One Health Platform. This international foundation brings together key opinion leaders of the One Health topic and provides them with a framework for information-sharing, cooperation and awareness raising activities.

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Health and Asylum Seekers in Europe

Authors' foreword

Truth is "the first casualty of war" [1]. Many refugees come from war zones, and there is little independent and even less empirical research into the emerging refugee situation in Europe. The authors strongly feel that available data should be presented without bias so that readers may make their own judgment.

First and foremost, the authors would like to applaud the countless volunteers including health professionals providing assistance to refugees across Europe and beyond. Many are going above and beyond the call of their professional duty to provide healthcare to refugees. The main purpose of this article is to describe the current refugee crisis. However, those providing this valuable assistance should be recognized.

Introduction

Each and every day, many individuals leave their home countries, where instability, repression, terrorism, forced labor, poverty and civil wars pose a threat to their lives and their families. Current instability in parts of the Middle East, Northern and Sub-Saharan Africa is driving the biggest movement of refugees across Europe since the Balkan wars in the 1990s [2, 3, 4].

Under the UN 1951 Convention and Protocol Relating to the Status of Refugees, a refugee is defined as an individual who "...owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion, is outside the country of his nationality, and is unable to, or owing to such fear, is unwilling to avail himself of the protection of that country" [5]. Refugee and asylum seeker are two distinct legally defined terms often used as synonyms in public and varying between jurisdictions [6]. This article focuses exclusively on health and, for this reason, will not explore this legal nuance; therefore, the terms are used synonymously unless otherwise stated.

The current crisis began in the wake of the Arab Spring when border crossings began to rise in 2011. In addition, refugees originating in both Northern and Sub-Saharan Africa who had previously migrated to Libya began to flee the unrest of the post-Qaddafi era [4]. However, numbers have increased sharply in 2015. The latest data, gathered in September 2015, indicate a total of 473,887 men, women and children have arrived in Europe by sea. Just under 40% were from Syria, fleeing the country´s civil war and the threat posed by the self-styled Islamic State (IS). In 2014, between 25-33% of those arriving by sea were from Syria [2].

Turkey has an open door policy granting "temporary protection status" to every Syrian fleeing the conflict. Currently, Turkey hosts the largest number of refugees in the world, with around 2 million people, while Lebanon has the highest quota of refugees per inhabitant [7, 8]. According to UN High Commission for Refugees (UNHCR), it is estimated that Lebanon will have more than 1.8 million refugees and asylum seekers by the end of 2015 [9]. This condition has become a severe economic challenge for these countries' economies. Approximately 260,000 refugees are located in refugee camps, while the remaining live freely in the cities [10]. The plight of children displaced by the Syrian conflict is particularly dire; Malta and Italy alone have received 10,000 separated or unaccompanied children this year [11].

Refugees and migrants typically use one of seven routes to reach Europe [7]:

- Western African
- Black Sea
- Eastern borders
- Western Mediterranean
- Central Mediterranean
- Eastern Mediterranean
- Western Balkan

In 2015, the Central Mediterranean, Eastern Mediterranean and Western Balkan route are most commonly used. Land borders within the Western Balkan region were the main entry points for refugees with the Hungarian-Serbian border being the most frequently crossed border in the region. Migrants entering Europe through this route include Western Balkan nationals and Syrians, followed by Afghans, Iraqis and Pakistanis [12]. Another highly popular route is through Turkey, over the Eastern Aegean Sea to the Greek islands. Refugees from Syria, Afghanistan, Iraq, Pakistan and Palestine, amongst others, often use this route. They may arrive in Turkey by land or ferry and continue on their way to Greece on cargo ships or inflatable boats [7]. The number of asylum seekers arriving in Greece each day typically reaches around 5000, with peaks of up to 10,000 [8].

Crossing the desert

For Sub-Saharan African nationals, the Central Mediterranean route is a primary point of entry into Europe. Little data are available describing events in the Saharan desert. The United Nations Office on Drugs and Crime (UNDOC) reports "only" 1691 confirmed deaths in the desert; however, it has been suggested that these numbers significantly underestimate the number of those killed with actual numbers at least three times higher [13].

Refugees are not only at risk due to heat stroke, thirst or starvation, but also face other dangers. According to UNDOC, many

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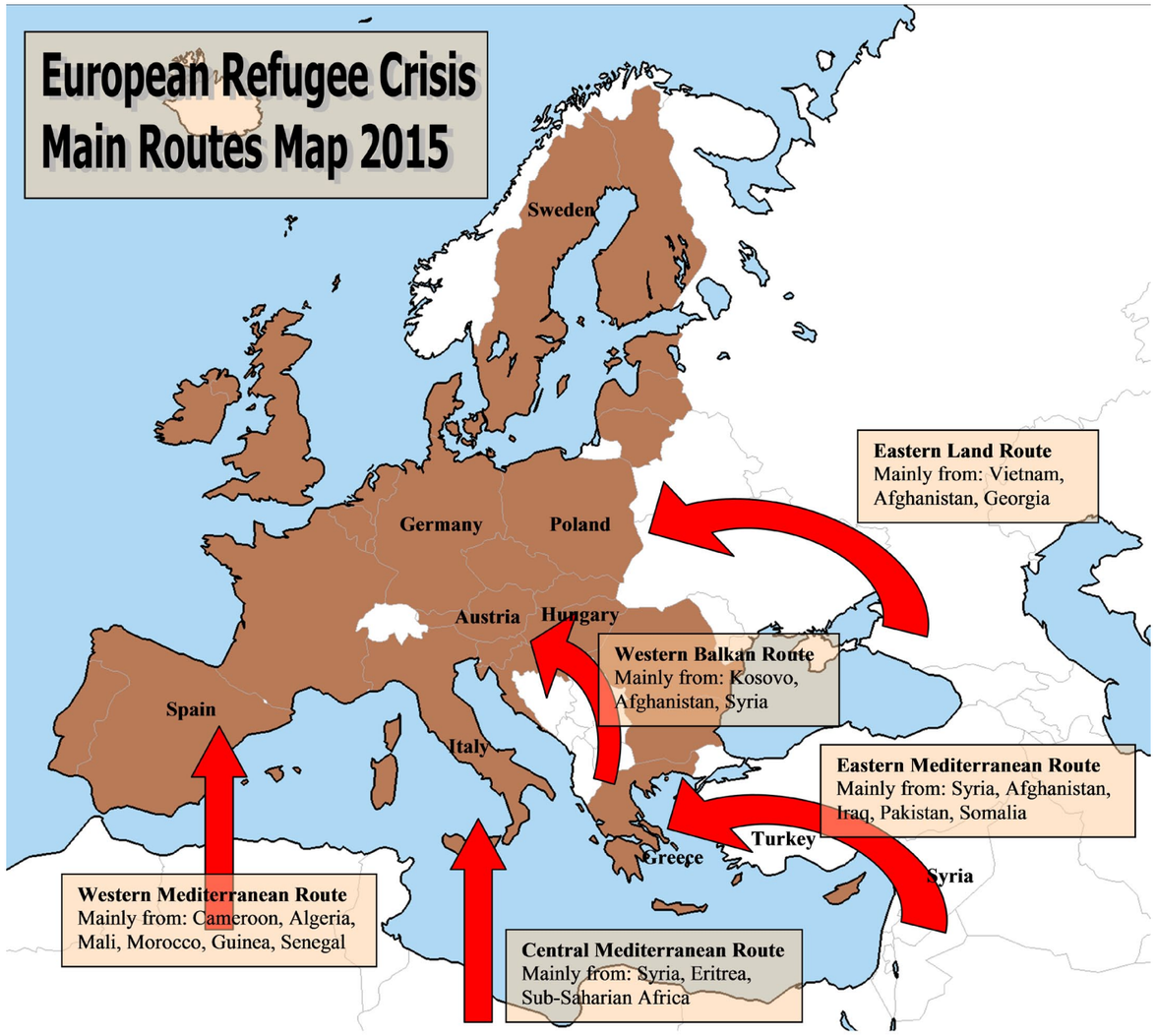
die in traffic accidents, overcrowded vehicles or by simply falling off of a vehicle and being left in the desert [13]. There are even more shocking reports of abuse, torture and other crimes against refugees. Until 2013, when the Egyptian Government reinstated the rule of law in the Sinai [14], many refugees became victims of rape, torture – or even homicide.

Physicians for Human Rights-Israel report that 59% of asylum seekers treated at their open clinic report being chained and/or locked up with 52% also reporting physical abuse [15]. A CNN crew visiting the Sinai reported that the morgue was packed with dead corpses daily [16] with refugees being abducted and tortured until their families



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paid a ransom. However, it is hard to verify this information. In a 2013 report, Reisen et al. that there have been an estimated 25,000-30,000 victims of Sinai trafficking with about 622 million USD in ransom collected [17]. While the Egyptian government's efforts have been successful in reducing these crimes, exploitation of vulnerable refugees may have simply shifted to other lawless zones.

Crossing the Mediterranean

Almost daily, powerful photos are emerging of refugees struggling to cross the Mediterranean – and in some cases, losing their lives in search of a better future. In 2015, an estimated 2,812 people have died crossing the Mediterranean Sea to date – an average of eight fatalities per day [18]. The International Organization for Migration estimates that about 75% of all refugee deaths worldwide are occurring in the Mediterranean [19].

Many human smuggling networks operate from the practically failed state of Libya, smuggling migrants mainly from Gambia, Senegal, Somalia, Syria, Eritrea, Ethiopia, Mali and Nigeria on wooden fishing boats or inflatable boats with no navigation capacities and engines which often fail. Usually a distress call is sent to the Italian authorities about 6-7 hours after departure from the Libyan coast [7].

Arriving in Europe

According to the International Organisation for Immigration, out of 430,000 refugees and migrants who have reached Western Europe since the beginning of 2015, 390,000 have passed from Greek territory. Daily, more than 4000 refugees set foot on the island of Lesbos having traveled across on small boats from the Turkish coast. Most refugees continue their journey via mainland Greece, Macedonia, Serbia and Hungary [20].

Germany and other neighboring Western European countries are the primary destinations for refugees. In absolute numbers Germany has admitted most refugees of all EU countries, resulting in multiple healthcare challenges [21].

Health of refugees

For most refugees, the journey to Europe is fraught with a multitude of health threats, although it is a common misconception that refugees themselves constitute a significant health risk [22]. In this context, it is also important to emphasize that stigmatization of refugees is never justified and only risks creating or exacerbating threats to health. Long and exhausting travel under unsafe conditions and the interruption of health care can exacerbate chronic diseases. Dangers specific to the routes and border-crossings pose health threats to young and healthy migrants as well. People spend a long time hidden in overcrowded trucks or boats. Injuries, burns and dehydration are frequently occurring health problems. Traumatizing experiences in the country of origin or on the journey, and exposure to violence and the loss of family members, increase their vulnerability to communicable and non-communicable diseases. Children, pregnant women, elderly and immunocompromised people are particularly susceptible to health threats [8].

Food insecurity among refugees also creates many additional potential health threats. Starvation and malnutrition are a reality for many refugees [23, 24]. In addition, refugees may resort to trying to obtain food wherever they can. In Germany, this has had disastrous consequences where more than thirty refugees have become seriously ill and at least one refugee has died after ingesting poisonous mushrooms. It is believed that these mushrooms were consumed because they look similar to common edible mushroom in Syria [25, 26, 27].

Infectious Diseases

Due to poor hygiene conditions in transit and in receiving facilities, diarrhea, acute respiratory infections, skin infections, scabies and head lice may occur [28, 29]. The supply of safe water and food may be limited during the journey. Unsanitary conditions can often be found at border points and in receiving facilities, with a lack of safe drinking water, shower facilities and regular removal of waste. The result can be outbreaks of food- and water-borne diseases such as salmonellosis, shigellosis, campylobacteriosis and hepatitis A [8].

Communicable diseases are often associated with poverty. An efficient health system, good housing, hygiene, vaccinations and clean water reduce the prevalence of diseases such as TB, measles, rubella, and hepatitis. They still exist in the European region, independent of migration. The influx of people from countries where infectious diseases are more prevalent can change the disease burden in Europe, although there is no proven association between migration and the importation of infectious diseases. Experience shows that if cases of exotic infections, such as the Ebola virus, occur in Europe it affects regular travelers or health care workers rather than migrants [8].

Other infectious diseases such as scabies have also emerged as a public health challenge. In Germany, Hamburg, health authorities declared a health emergency on August 21st due to an outbreak of scabies in an emergency shelter for newly arrived asylum seekers. At the time, only topical anti-scabies therapies were available within Germany (Permethrin and Benzylbenzoate) [30]. Ivermectin, an antifilarial on WHO's list of essential medicines [31] and the de facto oral therapeutic standard for scabies [32], is publicly available in France but only with indications for treatment of strongyloidiasis and elefantiasis not scabies [33]. On September 2nd, the Federal Ministry of Health declared scabies a dangerous

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communicable disease and authorized importation of Ivermectin without prior marketing approval [30].

The prevalence of HIV is low among people from the Middle East and Northern Africa [8]. Most HIV cases in migrants are found in Sub-Saharan African nationals. About 40% of HIV cases in Europe are migrants. There is also growing evidence that some migrant populations acquire HIV after arriving in Europe [34]. Antiretroviral treatment can be interrupted for refugees living with HIV with potentially devastating consequences. In some European countries, no HIV services are offered to people with uncertain legal status [34].

The majority of tuberculosis (TB) cases are detected in the native-born population in Europe, with substantial variation across European countries. People with severe cases of TB are often not fit for travel and therefore do not attempt the journey. TB is not easily transmissible and active disease occurs only in a small proportion of those infected. However, crowded and humid spaces such as those found in trucks and ships may facilitate the transmission of TB when an infected person is present [8]. The overall incidence is declining, while it is on the rise among migrants [34].

The mass influx of refugees increases the risk of the reintroduction of vector-borne diseases such as Malaria, Leishmaniasis and to the European region. Tajikistan and Turkey are at particularly high risk at the moment [8, 34, 35].

Outbreaks of measles, rubella and other vaccine-preventable diseases can occur in the migrant population and spread to unvaccinated people of the receiving country. There is still a gap in vaccination coverage in European countries due to refusal to vaccinate. In migrants' countries of origin, access to vaccinations is often considerably lower than in EU countries, creating conditions under which outbreaks may emerge. The 2015 outbreak of measles in Berlin had originated within a group of asylum seekers from Serbia and Bosnia and Herzegovina [36, 8].

In Turkey, registered refugees are provided temporary protection status and are then placed in provinces based on a national plan. However, the rapidly increasing number of refugees has made execution of this plan difficult and created new medical challenges. According to an official field survey report by AFAD in 2013, 26% of children in refugee camps and 45% of children not living in camps did not receive polio vaccination. One in three children in camps and 41% of the children out of the camps did not have measles vaccination [37]. This situation introduced the risk of polio to a country which was polio-free for more than 15 years. There has been also a rise in other infectious diseases including measles, tuberculosis and cutaneous leishmaniasis [38, 39].

Many developing countries experience a high burden of hepatitis B cases. Incidence is higher among migrants than among native populations in most European countries. Chronic infections are particularly increasing. In most cases, migrants acquired the virus in their countries of origin or from mother-to-child transmission [34].

In Lebanon, the sanitation conditions in refugee camps are very basic and a surge of diarrheal diseases has been observed in 2014 by the epidemiologic surveillance unit of the Lebanese Ministry of Public Health. Lebanon has seen an increase in the number of reported tuberculosis, hepatitis A and measles cases [40]. In addition, a vector borne disease, cutaneous leishmaniasis, which was not present in Lebanon before, has made its appearance with 476 cases in 2014, all in Syrian Refugees. There is a concern about the introduction of the sandfly vector to Lebanon, but this has not been proven with certainty yet. The community physicians have faced a major challenge in making a timely diagnosis of Leishmaniasis, a condition they had not be accustomed to evaluating and treating in the past[35]. Major education efforts for healthcare workers through tertiary care and academic medical centers in Lebanon, are undertaken to spread the knowledge about the disease.

NCDs

Noncommunicable diseases are a significant problem in the refugee population. Diabetes, cardiovascular diseases, chronic lung diseases and cancer are the most common of these. The exhausting and demanding circumstances of the journey often lead to exacerbations of chronic diseases. A common characteristic is that these conditions require regular and continuous treatment. The supply of drugs and the access to necessary procedures and care can be interrupted, resulting in poorer health outcomes including unnecessary morbidity and mortality [8, 41]. In the process of uprooting and social marginalization, migrants may lose self-esteem and feel powerless to manage chronic illness. The situation is exacerbated by linguistic barriers and a real or perceived inability to seek health care [42, 18]. For many refugees fleeing the Syrian civil war, access to non-communicable disease management and prevention may have been limited for years as the Syrian health care system has been "shattered" by the conflict with more than 75% of physicians having fled the country [43, 44]. Numerous reports have described attacks on health care facilities in clear violation of international humanitarian law [45].

Mental Health

The effect of migration on an individual is pervasive – everything in person's life changes: diet, family, culture, social relations, status, etc [46]. Migratory experience is essentially a psycho-social process of loss and change, which can be labeled as a grief process. This can be explained through a model comprising of seven griefs of losses that a person (migrant) will experience with time: "family and friends, language, culture, homeland, loss of status, loss of contact with the ethnic group, and exposure to physical risks" [46]. Reception in the intended destination country can be very important for completion of this grief process [46].

McColl et al. defined some pre-migration and post-migration adversities in the context of UK asylum applicants. Pre-migration adversities include war, imprisonment, genocide, physical or sexual violence, traumatic bereavement, lack of healthcare, etc., while post-migration adversities are the "seven Ds": discrimination, detention, dispersal, destitution, denial of the right to work, denial of healthcare, delayed decisions on asylum applications [47].

It is important to emphasize that the majority of refugees and asylum seekers do not suffer from a psychiatric condition [47]. In this context, traumatic experiences should be addressed without pathologizing normal human reactions [48].

A meta-analysis by Porter and Haslam found that, compared to non-refugees, refugees had somewhat poorer outcomes in psychopathology measures. They also found that the mental health outcomes are influenced by postdisplacement conditions, and that refugees who are living in institutional accommodation, economically restricted, internally displaced, persons who were repatriated, or whose initiating conflict was unresolved had worse outcomes. Worse outcomes were also found in more educated, older, female, persons with higher socioeconomic status and rural residence before the migration [49].

Studies suggest that two thirds of refugees experience anxiety and/or depression, and have a higher incidence of post traumatic stress disorder, panic disorder and agoraphobia, in addition to depression and anxiety [46]. Post traumatic stress disorder is the leading mental health condition among refugees and asylum seekers, probably connected to the experiences in the country of origin (persecution, conflicts, etc.) [46]. A review by Fazel et al. in 2005 found that refugees placed in Western countries were 10 times more likely to have PTSD than the general population [50]. There is also a difference between the group of migrants – for example, a Norwegian study found asylum seekers to have higher rates of PTSD than refugees [51]

In addition, asylum interviews are shown to have a stressful effect on asylum seekers, especially when the asylum seekers were already traumatized [52]. Apart from the procedural difficulties in obtaining asylum, access to healthcare also poses a major challenge for many refugees.

Undocumented migrants, or the migrants without legal status, face obstacles to receiving adequate healthcare services – particularly mental health services – in destination countries. Many times healthcare access for refugees is limited to emergencies curbing accessibility to mental health services and therefore influences the overall health of refugees.

It is important to protect and ensure adequate treatment of persons who are already suffering of a severe mental disorder. This group of refugees is particularly vulnerable and can be considered neglected in complex emergencies, such as conflicts [53].

Some countries provide mental health services to the refugees who enter their borders (e.g. temporary protection status in Turkey includes mental health services). However, resource shortages limit these services to life-threatening emergencies in many places.

Women and LGBT Health

Refugee women face higher rates of exposure to violence, sexual exploitation and abuse than men [54]. Risks increase on their journey and can be exacerbated by lack of access to emergency sexual assault treatment and obstetrical care [55]. The stress of the migratory process can also trigger or intensify intimate partner violence [56, 57].

Sexual violence, abuse, trafficking and rape by smugglers, officials, policemen and male refugees are a common experience among refugee women. Some may be forced into prostitution [58, 59, 60]. The selling of Syrian brides has become a business in Turkey. Unwanted pregnancies without access to safe abortions and venereal diseases without access to appropriate treatment may occur as a result [61, 62].

In July and August of 2015, 36160 Syrian males applied for asylum in the EU-28 only 10970 female Syrian refugees did so [63]. This is in sharp contrast to the 1:1 ratio worldwide. [64] It is reported that many families can only afford paying for one person's trip and will send young healthy males as a pilot, hoping for their female family members to be allowed to join them later [65]. However, it should not be neglected female refugees are an even more vulnerable group [66, 67].

In Germany, emergency shelters are currently so overcrowded that males and females share sleeping space in gyms, as well as toilets and showers [66]. Even though authorities were not able to confirm, German NGOs reported widespread cases of rape and forced prostitution in an emergency shelters for new arrivals in Gießen, Hesse Germany [68].

According to a report from the German Institute for Human Rights on refugees and gender-specific violence, protection through "restraining and protection orders" are available for refugees as well; however, refugees' choice of accommodations and even movement is limited by law. In many cases, only the husband claimed reasons for asylum and in that case under German law the partner's asylum will depend on continued marriage. Legally violent partners may be separated to different accommodations even against a

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violent partners wishes and women's shelters may be accessed, however, there are still many bureaucratic hurdles. In the case of violence, the Institute recommends either lifting restrictions causing vulnerability for victims or introducing fast track procedures for victims to offer them different shelters and making emergency accommodations available. It further recommends making refugee shelters safer places by ensuring lockable rooms and sanitary facilities, informing residents about their rights, setting up women's rooms, sensitizing staff, integrating NGOs and ensuring there is female as well as male security staff at shelters [69].

Pregnant women in refugee or migrant communities can have limited access to antenatal care or safe delivery facilities [70]. This can result in late diagnosis and sometimes life-threatening conditions for mothers and their babies [8].

In addition, discrimination and violence based on sexual orientation and gender identity is an unfortunate reality for refugees who identify as lesbian, gay, bisexual, transgender, queer or intersex (LGBTQI). Although data are limited, anecdotal evidence suggests these refugees face additional health threats including psychological such as "humiliation" [71].

Implications for Health Systems: Examples

European Union

According to the Fundamental rights of migrants in an irregular situation in the European Union – Comparative report from 2011, in "19 out of 27 EU Member States migrants in an irregular situation are entitled to emergency healthcare only" [72]. For example, Croatia's law on asylum (28th member state of the European Union) states that health care services for asylum seekers include emergency medical services.

Turkey

In Turkey, registered refugees are offered free primary healthcare services in public hospitals for both emergency and elective procedures. Since the beginning of the Syrian conflict, 4.383.907 outpatient visits have occurred in the temporary shelters and 4.914.920 polyclinic examinations were performed in hospitals across the country, while 389.837 of them ended up with inpatient service. 62.022 deliveries and 278.035 surgeries were performed according to official numbers [10]. This put the healthcare system of the country under extra stress, which had already limitations with the shortage of healthcare workers [73, 74].

Lebanon

Since the beginning of the Syrian conflict in 2011, Lebanon as one of the closest bordering states has witnessed a continued influx of refugees to reach about 1.5 million in official numbers provided by the UNHCR. This has propelled the country into the pole position, having the highest refugee per capita in the world (232 refugees per 1000 inhabitants). The already strained healthcare system is now stretched very thin with the healthcare needs of the refugee population [75]. The drop in vaccination rates in Syria has impacted the reemergence of infectious diseases thought to be close to eradication from Lebanon such as measles [76, 43].

Greece

Greece faces an unprecedented economic crisis that has led the country to a continuous depression since 2010. The current refugee crisis creates therefore tremendous problems in Greece, which the Greek state cannot handle by itself. As a common point of entry to Europe, lack of first reception and accommodation infrastructure in Greece may exacerbate public health issues and prove hazardous to refugee populations and local societies. It is a humanitarian need that healthcare services and infrastructure in Greece, a country at Europe's doorstep, be financially supported by European funds to ensure refugees have access to holistic care upon arrival in Europe [77].

Germany

Upon arrival, refugees receive a preliminary medical examination and are offered vaccinations according to German national recommendations. Due to this policy and the sheer number of refugees, vaccine stocks for many combination vaccines were exhausted during the summer of 2015 [78].

Refugees are distributed throughout Germany under a pre-agreed quota system [79]. Local authorities are required to provide food and shelter for refugees, sometimes with a few hours of prior notice [80]. In order to meet the need, gyms, empty school or stores and tents have been set up as makeshift shelters with only basic sanitary services available [21].

Overall, under German law, refugees are entitled to free healthcare for alleviating pain and acute disease. The only exception being pregnant women, who are entitled to the same health care standard as all publicly insured women [81]. Until recently refugees had to first go to public administration receive a written approval before having their doctors visit for acute disease covered. This has often been criticized as discriminatory, especially as public officials in charge of granting the visit had no formal medical expertise [82]. Recently most states changed statutes to issue refugees standard German health insurance cards [83]. They do not extend coverage, however, allow refugees to see doctors without prior approval and for doctors to receive reimbursement through standard health insurance processes.

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Conclusion

People travel with their health profiles, values, culture and beliefs. Health workers in Europe and beyond need to be aware of this and have the necessary knowledge to provide high quality care to refugees. Recipient countries must be prepared to be responsive in the event of a crisis, so as to deliver basic services to migrants in recognition to their basic human rights [28].

Large numbers of people moving between countries may have implications for the character and distribution of a country or region's disease burden. Acute conditions, many of them infectious disease, psychiatric illness or injuries sustained fleeing their home countries might be the most obvious. Many refugee lack access to mental healthcare and delayed treatment for mental health problems may worsen refugees' prognosis. Attention must be given to persons with pre-existing psychiatric disorder as well as other vulnerable groups.

However, host countries themselves are also important factors for refugees' health. Cultural and language barriers can in worst case cause innocent, yet deadly confusion. The basic rules of hygiene and sanitation are an important factor for today's increased life expectancy [84], ensuring these basic rules for refugees should be of immediate concern.

However, we believe that after the acute phase refugees and health care systems will adapt to each other and chronic conditions will set in. The social determinants of health have been shown to be crucial for health [85] and first and second generation immigrants face many challenges, amongst them often lower wages and less education [86]. While today's situation may seems to be a crisis, it should not be forgotten that refugees health challenges will not end when an asylum decision has been made. Like with any other human being, health is a lifelong process even setting the course for future generations. For this reason, it is critical that governments, national medical associations and health professionals ensure a sustained, timely and appropriate response to the health implications of refugee crises [87, 88]. Refugee health is public health.

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International Committee of the Red Cross activities for refugees/displaced persons in the Middle East

IRAQ, 2013-09-25
© ICRC / MOHAMMAD, Flamerz

Dohuk governorate, Qsrouk sub-district, Qsrouk transit camp. Distribution of ICRC non-food assistance to Syrian refugees. A young girl carries the thermos her family received during the distribution.

In Qasrouk kits were distributed to a total of 561 persons (99 families and 35 singles). The kits consisted of basic hygiene and household items (stove, bucket, kettle, tea pot, thermoses and tarpaulin).

IRAQ, 2015-01-16
© ICRC / ACHKAR, Nora

Iraqi Kurdistan, Penjwin. ICRC assistance operation.

On Friday 16 January, the ICRC provides emergency aid to nearly 180 displaced persons who are currently living in Penjwin, 46 km from Sulaymaniyah. Penjwin lies at an altitude of 1500 m, where meteorological conditions are harsh in winter.

A similar distribution operation took place in December 2014, when the ICRC provided supplies for 660 people. The people that the ICRC is helping have fled from Naynawa, Salah al-Din, and Diyala governorates in Iraq, and from Ayn al-Arab/Kobani.

World Medical Journal

JORDAN, 2013-10-28,
© ICRC / REVOL, Didier

Mafraq Governorate. The ICRC and the Jordan Red Crescent Society distribute debit cards to vulnerable Syrian families living in host communities.

The mechanism for the cash transfer is done through ATM cards issued by a major bank. The project will last until March 2014, with one instalment per month. The amount of cash assistance varies according to the household size. To help Syrians withstand winter, the amount will increase during the cold season. The ICRC and Palestinian RC helped around 1000 syrian families with their cash transfer programme.

As the conflict continues unabated, Syrians are fleeing their homes every day to seek refuge in Jordan. With winter approaching, the ICRC and the Jordan National Red Crescent Society are finding new ways to help them cope with increasing needs.

Many Syrians who have found refuge in Jordan depend on aid provided by local and international aid agencies. The vast majority of the refugees have been taken in by local communities in northern areas near the Syrian border. Some have not received any other kind of assistance since arriving in the country.

"Between 200 and 500 people are arriving daily. Most have endured a gruelling journey across the desert," said Nana Chukhua, ICRC delegate in Jordan. "As soon as they arrive, they urgently need water, food and shelter."

"We were forced to travel dozens of kilometres through the desert with scarcely any food or water," said Abu Yazan, a Syrian refugee from Homs. "It was cold, and we had to sleep on the ground."

The majority have left all their belongings behind and cannot meet basic needs such as food, health care, house rent, water and electricity bills. Besides distributing relief items to the refugees, the ICRC and the Jordan National Red Crescent Society launched a programme in October to provide cash assistance for 1,000 families in Mafraq governorate, northern Jordan, with the dual aim of helping them and easing the burden on local communities.

"The cash money will definitely help us cover our basic needs, mainly house rent," said Um Anwar, a 32-year-old Syrian who resides in Mafraq. "The money will also help me obtain treatment for my 13-year-old daughter," the mother of five added.

An innovative cash transfer programme: In Jordan, the vast majority of Syrian refugees live in host communities and often have problems meeting their basic needs. To help them with expenses not covered by other relief mechanisms, the ICRC and the Jordan National Red Crescent Society launched a cash assistance programme in October in Mafraq governorate, in the north of the country, which will be implemented over a period of six months.

An initial group of 1,000 families have started receiving debit cards issued by a major bank that will allow them to withdraw money directly from ATM machines. The amount of money (from USD 70 to 310) made available to each family depends on the size of the household and will be increased during winter months.

As the ICRC's Hekmat Sharabi puts it, this programme "is much more flexible than just giving them assistance that they might not consider suitable. It preserves people's dignity by giving them the opportunity to determine on their own what they are most in need of."

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JORDAN, 2013-10-29
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Ruwaishid area, assembly point in Bustana. The ICRC distributes blankets, jerrycans and hygiene items.

The ICRC has, since July 2013, equipped three asssembly points and two transit sites in the area with water tanks and drinking-water coolers, sanitation facilities and waste containers; it has also ensured temporary accommodation for refugees fleeing Syria

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World Medical Journal

JORDAN, 2013-10-30
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Growing numbers of families in search of a safe haven are embarking on a dangerous journey across Syria to border areas in eastern Jordan. Between 200 and 500 people arrive every day in this remote desert area.

Refugees, iamong them the elderly and the very young, walk long distances, mostly at night, to cross the border.

Because of the intensity of the fighting on the Syrian side, the usual entry points in eastern Jordan are now harder to reach for the refugees. The refugees are gathered by the Jordan Armed Forces, first at assembly points and then at transit sites.

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JORDAN, 2013-10-30
© ICRC / REVOL, Didier

Ruwaished area, assembly point in Bustana. ICRC trucks regularly deliver blankets, jerrycans and hygiene items to refugees fleeing Syria; twice a day, a local NGO distributes meals paid for by the ICRC.

The ICRC has, since July 2013, equipped three asssembly points and two transit sites in the area with water tanks and drinking-water coolers, sanitation facilities and waste containers; it has also ensured temporary accommodation for refugees fleeing Syria.

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World Medical Journal

LEBANON, 2013-08-05
© ICRC / SPAULL, John

Bekaa Valley, close to the Syrian border, near Bar Elias. Tal Sarhoun informal Syrian refugee settlement. Children huddle around a flimsy tent.

Several makeshift settlements of this sort host hundreds of families, especially in the Bekaa region.

The ICRC is working to help family members separated by the conflict from their loved ones to reestablish links. It has also reminded the Lebanese government of its responsibility to ensure respect for the principle of non-refoulement.

LEBANON, 2013-08-05
© ICRC / SPAULL, John

Bekaa Valley, close to the Syrian border, near Bar Elias. Tal Sarhoun informal Syrian refugee settlement.

This informal refugee settlement hosts around 500 families. Having fled their homes, taking little of their belongings with them, the refugees need essential assistance, ranging from shelter, to food, water, hygiene items and sleeping material.

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World Medical Journal

LEBANON, 2012-10-09, © ICRC / PARRISH, Paula
Tripoli. ICRC nurses visits a Syrian wounded.

SYRIA, 2012-08-24, © ICRC / GARCIA VILANOVA, Ricardo
Aleppo. A wounded man is tended to.

SYRIA, 2012-07-08, © ICRC / GARCIA VILANOVA, Ricardo
Homs governorate, Qussayr. A wounded man is tended to at a hospital.

SYRIA, 2013-04, © ICRC / CARRIN, Jeroen
Zabdani. Ambulance damaged.

SYRIA, 2012-06-22, © ICRC / GARCIA VILANOVA, Ricardo
Homs governorate, Qussayr. A doctor takes care of a child in a field hospital.

SYRIA, 2014-02, © ICRC / KAS BARSOUM, Jack
Aleppo, Internally Displaced People Centre. The black buildings, which are used by the internally displaced persons.

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SYRIA, 2013-03-18
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Between Aleppo and Manbij. An ICRC convoy on its way to deliver medical supplies to Manbij an opposition held area.

Syria: Heavy fighting in Aleppo plagues lives of hundreds of thousands

Damascus/Geneva (ICRC) - Humanitarian needs in Aleppo are enormous, according to personnel from the International Committee of the Red Cross (ICRC) who have just concluded a five-day visit to Aleppo governorate together with the Syrian Arab Red Crescent.

During the visit, they gauged the humanitarian situation and delivered much-needed medical assistance.

«There are tens of thousands of displaced people in the governorate with no income and no savings who depend on assistance to survive,» said Marianne Gasser, head of the ICRC delegation in Syria, upon her return from the governorate. «Apart from the pressing humanitarian needs, several roads, hospitals, schools, other public facilities and world heritage sites have been damaged. Essential public services such as the distribution of power and water have also been disrupted as a result of the heavy fighting that has plagued the governorate over the past nine months.»

The ICRC has been unable to return to Aleppo since July of last year because of the ongoing fierce fighting. However, the Syrian Arab Red Crescent never stopped delivering food and household essentials, with ICRC support. In addition, the ICRC ensured that potable water was available to the population. «Our trip to Aleppo is an important step forward. It is a good example of how continuous dialogue with all parties concerned yields results, and makes it possible to reach people in need, including in opposition-controlled areas,» added Ms Gasser.

Together with the Syrian Arab Red Crescent, the ICRC visited a number of different areas in the governorate, including opposition-held territory in the eastern parts of Aleppo city such as Bustan Al-Qasr and Masaken Hanano, and Manbij in Rural Aleppo. «During these visits, we assessed humanitarian needs and spoke to people suffering the effects of the violence to better understand their needs as well as the situation,» said Ms Gasser.

Working with the Syrian Arab Red Crescent and the local water boards, ICRC water engineers surveyed the effect the fighting has had on the supply of clean drinking water in the city of Aleppo and surrounding rural areas. «We are planning to go forward with a number of upgrades and to provide support that will help the Aleppo water board solve some of the problems it is facing,» said Antonio Bolinches, an ICRC water engineer who participated in the visit.

ICRC health personnel also visited the governorate and checked on a number of health-care facilities, where they provided much-needed medical supplies and drugs for chronic diseases.

The Syrian Arab Red Crescent branch in Aleppo was highly involved in the activities carried out during the visit. «These young volunteers are doing tremendous work on the ground,» said Ms Gasser. «I was moved by their dedication and commitment to helping everyone in need – irrespective of where they are.»

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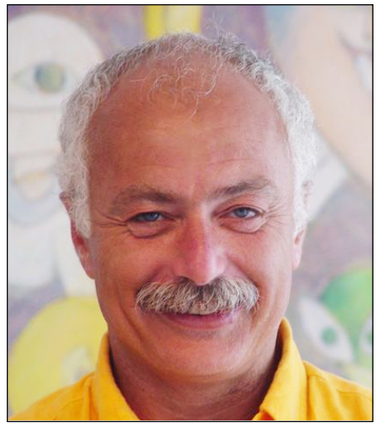
Subjectivity and Narratives in Primary Care: A Person Centered Issue



Michel Botbol

It has been extensively shown that mental health problems or symptoms are frequently brought up in the context of primary care either as the main reason to consult or as a concomitant symptom. It is at the heart of the WHO WONCA report "Integrating mental health into primary care" [1] and also extensively demonstrated by several well-designed studies more or less in line with the Alma Ata declaration on primary health care (see for example) [2,3]. Hence, it can no longer be disputed that primary care is the best setting to ensure that people get the mental health care they need, not only because "it is accessible, affordable, acceptable and cost effective" but also because while promoting "early diagnosis, respect of human rights and social integration", "primary care also helps to ensure that all people are treated in a holistic manner, addressing both their physical and mental health needs" [1]. To the point that – even if there is still a lack of evidence* – this holistic ambition is fulfilled in this perspective, many countries have tried more or less successfully to restructure their organization based on these principles including practical, rather than conceptual, adaptations to their cultural and socio economic context. In many cases their main objective is to find the most cost effective and sustainable way to diagnose a nosographic mental disorder using brief evidence based screening for such conditions [4]. In this type of adaptation "holism" is limited to the integration of a somatic and mental disorder centered appraisal of the health status without real consideration of the person as a whole including his values, expectations and subjective aspects. An apparent unanimity on benchmarked principles hides a profound heterogeneity of their definitions and, not surprisingly, a strong implicit tendency to maintain the health organizations in their usual biomedical type of approach to physical and mental health: a disorder centered approach. Various indicators, and particularly criticisms and complaints coming from users and stakeholders, show that this perspective is far from satisfactory.

* Mainly because there is a lack of criteria and metrics to evaluate these aspects

Towards a Person Centered Perspective

One of the main problems health professionals have to face when dealing with mental health or psychological issues is the fact that – maybe more than other medical disciplines – Psychiatry and Mental Health are exposed to the negative effects of a disorder centered approach. Because of the many competing theories about the very nature of one's mental life a disorder centered approach risks neglecting many of the non-objective aspects of the person's mental health, including key aspects such as subjectivity and psychodynamic dimensions. The implicit or explicit tendency is to mimic the paradigm based on the biomedical classifications in other medical disciplines.

The first stake of a person-centered perspective is to fight against this abusive reductionism that leaves us "with half a science" [5] and landmarks not well adapted to clinical practice [6]. The objective of this paper is to briefly consider and discuss the process allowing a professional to access subjective and psychodynamic dimensions of the patient's health status and consider how this process could be integrated into primary care.

In this perspective, the modernity and originality of Person Centered Medicine (PCM) resides in the fact that it does not satisfy itself with asserting its principles but strives to define conditions for effective implementation of this ambition in each medical situation. What counts the most here is to meet real patients' needs and not those of more or less paradigmatic entities defined by each medical speciality which trigger the reductionist approach imposed by the research methodology in a "classical" Evidence-Based Medicine approach.

Three conditions must be met to reach this goal [7,8]:

- To take into account the whole being of the patient (I am myself and my context) [9].
- To consider the diagnosis and therapeutic choices as a joint process involving the person of the patient, the persons of the carers (family and caregivers in general), and the person of the clinician.
- To consider as essential the subjective aspects of the person's health situation, and not only the objective aspects of the illness.

This last condition is the focus of this brief paper, starting with the idea that, in addition to the attention paid to the medico-biological aspects of the person's health status, a person centred assessment needs to give enough consideration to the patient's subjective feelings. Whether or not we suspect a psychic or psychosomatic causality to the disorder that a patient brings to us, it is essential to keep in perspective the factors involved in the patient's health situation. "Beyond reasserting this principle, we need to utterly enhance the methodology for accessing these subjective dimensions among different partners involved in the diagnostic process and the therapeutic relationship"[10]. For the professionals, the only way to access these subjective dimensions is through what the patient (and or his carers) says in words or shows in acting, as long as these words or acts can trigger in the professionals enough empathy to approach the patient's subjective feelings to which these expressions are related.

At first considered as the professional's ability to listen sympathetically to the comments of the patient and to integrate his wishes and needs, the notion of empathy has gradually widened to include representations that the physician (or the health professional) makes of the clinical situation in which the person in need of care is involved. In short, these are representations that the professional makes of the health situation of the person suffering through his/her (the professional) own empathy, triggered by the words and the acts of the patients and their caregivers. This mechanism is well described by the concept of "metaphorizing-empathy" proposed by Lebovici [12] from his work with babies and their mothers. It is also close to the notion of "narrative empathy" proposed by Jacques Hochmann [13] based on his work with autistic children and on the philosophical ideas brought by Paul Ricoeur, a famous French phenomenologist, in his book "Time and Narrative"[14]. It is also consistent with Kleinman's assumptions [15] on illness narratives. This important development in PCM marked the full recognition of the role of the physician's subjectivity as a diagnostic and treatment tool in the physician-patient relationship.

To approach the subjectivity of the person (in both its conscious and unconscious aspects) [10] the physician has to use his personal commitment in the relation with the patient and his use of his metaphorizing empathy. This perspective is very consistent with the reality of medical practice that, in one form or another, must deal with this vital dimension in every patient. Moreover, by establishing the subjectivity of the physician as a tool for understanding the patient and his disorder, the subjective involvement of the professional regains positive status which was lost with the progress of objective technical medicine. In this perspective the subjectivity of the professional can be properly included in practice and training if enough space is given to work it through. Rather than training the professionals to fight against their subjective movements or to deny it and to prevent them from getting closer to the patient's personal needs, Person Centered Medicine (PCM) proposes to train them to use these subjective movements as their best tool to access the patient's subjectivity. Thus, PCM acknowledges relevance for clinical practice of the clinician's congruence in the relationship, (i.e. his or her access to experiences arising in resonance with the patient). A required condition is, for professionals, to be trained to work it through properly, and develop enough reflexive capacities. This would enable them to take subjectivity and intersubjectivity as one of the bricks of the therapeutic relationship, i.e. the interactive construction they should build with the patient and for him or her, involving all those who are contributing to their health care and health status [10]. The teamwork and peer supervision are crucial to enhance and sustain this interactive process.

What about subjectivity and narrative in primary care?

Obviously, subjectivity is of crucial importance in primary care, not only because a primary care visit usually is the first contact with health professionals but also because it is the first step in a process transforming a suffering or a distress into a medical disease or disorder. In this complex process contributing eventually to the transformation of "pain into suffering" [16]*, the proximity of primary care with the person's every day life can obviously be a major asset to take into account the subjective feelings induced by his/her health experience and status, and potentially their subjective determinants. It is generally considered and well documented that this asset contributes to the accessibility of care and their cost effectiveness in most medical conditions. However, there are emerging concerns that this asset could become an obstacle to care when proximal relations do not help the patient to address the subjective aspects of his health in relation or not with his/her somatic condition. Schematically, three reasons can transform primary cares proximity and generality into an obstacle for such subjective appraisal:

- The patient's fear to disclose a stigmatizing situation to a health professional integrated in his every day life
- His difficulty to recognize subjective aspects and psychological distress related to health questions (physical, mental or both) due to the health problem itself, either when this difficulty is one of the symptoms of this condition (Alexithymia as symptom of various health disorders**) or when the pervasiveness of the somatic issues tends to mask the psychosocial aspects of the disease
- In these various situations, the lack of time and expertise of primary care's professionals to recognize and overcome adequately such obstacles in clinical situations

* For Paul Ricoeur, there is a crucial difference between Pain and Suffering. In Pain, physical or psychical, painful experience suppresses all psychical representations and reduces communication with others, whereas in Suffering, the painful experience triggers psychical representations and the need to communicate with others [17].

** It can be related to various health issues or disorders: suffering Adolescents [18], Psychosomatic conditions [19] , Personality disorders [20], or other medical of psychiatric illnesses [21].

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In a person-centered perspective, these obstacles should be addressed in the situations in which they occur. While in many cases, this could be achieved through the better promotion of person-centered medicine principles (given that person-centeredness in medicine is not only an ethical stance but also a technical advancement), we have to study more closely if the current "WHO service organization pyramid for an optimal mix of services for mental health" [1:16] is sufficiently adapted to tackle the problem raised by the integration of the subjective aspects of health into health care. To do so, there is an urgent need to elaborate relevant metrics to evaluate more thoroughly how this issue is tackled in the currently recommended health service models. My hypothesis is that, if we want to address seriously the problem raised by the integration of subjective dimensions into primary health care, we may have to consider amending this optimal model to make sure that renouncing the integration of subjective aspects of health into primary care will not be the price to pay to the cost effectiveness, affordability and transparency claimed by the model.

Conclusion

PCM has brought back the person of the patient at the centre of medicine, allowing integrating the subjective dimensions of the patient's mental health into the health cares from where they have been generally excluded by the disease-centered approach. Because it involves the personal commitment of the health professional and his empathic capacities the approach of this dimension needs time and specific training. As first interface between the patients and the health system, primary care is of crucial importance for the implementation of person-centered principles into the health system. It is the reason why, after being the focus of the International College for Person Centered Medicine (ICPCM) last Geneva Conference, it is going to be the topic of the 2015 ICPCM International Congress in London. The usefulness of the optimal use of primary care is well documented for its cost effectiveness and affordability; in contrast, however, more studies are needed to better know the conditions that primary cares have to meet to be person-centered, especially when it comes to integrating subjective aspects of health. This paper claims that, besides the well-demonstrated usefulness of the primary care oriented model, there is still a long way to go to ensure that this subjective dimension will not be lost in primary care.

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The Integration of Mental Health and Primary Care: A Person-centered Approach

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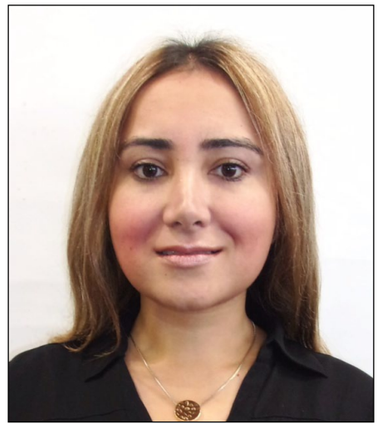

Ladan Khazai

Introduction

Ancient as well as modern concepts of "health" have highlighted the holistic understanding (emphasizing the importance of the whole and the interdependence of its parts) in medicine. Ancient Chinese medicine used diagnostic indicators in a holistic framework to provide an understanding of the disease process. The Indian medicine Ayurveda (or the knowledge of living), viewed health as harmony between body, mind and spirit. Ancient Greek philosophers affirmed that "*if the whole is not well, it is impossible for the part to be well*" [1, 2]. A modern articulation of this understanding is expressed in the World Health Organization (WHO) constitution published in 1946 which defined health as "*a state of complete physical, emotional, and social well-being and not merely the absence of disease or infirmity.*" [3]

The extraordinary advances in medicine post World War II, with its emphasis on specialized care, resulted in the provision of medical care unimaginable only a few decades ago, especially for complex and advanced medical-surgical problems. This emphasis and the current progress has changed our expectations of medicine and has increased hope in prolonging life and improving the quality of life for people suffering from these ailments, an obvious example being the field of organ transplantation. On the other hand, the focus on disease specialization has led to an unfortunate shift in the practice of medicine away from a view of health as an interdependent whole with artificially parceling out care, resulting in fragmentation, incoordination, and in some instances decreased access to care.

Furthermore, the worldwide increased prevalence of non-communicable chronic diseases, the interconnectedness and exceptional burden of chronic diseases and mental health conditions, along with the key role of behavioral determinant of health strongly demand models of care that address the totality of health with emphasis on disease prevention and health restoration. In this paper, we will review the rational for integrating mental health within primary care along with reported positive experiences in the field. We will also discuss the Person-centered Integrative Diagnosis (PID) model, an emerging person- and patient-centered approach to care anchored in person-centered medicine. The PID considers the person-in-context as the center and goal of interventions and care [4, 5].

Why Integrate Mental Health Care and Primary Care

The need for integrated care is almost universally appreciated and it has risen from the recognition that specialized care often leads to fragmentation of care, inadequacy of addressing comorbid problems, limits access to care and largely neglects preventive efforts. In contrast to disease focused specialized and fragmented system approach with clear barriers to care, integrated care is the systematic coordination of care for physical and mental disorders. It allows for the provision of adequate care for the whole person (addressing any presenting health-related problems) facilitating a holistic approach to care.

Multiple lines of evidence point to the relevance of this model for addressing mental and physical disorders. There is a high prevalence of mental disorders among people presenting to primary care settings. Likewise, people with mental disorders have high rates of physical disorders.

Medical comorbidity is the most significant cause of mortality in people with mental disorders, and these disorders are less likely to receive adequate attention in non-integrated care systems. Patients with chronic mental disorders such as major depression, bipolar disorder, schizophrenia, alcoholism and other substance use disorders have high rates of physical disorders such as diabetes, cardiovascular, chronic respiratory diseases, human- immune deficiency virus (HIV) in-

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fection, Hepatitis, sexually transmitted diseases (STD), tuberculosis (TB) and trauma with excess mortality. Factors that increase risk for physical disorders in mental disorders include high rates of smoking, substance abuse, and obesity [6]. Studies have shown that those with serious mental illness have 25 years less life expectancy compared to the general population [7]. They are over three times more likely to die from cardiac diseases and over six times more likely to die from respiratory ailments. These patients often suffer from multi-comorbid problems. For example, patients with bipolar disorder have high rates of cardiovascular and respiratory diseases, in addition to substance use disorders which increase their risk for chronic infectious diseases such as viral hepatitis and HIV infection [8, 9]. Three or more chronic comorbid conditions were found, on the average, among people with bipolar disorder [10]. Additional comorbidity increases the risk for mortality. In a study of mortality among Medicaid beneficiaries, while the most common causes of death were attributed to heart disease and cancer, death by injury was found to be twice as likely among the mentally ill compared to the general population. Those with mental illness and comorbid substance abuse were 6-8 times more likely to die of injury, primarily poisoning, than their counterparts treated for medical conditions only [11]. While that study did not look at the trajectory of care for those patients, limited access to appropriate care may have been a key contributing factor for those with excess mortality. Integrated care will substantially facilitates access to care for patients with severe mental disorders.

The need for integrated care stems from an even more fundamental reason for a holistic view of health. Studies have long reported that psychosocial determinants generate the majority of health care visits [12]. Psychosocial distress or depressive disorders often are expressed as physical distress seen by primary care physicians. Likewise, depression may develop as a consequence of chronic physical disorder such as diabetes or cardiovascular disorder [13]. Furthermore, behavioral and life style factors are overrepresented among the preventable risk factor for developing chronic diseases. The World Health Alliance (World Medical Association, International Council of Nurses, World Dental Federation, and International Pharmaceutical Federation) has recently identified through a Health Improvement Card a number of key risk factors to prevent chronic diseases. Among these are diet, exercise, avoidance of alcohol and other hazardous drugs, stress-control, adequate rest and sleep, and participation in social and creative activities [14]. Addressing behavioral health problems in primary care is essential because of the prevalence of these problems in primary care setting with reported prevalence of smoking at 20%, obesity at 30% and sedentary lifestyle at 50%. Chronic conditions that require a behavioral health component in a standard care protocol include asthma, diabetes, cardiovascular disease, irritable bowel syndrome, obesity and substance abuse. Alcohol abuse is linked to over 60 medical disorders [15].

Primary care practices are de facto where the overwhelming majority of patients with mental health problems receive care [16]. There is mounting empirical evidence demonstrating that integrated care improves access to both mental health and physical health services, decrease stigma of receiving mental health care, improves outcome and reduces health care costs [17–25].

The importance of integrating mental health into general health and public health practice has been recognized as a way for promoting mental health [26]. Integration of mental health and substance use disorders treatment in primary care has been also supported by legislative acts, such as the Patient Protection and Affordable Care Act of 2014 in the United States of America and have been highlighted by the US Surgeon General and the Institute of Medicine reports [27, 28].

Levels and Models of Integrated Care

Integration may need to be addressed at multiple levels. At the **systems' level**, major factors such as financing of care and facilitating access to care need to be addressed to facilitate integration. At the **providers' level**, training and commitment are essential. For example, integrating mental health and substance abuse treatment into primary care there is a need for a three-way enhancement of training. Medical care providers need to have enhanced training in mental health and substance abuse recognition and need for intervention. Likewise, mental health and substance abuse providers need to have enhanced training in the recognition and need for intervention for medical, mental health or substance abuse problems. At the **interventions' level** there is a need to identify, select, and develop integrated pharmacological or psychosocial interventions that are most appropriate for the patient. Repeated studies have highlighted the superiority of integrated interventions, tailored to the patient's comorbid conditions, compared to interventions that are condition specific. These studies highlight the importance of addressing the dynamic interplay between comorbid conditions and their reciprocal negative impacts on the overall outcome. **Patients' factors** is another crucial factor for integration of care, especially with the increased patient's awareness and participatory, protagonist role in the process of care. This involves enhanced patients' recognition of interrelationship of health problems and enhanced commitment to wellness maintenance and health restoration [5, 8].

Integration of care between different service providers is facilitated by addressing a number of features. These include the level of communication between the services, their physical proximity (co-located or not), their accessibility to patients in terms of distance and time for the appointment, the availability of expertise and cross-trained personnel, the availability of unified support systems such as shared medical information and referral systems, the degree of shared goals and vision among the health care teams and the degree of shared financing streams.

Health services have been graded on a continuum of integration of care, from low to fully integrated systems, based on the level of collaboration between the various disciplines of health care providers. The lower the level of care, the less being able to address more complex conditions. Level one identifies a low level of integration with minimal collaboration between health professionals. Level two identifies basic collaboration and loosely coordinated care, with periodic communications between health providers in separate systems of care and separate locations. Level three refers to closer collaboration among health providers who still are part of different teams but share the same facility (co-located). The co-location facilitates more frequent communications, including occasional meetings. Level four identifies close collaboration in a setting where there is partial integration between mental health and other medical care. Providers are co-located at the same sites and share other functions such as the medical information system or scheduling. There is more formal collaborative work and meetings that may involve coordinated treatment plans for certain cases. The most integrated level is level five. There is close collaboration in this fully integrated model where health professionals operate as part of the same team, with shared vision, and using the same supportive system. There is regular and systematic team meetings and treatment planning with similar emphasis and expectations on prevention and treatment.

The Four Quadrant Model is a conceptual population-based planning model for integrated care developed under the auspices of the National Council for Community Behavioral Healthcare (NCCBH) [29]. Health risk and complexity are considered in each quadrant and used as a guide for interventions and levels of services to meet the individual patient's need. Quadrants range from low risk/low complexity (quadrant I) to high risk/high complexity (quadrant IV) on both mental health/substance abuse and physical health. Quadrant II indicates high risk/complexity on mental health/substance abuse and low to moderate risk/complexity on physical health; quadrant III indicates low to moderate risk/complexity on mental health substance abuse and high risk/complexity on physical health. The Care Model is another conceptual model developed for improving care for chronic illnesses by refocusing the emphasis from an illness-centered reactive model to a health-centered preventative model. It addresses key features for enhancing care at multiple levels including community, organization, practice and patient levels [29].

Models have been advanced for linking integrated care to the processes of care through systematic screening and identification of mental and behavioral disorders. This provides targeted linkage to appropriate interventions within an integrated primary care providers with the goals to enhance access to care, reduce stigma, and enhance engagement and adherence to care [30].

An example of systematic screening and brief intervention highly relevant to primary care is the Screening, Brief Interventions, Referral and Treatment (SBIRT) program for unhealthy alcohol use [31]. The SBIRT is an evidence-based practice aimed at identifying, reducing and preventing problematic alcohol use. The SBIRT has three major components: *Screening*, using highly efficient and practical standardized screening tools such as the CAGE questionnaire, the Alcohol Use Identification test (AUDIT) or the three questions AUDIT-C [32–34]. *Brief Intervention*, providing feedback and advice for patients with unhealthy alcohol use. *Referral to Treatment,* for either brief therapy or for additional more intensive treatment. Similarly, interventions for the highly prevalent depression in primary care have been developed and extensively tested [35]. Community friendly interventions that could be incorporated into integrated primary care programs for serious mental disorders are less developed. Two examples of integrated counseling interventions for bipolar disorder with comorbid alcohol or substance use that are designed to be simple and easily adaptable to community settings include a group therapy format [36] and an individual counseling approach [37]. These interventions utilize integrated disease management and educational strategies along with motivational enhancement approaches that are practical and easily applicable in community settings.

The Person-centered Integrative Diagnosis (PID) Model

The Person-centered Integrative Diagnosis model (PID) may provide a conceptual approach to integrative care. The emerging PID model aims at putting into practice the vision of Person-centered Medicine affirming the whole person of the patient in context as the center of clinical care and health promotion at the individual and community levels [4, 5]. The PID motto of "persons caring for persons" recognizes that the person of the patient and the person of the health providers are in a respectful and empowering partnership. The PID considers the totality of the person's health, including both ill health and positive aspects of health with primary emphasis on prevention and health restoration. It is based on a holistic, contextual and humanistic approach to care emphasizing recovery and wellbeing. It views the process of care as a partnership (equalitarian) approach, including the patient, family, care givers and other stakeholders and the health professionals forming a health support network.

The PID scheme could be easily incorporated into other models of integrated care, and it provides a comprehensive and dynamic

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assessment of the health status of the person presenting for care. The PID is a multilevel approach to assessing the health status. The first level includes the assessment of health. This includes the assessment of ill health, such as any physical or mental disorders along with assessment of functional abilities. This level also includes the assessment of positive aspects of health and wellbeing. Positive aspects of health and wellbeing are key to the recovery, health restoration and health preservation efforts. The second level in the PID is the assessment of contributors to the health status. These contributors are considered on a bio-psycho-social continuum. Contributors to health are divided into health promoters and health risks. The PID has incorporated the health contributors included in the Health Improvement Card developed by the World Health Professions Alliance [14]. Health promoters include diet, physical activity, creative activity, social involvement, and other. Health risks include overweight, elevated lipid, elevated glucose, high blood pressure, alcohol and tabacco use, family history, early trauma, significant stress, and other. The third level of the PID is the experience of health which includes the experience of wellbieng and the experience of ill health. This provides assessment of personal and cultural identity, suffering, meaning of illness and expectations for the health care encounter. These subjective contributions to the process of diagnosis and care provide idiographic narrative crucial for the processes of empowerment, engagement, partnership and recovery [38–40].

Future Directions

Integration of care has become a pressing prerogative to provide an adequate response to the growing pandemic of chronic diseases and to the increase of the aging world-population with substantial rise of the burden of comorbid chronic conditions. The integration of mental health into primary care and general health responds to the considerable evidence of the strong impact of mental and behavioral health on physical health, and also to the need for adequately addressing ill physical health in people with mental health problems. The dictate that "*there is no health without mental health*" and the goal of eliminating disparities in health care are best served by integration of care. Refocusing medicine from an essentially disease-centered, "reactive" attitude to an approach focusing on disease prevention and health restoration with emphasis on enhancing wellbeing and healthy living also calls for integration of care.

The Person-centered Integrative Diagnosis approach, embodying the vision of Person-centered Medicine as expressed to a large extent in the various Geneva Declarations and proceedings of the International College of Person-centered Medicine (ICPCM), provides an overarching conceptual framework for integrated care converging on the person in context as the center and goal of care and public health.

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The Road to Paris: What is at Stake for Health in COP21 Negotiations?

Climate change is considered one of the greatest threats and/or opportunities for (human) health [1, 2, 11, 13]. Although the relationship between climate change and health is complex, concrete examples include extreme heat and weather events [46], poor air quality exacerbating pulmonary disease [47, 48], increased water-borne and vector-borne infectious disease outbreaks and food insecurity and malnutrition caused by drought and crop failure.

Despite widespread recognition of the numerous health implications of climate change, evidence suggests that climate change continues relatively unabated [15]. In this context, there is an imperative for health professionals to be involved in the discussion and act on this issue which threatens to undermine public health efforts worldwide [2, 34, 35]. This paper provides a brief introduction to the United Nations Framework on Climate Change (UNFCCC), current climate change negotiations and health sector engagement in global efforts to tackle climate change.

I. The Climate-Health Nexus

Broad scientific evidence shows that climate change has and will continue to have profound health implications [2, 4], primarily driven by carbon and other greenhouse gas emissions [16]. The effects of climate change on health are diverse and complex; some directly attributable to rising temperatures and changes in precipitation patterns, others are mediated through social and ecological changes such as population displacement, vector migration, conflict and agricultural failure [7, 8, 14].

In 2014, the Intergovernmental Panel on Climate Change (IPCC) highlighted some of the most significant threats to human health posed by climate change including but not limited to:

- Spread of infectious diseases including malaria, dengue fever, and water-borne diseases;
- Increased frequency and severity of natural disasters and flooding;
- Worsening food insecurity;
- Increased migration and conflict; and
- More than 7 million deaths annually attributable to rising temperatures and air pollution [2].

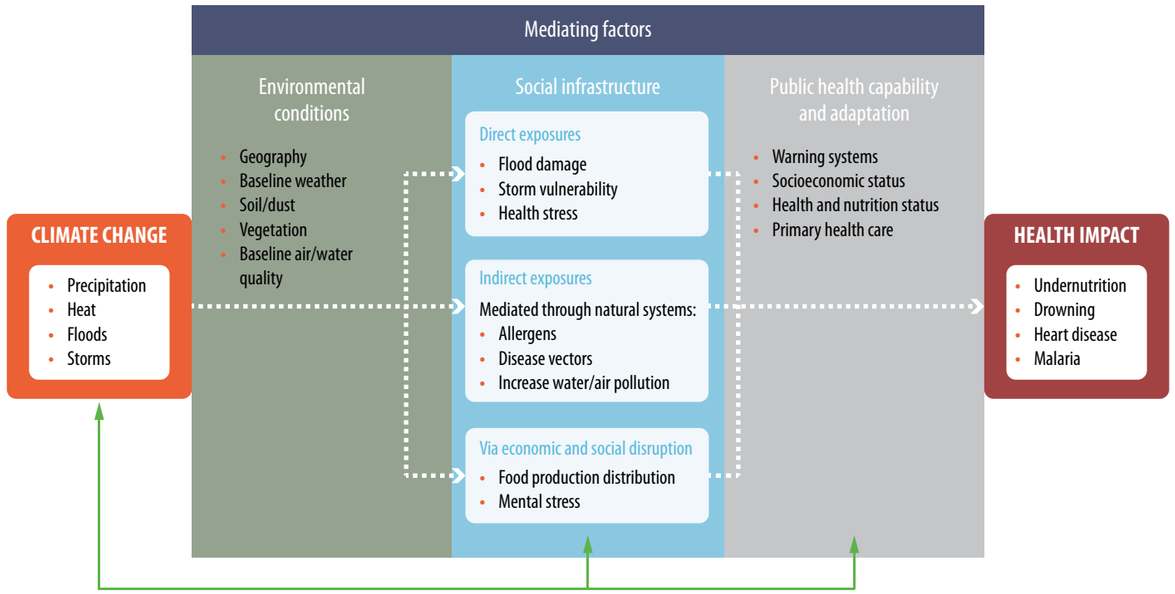

Figure 1. Diagram of the three exposure pathways through which climate change affects health [3]

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Climate change has been recognized as one of the many social determinants of health [5, 6]. Not surprisingly, health implications of climate change are inequitably distributed worldwide, excessively affecting populations in low-and-middle income countries and vulnerable populations around the globe [10, 18, 19, 49, 54].

Synergistic adaptation and mitigation strategies are widely viewed as necessary to address climate change broadly and, more specifically, the resulting health effects. Mitigation strategies seek to prevent or otherwise avert climate change, while adaptation implies modifying systems in response to the effects of climate change [38]. Health impacts of climate change are indeed mediated through the environmental conditions, the social infrastructure and the public health adaptation [3, 49]. As a result, mitigation and adaptation strategies demand a multisectorial approach which includes the health sector [9, 10, 12, 32, 33].

II. The Road to Paris/COP21

Adopted as part of the Rio Convention at the Rio Earth Summit in 1992, UNFCCC entered into force in 1994 and now includes 196 parties [37]. Each year, the Conference of Parties (COP) is convened to review UNFCCC progress.

In December 2014, COP20 was held in Lima, Peru, and resulted in the Lima call for climate action [20], a precursor to this year's much anticipated COP21 negotiations. The Lima call for climate action represented the first time parties revived the health effects from Art. 1 of the Convention [37] and recognized the need to further assess the health co-benefits of climate change mitigation.

A new ambitious agreement on climate change is anticipated this December at COP21 ("2015 Paris Climate Conference")

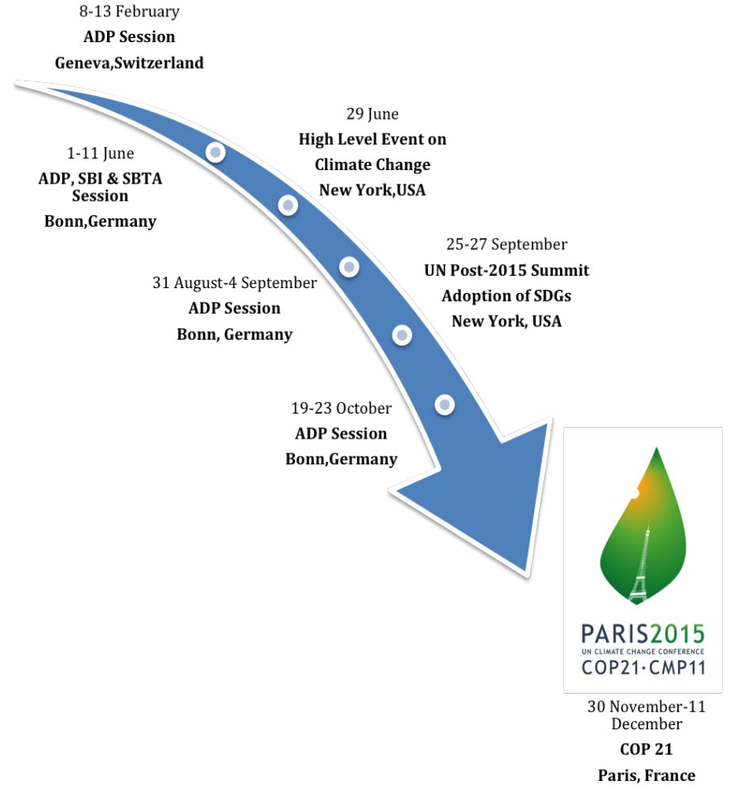

Figure 2. Diagram of the Road to Paris

World Conference Center Bonn (ADP 2.9, June 2015)

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[50] and is expected to be an important step in addressing this huge challenge for humanity. This agreement is meant to succeed to the Kyoto Protocol [51, 52] in setting very ambitious long-term goals for addressing climate change. High profile targets may include limiting global mean temperature increase and carbon emissions. Current long term goals under discussion are: a maximum of a two degree temperature increase and carbon neutrality by 2050.

Since 2011, the Ad Hoc Working Group on the Durban Platform for Enhanced Action (ADP) has been meeting regularly to discuss the post 2020 agreement as well as the pre-2020 ambitions needed to reach the long term goal(s). The mandate of the ADP is set to conclude in December 2015; thus, several ADP meetings are scheduled in 2015.

The first ADP meeting of the year (ADP 2.8) took place in Geneva in February, 2015 where an early draft of the party-led negotiating text was created, the so-called Geneva Negotiating Text [21]. This text, essentially a compilation of all possible components parties would want to see in an agreement, was the first time that health co-benefits were recognized with preamble language initially tabled by Switzerland. At the conclusion of ADP 2.8, all parties agreed that this text would need to be streamlined in the months to come.

In June 2015, ADP 2.9 convened at the UNFCCC Headquarters in Bonn, Germany. Although ADP 2.9 was a much anticipated opportunity to refine the 90-page Geneva Negotiating Text, little significant progress was made to streamline the document. Parties met and started the streamlining process but only managed to reduce the negotiating text to 85 pages [22]; however, progress was made in defining the way forward and the Co-Chairs of the ADP will produce a tool which will facilitate the work at the next session at the end of the month of July [23, 24].

Despite the lackluster progress at ADP 2.9, G7 leaders concurrently announced a commitment to "...a protocol, another legal instrument or an agreed outcome with legal force" under the UNFCCC in Paris including an explicit political commitment to the "global goal to hold the increase in global average temperature below 2°C" [25, 26]. However, this commitment was not reflected in concurrent negotiations at ADP 2.9 in Bonn.

In 2013, parties adopted a new approach to climate change negotiations which includes submission of Intended Nationally Determined Contributions (INDCs) , or post-2020 climate commitments and plans. INDCs are expected to be submitted by all countries and are intended to shape the anticipated COP21 framework. In anticipation of COP21 and a new comprehensive international climate agreement, parties will continue to unveil their INDCs in the months to come [17]. At COP20, parties agreed that INDCs would focus on reducing emissions, although little additional INDC guidance for parties was agreed upon [53]. The next INDC deadline is currently 1 October 2015 with a synthesis report from the Secretariat anticipated by 1 November 2015.

III. Health Professionals and Climate Change Negotiations

Health is included in the first article of the UNFCCC as an requiring action: "Adverse effects of climate change" means changes in the physical environment or biota resulting from climate change which have significant deleterious effects on the composition, resilience or productivity of natural and managed ecosystems or on the operation of socio-economic systems or on human health and welfare." [37] The grave and omnipresent threat of climate change demands coordinated multisectoral action [27] and the health sector has the potential to unite actors behind a shared well understood and tangible common cause [2].

Yet, the climate-health connection has not been consistently recognized in UN processes including development of the post-2015 development agenda [38], and the health sector – and physicians more specifically – have only distantly been involved in climate change negotiations. In the current streamlined and consolidated Geneva Negotiating Text, health is highlighted only in the preamble: "Recognizing that actions to address climate change simultaneously contribute to the attainment of the highest possible level of health and that climate change policies and health policies should be mutually supportive." [21] It is, however, generally recognized that health sector interventions both mitigation and adaptation and that financial resources will be flowing through climate dedicated funds to the health sector. At a minimum, given the relationship between climate change and health, the health sector will need to be ready to anticipate the effects of climate change on the natural history of disease, distribution of illness and severity of disease burden for vulnerable populations [2]. It will be important to mitigate these effects while also working to change the factors leading to worse health outcomes and supporting smart public policy decisions to improve population health. Health care providers are uniquely positioned to assume a leadership role through both education and advocacy to advance mitigation and adaptation [14, 29, 30, 31].

It is critical, however, that the health sector engages in development of the global framework for climate change action – namely, the anticipated COP21 agreement. As recommended by the recent Lancet Commission report, this agreement should, at a minimum, provide clear support and direction for countries transitioning to a low-carbon economy, a strong predictable carbon pricing mechanism and ensuring access to renewable energy [2].

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Specific advocacy targets for health professionals and organizations could include [2]:

- Urging negotiators and national policymakers (both within and beyond Ministries of Health) to ensure urgent, ambitious binding action on climate change as reflected in both national level commitments (INDCs) and the COP21 Paris agreement;
- Leveraging media to communicate the health risks of climate change and health co-benefits of mitigation and adaptation as well as the need for emergent action;
- Investing in climate-health research to more clearly define and measure the health co-benefits of adaptation and mitigation; and
- Supporting integration of climate change education into health professions curricula.

Over the last several years, several international health and health professions organizations [61] including the World Health Organization (WHO) [62], World Medical Association (WMA) [34-36, 60], Global Climate & Health Alliance (GCHA) [31] and International Federation of Medical Students' Associations (IFMSA) [57-9] have been engaging in UNFCCC processes and negotiations.

However, the urgency and severity of the threat to health from climate change demands further action and participation by health professionals and organizations on a local, national and global scale.

There are a growing number of successful examples of health professional advocacy for policy change that recognizes the health co-benefits of climate change mitigation and adaptation. The divestment movement has been rapidly growing within the last few years and seeks to support the transition to a low-carbon economy through "disruptive innovation" [55]. Divestment is generally defined to include the withdrawal of all existing investments in fossil fuels and a commitment not to make any new investments. In some cases, divestment may be coupled with investment in renewable energy or similar more socially responsible industries. In 2014, the British Medical Association (BMA) passed a motion to divest from the fossil fuel industry [40, 41, 13, 45]. Other national medical associations, academic institutions and other organizations are increasingly considering and adopting similar divestment policies [42-44]. Similarly, Health Care Without Harm, an international coalition of hospitals and health care systems, professions and other organizations, has developed and executed numerous successful local, national and international advocacy campaigns around environmental health and justice – including climate change [56].

IV. Conclusion

Unchecked climate change will inevitably have grave negative implications for health; conversely, addressing climate change through mitigation and adaptation presents an extraordinary opportunity to protect global health [2]. Without concerted global action, climate change will continue to have profound negative effects, both directly and indirectly, on the patients and communities health professionals serve – and global population health more broadly. Many health sector interventions addressing climate change are no-regret policies which even without accounting for the benefits for climate change are valuable for the health of population [2]: health professionals have a role to play in illustrating that to policymakers.

In this context, the medical community has a professional obligation to engage in an effective multisectoral global response to climate change and to ensure a strong climate change agreement [34, 35]. The urgency around this action and engagement by health professionals could not be stronger in the coming months as ADP/COP21 negotiations proceed down the "road to Paris".

Keep up with upcoming COP21 negotiations and the road to Paris on Twitter by following @medwma and #COP21, #ADP2015, #ClimateHealth.

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More Good Days: Person-Centered Care at the End of Life

"Modern medicine is good at staving off death with aggressive interventions – and bad at knowing when to focus, instead, on improving the days that terminal patients have left" [1].

Are we asking the right question?

Is more care better than less care at end of life? It's a highly personal choice calling for a person-centered response.

According to Pew Research Center polls, Americans' preferences for end-of-life medical treatment vary depending on the exact circumstances they might face [2]:

- 57% would tell their doctors to stop treatment if they had a disease with no hope of improvement and were suffering a great deal of pain;
- 52% would ask their doctors to stop treatment if they had an incurable disease and were totally dependent on someone else for their care;

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- But about 35% (about a third) say they would tell their doctors to do everything possible to keep them alive – even in dire circumstances, such as having a disease with no hope of improvement and experiencing a great deal of pain.

In light of this variation, as we strive to make all care person-centered, perhaps we need to expand, even change, the traditional questions around end of life care.

In addition to asking what level of care patients want at the end of their lives-curative care or comfort care, more care or less care, in other words: "What is a good death for you?" – perhaps we should be asking each patient: "What is a good life for you? What, for you, is a good day? What can we do together to ensure that you have more good days?"

Goals of care, then, can be refocused on maximizing the number of "good days" that the patient can enjoy, ensuring care that is truly patient centered [2].

We are failing our patients at end of life

Woody Allen, an American comedian, famously said, "I'm not afraid of dying, I just don't want to be there when it happens." Most of us are more realistic, and we still hope for a good death.

In a narrative study of patients, physicians, family members and others, several common themes about what constitutes a good death emerge: freedom from pain, the sense of a life well lived, and a sense of community [3]. However, while people hope for a "good death", they don't necessarily get one. Instead, research shows that although 70% patients want to die at home, approximately 60% die in hospitals, nursing homes or other care settings [4].

People are getting expensive high-tech care when they prefer more conservative treatment. Overtreatment in the form of aggressive interventions-repeated hospitalizations, intensive care, cardiac resuscitation, multiple rounds of chemotherapy, etc.-is costly. In the US, approximately 30% of Medicare funding goes to 5% of beneficiaries who die. Acute care, not comfort care, accounts for 78% of costs incurred in the final year of life. One-third of those expenditures are spent in the last month of life [5].

Is Geography Destiny?

Even though patients often prefer more conservative end-of-life care than they actually receive, a patient's wishes can be less influential than the practice patterns at the hospital where care is delivered. In other words, the degree to which care at the end of life is most closely aligned with a patient's values and preferences may depend more on *where one dies* than on *how one dies* [6].

Tracking these geographical differences, the authors of the Dartmouth Atlas of Health Care's report on end of life care suggest:

These findings underscore the importance of innovative approaches to care that help ensure that patients and their families engage in discussions of their preferences before they become seriously ill and that providers respect these preferences [7].

Patient Preferences at End of Life: Arriving at a Tipping Point

These hoped-for "innovative approaches to care"include advanced care planning (ACP), a series of actions to help care providers understand what a patient's treatment preferences would be if that patient could not speak for herself. Driven in part by the mismatch in goals between what patients want and what they get in end of life care, and by the desire to align care with outcomes that matter to the patient, several patient education and engagement programs have begun to emphasize the importance of ACP. (See the Resource List below for a small sample of current programs.)

In years past, advance care planning was a political "hot button" for physicians and provider systems. However, changes are afoot that indicate that embracing advanced care planning as a vital component of person-centered care has reached a tipping point. For example, in the US, two new proposed Medicare billing codes for advance care planning would allow physicians and other qualified health professionals to be reimbursed for time spent explaining and discussing advance directives during a visit. Reimbursing clinicians for this use of their time with their patients supports care delivery that is "high-quality, comprehensive and person-centered" [8].

The Goal: More Good Days

We need to plan our lives to the end, beyond the administrative work of completing advance directives. We need to plan to go even further than the very important discussions about treatment choices and documentation of health care proxies. Equally important in making end-of-life care person-centered is the exploration of *more good days*.

A focus on more good days engages the patient by asking: "What is a good day for you?"

Each person's "good day" is uniquely their own. For some, any day alive is a good day. For others, a good day may mean the opportunity to enjoy an activity or the company of loved ones. With this in mind, questions about advanced care options help patients discover how likely each proposed treatment will create more good days than it takes away. With the focus on good days, it becomes easier to discuss which treatments might result in the greatest net number of good days. That can be a welcome shift from answering the question of more care vs. less care.

Perhaps truly person-centered care in advanced illness is not so much about how we plan the end of our lives, but rather how we want to live our lives to the end. (Focus groups and provider interviews we've conducted suggest that this approach can open up communication among patients, families and providers.)

Patients and families can help protect and support "good days" by becoming well-informed about treatment options and their potential clinical outcomes, and by becoming well-prepared for what is likely to happen throughout the course of an illness. Framing care planning around more good days would mean making decisions that protect "good days," that is, making decisions based upon a balance of two things:

- The chance that any proposed treatment *will extend the number of good days* for the patient.
- The chance that any proposed treatment *will reduce the number of good days* for the patient.

Using a person-centered approach focusing on more good days, patients, families and caregivers gain from each other these benefits:

- Understanding of the patient's treatment and care options and each option's likely impact on remaining good days.
- Understanding of the patient's options for effective pain control either at home or in care facilities.
- Emotional support and practical tips for when the patient chooses to receive late life care in their own home with family and friends present.
- Consensus and acceptance among family members for a chosen care plan or advance directive.

Conclusion

Good days become particularly precious when one's health is fragile and failing. Choosing a more good days approach is to seek to improve patient understanding and to help them get care aligned with what they prefer and want. In no way does it suggest that patients be deterred from making a choice to pursue life-extending treatment. For some people, fighting for life every inch of the way could constitute a day well-spent. We, as care professionals, cannot judge any patient's choices if we seek to be person-centered in our care.

Making it possible to gain clarity about more good days and helping people express their preferences to their families and care providers will help make care, right up until the end, truly person-centered.

Resource List: USA-based programs that promote patient-centered Advance Care Planning:

- ACP Decisions: *www.acpdecisions.org*
- Advanced Illness Management (AIM) ®: *http://www.sutterhealth.org/quality/focus/advanced-illness-management.html*
- Healthwise Advanced Care Planning Assets: *http://www.healthwise.org/docs/DOCUMENT/8349.pdf*
- Respecting Choices®: *http://www.gundersenhealth.org/respecting-choices*
- The Conversation Project: *http://theconversationproject.org*

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6. End-of-Life Care. Dartmouth Atlas of Health Care. 2015. http://www.dartmouthatlas.org. Accessed April 10, 2015. http://www.dartmouthatlas.org/keyissues/issue.aspx?con=2944 *"People with severe chronic illness who live in communities where they receive more intensive inpatient care do not have improved survival, better quality of life, or better access to care than patients who live in communities where they receive less care. Patients' experience of care, however, differs dramatically; they receive a much more aggressive brand of medicine, seeing medical specialists more frequently, spending more days in the hospital, and dying in an ICU more often than those in lower intensity regions."*
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Healthwise is a not-for-profit consumer health information organization whose mission is "to help people make better health decisions."

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