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In the modern world, pharmaceutical business is an honorary second-rank job among the most lucrative professions, 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 straightforward 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, America) involve uncertainties about the immigrants’ state of health, and limited availability of raw materials;

(V) medicines launched to the market at an early stage and having a global problem as a result of internet pharmacies chains, re-export with the purpose of price arbitrage and parallel import;

(VI) resistance to drugs is increasing, and not exclusively to anti-infectious and parasitic diseases, vaccination against dangerous diseases, 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;

(VII) medicines are continuously being discarded in open environments, and other chemically active substances are used;

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World Medical Journal

Editorial

Doctor in the World and Medicines

In the modern world, pharmaceutical business is an honorary second-rank job among the most lucrative professions, 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 straightforward 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:

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

By Dr. Peteris Apinis. September, 2015

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 chemicals, 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 human/sympathetica?

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 NGOs, 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.

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?

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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 inequalities 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, wherever and whenever 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.

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.
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 roles are 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, child and maternal 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 four European countries. 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 for maternal and child health with 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 four European countries. By tapping into new sources, improving efficiencies and giving high priority to health, all countries can find ways to raise sufficient funds for health.

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

Q. If there is an opposition to vaccination in Latvia, 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 ill health 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 vaccination communication programmes; introducing new and underused vaccines; eliminating measles and rubella and maintaining the polio-eradication 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. Thus far 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 administrative institutions, workplaces, 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?

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 signed 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 2030 and the UK Scotland by 2034. Tobacco free country is defined by less than 5% of adult population smokers. 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.
Interview with Dr. Jacques de Haller, Vice President, President Elect 2016–2018 (Switzerland) of CPME

By Dr. Petris Aplinis. 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 physicians 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, pneumococcus) 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 unification. 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 vacinate 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 immuno deficiency, 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 immunisation: some surgical procedures show the same pattern, for instance.

Community cooperation is needed. We don’t have the right to give up!

From Zoonosis to Pandemic

A.D.M.E. Osterhau

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. Monkeys were sources or recipients of these human pathogens. A recent panzoonotic 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.

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!
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 harbor 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 new 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.

References

Prof A.D.M.E. Osterhaus, Director Research Centre for Emerging Infections and Zoonoses (RIZ), Hannover, Germany
E-mail: a.d.m.e.osterhaus@riz.hannover.de

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 health-care 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 war 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 23-33% 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 several 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. Migrants 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 (UNODC) 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 UNODC, many...
The Egyptian Government reinstated the rule of law in the Sinai [14], allowing asylum seekers to travel freely 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 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 – 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 navigational 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 Organization 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 the Mediterranean Sea – 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 – 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].

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 health threats to the 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 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 mushrooms in Syria [25, 26, 27].

Refugees and Health Care

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].

Infectious Diseases

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-scaries therapies were available within Germany (Permethrin and Benzylbenzoate) [30]. Ivermectin, an antifilarial on WHO’s list of essential medicines [31] and the 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
COMMUNICABLE DISEASES

Refugees and Health Care

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]. Migrant populations suffer from the same risk factors for HIV/AIDS as the general 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 humiliated spaces such as those found in trucks and ships may facilitate the transmission of TB when an infected person is present [8]. The prevalence of HIV/AIDS is increasing, while it is on the rise among migrants [34].

The mass influx of refugees increases the risk of the re introduction of vector-borne diseases such as Malaria, Leishmaniasis and to the European region. Tajikistan and Turkmenistan have a high rate at the moment [8, 34, 35].

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 43% of the children out of the camps did not have measles vaccine [37]. This situation introduced the risk of polio to a country which was polio-free for more than 15 years. There has been 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. The port of Lebanon has seen an increase in the number of reported tuberculoses, 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.

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]. Reintegration 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, transnational interaction, loss 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 informal accommodation, economically restricted, internally displaced, were those who were repatriated, or whose initiating conflict was unresolved had worse outcomes [49]. A study from the World Health Organization found that, compared to non-refugees, refugees had higher rates of 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]. Avoiding the procedure 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 access 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. These programs consider also includes mental health services). However, resource shortages limit these services to life-threatening emergencies in many places.

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 a woman’s body or sex does not necessarily mean to accept a sexual relationship. Women are often forced into prostitution to make ends meet. Women may be forced into prostitution by circumstances such as poverty, lack of education, lack of work opportunities or other personal circumstances.

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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. 622.022 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 continuing influx of refugees to reach about 1.5 million people 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. 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 to the country 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 spread preventable and severe diseases to refugees and local societies. It is a humanitarian need that healthcare services and infrastructure in Greece, a country at Europe’s doorknob, 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. In order to meet the need, gyms, empty school or stores and tents have been set up as make-shift 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 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.

Conclusion
People travel with their health profiles, values, culture and beliefs. Health workers in Europe have to be prepared to receive refugees 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 health of the community and of country’s region’s disease burden. Acute conditions, many of them infectious disease, psychiatric illness or injuries sustained fleeing their home countries may develop in refugee camps.

Many refugee lack access to mental health and delayed care and treatment for mental health problems may worsen refugees’ prognosis. Attention must be given to persons with pre-existing psychiatric disorders 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 unnecessary, yet deadly confusion. The basic rules of hygiene and sanitation are an important factor for today’s increased life expectancy [54]. Creating 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 [56]. While today’s situation may seem 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 those babies born in refugee camps and prove hazardous, national medical associations and health professionals ensure a sustained, timely and appropriate response to the health implications of refugees crisis [87]. Refugee health is public health.

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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.

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 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 household size 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.”
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 assembly 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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«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.»

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

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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 reestablish links. It has also reminded the Lebanese government of its responsibility to ensure respect for the principle of non-refoulement.

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.
Refugees and Health Care

SYRIA, 2012-10-09, © ICRC / MARRISH, Paula
Tripoli. ICRC nurses visit a Syrian wounded.

LEBANON, 2012-10-09, © ICRC / PARRISH, Paula

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

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

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

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

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

SYRIA, 2013-04-02, © ICRC / KAS BARSOUM, Jack
Aleppo. Internally Displaced People Centre. The black buildings, which are used by the internally displaced persons.

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Subjectivity and Narratives in Primary Care: A Person Centered Issue

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 [2]. Subjectivity is of crucial importance. Obviously, subjectivity is of crucial importance. Subjectivity and psychodynamic dimensions. The 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.

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 subjective and psychodynamic dimensions. The implicit or explicit tendency is to mimic the paradigm based on the biomedical classifications in other medical disciplines.

The first state 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 transformative 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 specialty 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 caregivers (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 medical biological aspects of the person’s health status, a person centered assessment needs to give enough consideration to the patient’s subjective feelings. Whether or not we surmise 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.

This perspective is very consistent with the current 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 clinicians’ congruence in the relationships, (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 reflective 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 everyday life can obviously be a major asset to take into account the subjective feelings induced by his/her health experience and status potentially their subjective determinants. It is generally considered and well document ed 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, there are several reasons why 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 the primary care, as symptom of various health disorders)* or when the perversiveness of the somatic issue superimposes on 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 Ricœur, there is a crucial difference between Pain and Suffering. In Pain, physical or psychical, painless experience suppresses all psychic representations and reduces communication with others, whereas in Suffering, the painful experience triggers psychic representations and the need to communicate with others [17].

** It can be related to various health issues or disorders: suffering Adolescents [18], Psychosomatic symptoms [19], Personality disorders [20], or other medical of psychiatric illnesses [21].
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 how 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 transpar- ency 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 care from where they have been 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.

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Why Integrate Mental Health Care and Primary Care

The need for integrated care is almost univer- sally appreciated and it has risen from the recognition that specialized care often leads to Fragmentation of care, inadequacy of addressing comorbid problems, limited access to care and largely neglects preventive efforts. In contrast to disease focused spe- cialized 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 ap- proach to care.

Multiple lines of evidence point to the rele- vance of this model for addressing mental and physical disorders. There is a high preva- lence of mental disorders among people presenting to primary care settings. Like- wise, 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-intre- grated 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-
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 is necessary for 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 dyad nature of treatment. For example, the local medical community and the community organizations and their reciprocal negative impacts on the overall outcome. Patients’ factors are 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 interrelatedness of health problems and enhanced commitment to wellness maintenance and health restoration [5, 8].

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 also been 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].

In each quadrant and used as a guide for integration, the model reduces the complexity of the individual patient’s need. Quadrants range from low risk/low complexity (quadrant I) to high risk/high complexity (quadrant IV) [21–24]. There is a need for the care provider 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 across the care. The most integrated level is level five. There is closer collaboration in this fully integrated model where health professionals operate as part of the patient 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 integration, the model reduces the complexity of the individual patient’s need. Quadrants range from low risk/low complexity (quadrant I) to high risk/high complexity (quadrant IV) [21–24]. There is a need for the care provider 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 across the care. The most integrated level is level five. There is closer collaboration in this fully integrated model where health professionals operate as part of the patient 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.
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 (ICP- CM), provides an overarching conceptual framework for integrated care converging on the person in context as the center and goal of care and public health.

References
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].

II. The Road to Paris/COP21

Adapted 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 was anticipated this December at COP21 (“2015 Paris Climate Conference”).
Investing in climate-health research to address climate change. High profile targets may include limiting global mean temperature increase and carbon emissions. Current long-term goals under discussion are: a minimum 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 to set concludes 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 negoti- ating 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 con- clusion 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, Ger- many. Although ADP 2.9 was a much an- ticipated opportunity to refine the 90-page Geneva Negotiating Text, little significant progress was made to streamline the docu- ment. Parties met and started the streamlin- ing process but only managed to reduce the text to 85 pages [22]; however, this commitment was not reflect- ed in concurrent negotiations at ADP 2.9 in Bonn.

In 2015, 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 part- nership of COP21 and a new comprehensive international climate agreement, parties will continue to unveil their INDCs in the months to come [23]. At COP20, parties agreed that INDCs would focus on reduc- ing emissions, although little additional INDC guidance for parties was agreed upon [53]. The next INDC deadline is cur- rently 1 October 2015 with a synthesis re- port 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 un- present threat of climate change demands coordinated multilevel action [27] and the health sector has the potential to unite actors behind a shared well understood and tangible common cause [2].

Despite the lackluster progress at ADP 2.9, G7 leaders concurrently announced a com- mitment to “...a protocol, another legal instru- ment or an agreed outcome with legal force” under the UNFCCC in Paris includ- ing 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 reflect- ed in concurrent negotiations at ADP 2.9 in Bonn.

Yet, the climate-health connection has not been consistently recognized in UN process- es 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 stream- lined and consolidated Geneva Negotiating Text, health is highlighted only in the pre- amble: “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 sup- portive.” [21] It is, however, generally recog- nized that health sector interventions to mitigate 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 sector, the health sector will be ready to act to 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 ef- fects while also working to change the fac- tors leading to worse health outcomes and supporting smart public policy decisions to improve population health. Health care pro- viders are uniquely positioned to assume a leadership role through both education and advocacy to advance mitigation and adapta- tion [14, 29, 30, 31].

It is critical, however, that the health sec- tor 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 be at a minimum, provide clear support and direction for countries transitioning to a low-carbon economy, a strong predictable carbon pricing mechanism and ensuring ac- cess to renewable energy [2].

Specific advocacy targets for health profes- sionals and organizations could include [2]:

- Urging negotiators and national policy- makers (both within and beyond Ministries of Health) to ensure urgent, ambi- tion action on climate change as reflected in both national level commit- ments (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 emergency action;
- Investing in climate-health research to more clearly define and measure the health co-benefits of adaptation and mit- igation; and
- Supporting integration of climate change education into health professions curricula.

Over the last several years, several interna- tional health and health professionals orga- nizations [61] including the World Health Organization (WHO) [62], World Medical Association (WMA) [34-36, 60], Global Climate & Health Alliance (GCHA) [51], 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 de- marks 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 transi- tion 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 in- vestments. In some cases, divestment may be coupled with investment in renewable energy or similar more socially responsible industries. In 2014, the British Medical As- sociation (BMA) passed a motion to divest from the fossil fuel industry [40, 41, 13, 45]. Other national medical associations, aca- demic institutions and other organizations are increasingly considering and adopt- ing 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 in- ternational advocacy campaigns around environ- mental 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 communi- ties health professionals serve – and global population health more broadly. Many health sector interventions addressing cli- mate change are no-regret policies which even without accounting for the benefits for climate change are valuable for the health sector [2]. Health professionals could have a role to play in illustrating that to policy- makers.

In this context, the medical community has a professional obligation to engage in an ef- fective multilevel global response to address climate change and to ensure a strong climate change policy [34, 35]. The urgency around this action and engagement by health professionals could not be stronger in the coming months as COP21 or ADP21 nego- tiations proceed down the “road to Paris”.

References

The chance that any proposed treatment will create more good days than it destroys is a question of the patient's treatment preferences. Treatment options can be ranked, at least in part, by their potential to create good days. For some, a good day may mean the opportunity to be with loved ones; for others, a good day may mean the opportunity to be as free of pain as possible. For many, a good day may mean the opportunity to be as productive as possible. For others, a good day may mean the opportunity to be able to express oneself fully. For all, a good day may mean the opportunity to be able to do things that one enjoys. The chance that any proposed treatment for the patient will create more good days than it destroys is a question of the patient's treatment preferences.

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].

Even though patients often prefer more conservative care, when they receive care, 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 those 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, advanced care planning was a political "hot button" for physicians and provider systems. However, changes are afoot that indicate that embarking upon 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. Reimbursement for this visit and time with their patients supports care delivery that is "high-quality, comprehensive and person-centered" [4].

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?" For others, a good day may mean the opportunity to be with loved ones; for others, a good day may mean the opportunity to be as free of pain as possible. For many, a good day may mean the opportunity to be as productive as possible. For others, a good day may mean the opportunity to be able to express oneself fully. For all, a good day may mean the opportunity to be able to do things that one enjoys.

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.
- Conscious 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:

- Advance Care Planning: www.nationaladvancecareplanning.org
- Advanced Illness Management (AIM): http://www.centerforhealthquality.org/focus/advanced-illness-management.html
- Respecting Choices: http://www.respectingchoices.org
- The Conversation Project: http://thecommunicationproject.org

References

7. "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 (US) 20% more often than those in lower intensity regions." 8. Ibid. Dartmouth Atlas of Health Care, 2015.

Healthwise is a not-for-profit consumer health information organization whose mission is "to help people make better health decisions."