



HUMANITARIAN HEALTH DIGEST

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JOHNS HOPKINS
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WELCOME

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

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

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

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

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

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

Paul Spiegel MD, MPH
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Richard Horton FRCP, FMedSci
Editor-in-Chief of *The Lancet*

COMMENT I.

The ‘healthy migrant effect’ re-examined among North Koreans in South Korea

by Courtland Robinson, Associate Professor, Johns Hopkins Bloomberg School of Public Health and Center for Humanitarian Health



<https://www.brookings.edu/articles/human-rights-and-humanitarian-planning-for-crisis-in-north-korea/>

▲ North Korean refugees arriving in China.

Since the separation of Korea into North and South and the end of the Korean War in 1953, more than 31,000 North Koreans have fled their country and settled in South Korea. Most of these refugees (alternatively called defectors or migrants) came south since the mid-1990s when years of famine were followed by economic hardship, food shortages, and human rights abuses. The most common route has been through China and then following various routes through other Asian countries to reach South Korea. More than 70% of North Koreans in South Korea are female. While the journey can be long and difficult—particularly since China does not grant North Koreans refugee protection—North Koreans who reach South Korea are recognized as citizens and provided permanent residence and settlement assistance.

While many studies have examined the health and mental health of North Korean refugees as a proxy measure of conditions inside North Korea, more recent work has focused on the health of this population in the process of displacement and settlement. As South Korea is a high-income country, and the transition from communicable to non-communicable disease burden

is well-progressed, there is a need to know how North Korean refugees may reflect that transition. Two very recent studies^{1,2} cited in this quarter’s *Digest* focus, respectively, on cardiovascular disease and reduced kidney function, and general and central obesity.

Kim and colleagues¹ found that male sex, age, and longer duration after defection from North Korea (≥ 10 years) were positively associated with obesity; Song and colleagues² found that low estimated glomerular filtration rates (eGFR < 90 mL/min per 1.73 m²) were more prevalent among North Korean refugees than a comparable South Korean population, even though North Koreans had lived had an average of only 6.7 years in the south. Weight gain among refugee and migrant populations settling in high-income countries has been well documented and is attributed to reduced physical activity, changes in diet, and acculturation.

The ‘healthy migrant effect’ (which Song cites) posits that migrants in general have better health than host populations, though a less well-known corollary suggests that this wears off over time. North Koreans may have left their country in relatively poor health (compared to South Koreans) and their journey out was hazardous; thus we should expect that health might improve once they have arrived in South Korea. But North Koreans who leave their country, even under duress, self-select as healthier than the population they left behind, and, as noted, the displacement/migration experience imposes further stressors, and adjustment to life in South Korea may impose still more. Further research could help measure the burdens and the benefits of settlement in South Korea and, we may hope, generate better evidence to inform and improve settlement programs and policies.

¹ Kim YJ, Kim SG, Lee YH. Prevalence of general and central obesity and associated factors among North Korean refugees in South Korea by duration after defection from North Korea: a cross-sectional study. *Int J Environ Res Public Health*, **15**. doi:10.3390/ijerph15040811

<https://www.ncbi.nlm.nih.gov/pubmed/29904012>

² Song YS, Choi SW. Low estimated glomerular filtration rate is prevalent among North Korean refugees in South Korea. *Korean J Fam Med* 2018; **39**: 161–67. doi:10.4082/kjfm.2018.39.3.161

<https://www.ncbi.nlm.nih.gov/pubmed/29788704>

COMMENT II.

Facing the realities of migrants in Europe for better infectious disease control

by Marianne Guenot, Senior Editor, *The Lancet*

Migrants in Europe are disproportionately affected by infectious diseases. This burden is likely to be due to a higher prevalence of infectious diseases in migrants' countries of origin, as well as to poor living conditions and barriers to health care, both during the migrant journey and on arrival in destination countries.

A study¹ cited in this quarter's *Digest* assesses approaches used for infectious disease screening for migrants residing in the EU or European Economic Area. The authors compiled the information from 47 studies done in ten EU countries reporting screening for infectious diseases across 248,402 migrants.

The analysis shows that migrants are likely to be proactive about their health and willing to be screened for infectious diseases, with 80% of the migrants agreeing to be screened after being offered screening for a disease. However, just 39% of eligible persons were screened, and almost a quarter of screened migrants did not complete the screening and did not have a final diagnosis.

Barriers to screening uptake by migrants exist within health care settings that are complicated and hostile to the migrant communities: perceived migrant insensitivity at the point of service—for instance, fear of discrimination, fear of racism,

and anxiety about breaches in confidentiality; cultural and individual mindset barriers—such as low perception of infectious disease risk or fear of disease-related stigma and social rejection; structural and service barriers—such as communication problems, screening procedures requiring too many steps, or being inconsistent between different settings, which is incompatible with the high mobility of some of the migrant community.

Migration is increasingly seen as a high-priority policy issue by many governments, and the broader public, throughout Europe, but is now often filtered through a lens of anti-migrant sentiment. Much of the discourse is centred around control of immigration, which is not necessarily effective. Following the European Union (EU)-Turkey Statement of March 18, 2016, the number of arrivals by sea in Greece dropped dramatically, reaching just over 170,000 in 2016—a significant decrease compared with the over 850,000 arrivals by sea to Greece in 2015. However, a 16% increase in the number of migrants arriving by sea to Italy showed that migration routes

can circumvent the barriers to entry in Europe.

1.8 million migrants have come to Europe since 2014, migrants who could be an asset were these populations given the ability to productively integrate into society. When it comes to infectious disease screening, the authors of the review suggest that interventions such as proactive training of staff to reduce discrimination, community engagement to better inform migrant populations about screening processes, harmonisation and simplification of screening processes, and better data collection would ameliorate screening for infectious diseases in migrant populations.

Focussing European migration policy on immigration control is not humanitarian and it is short sighted. Infectious diseases screening should be seen as part of a holistic approach to migrant health, which includes access to health care for reproductive and maternal health and mental health, among others. People will continue to be displaced, and will continue to need a place to call home. The EU must push a radical change in its rhetoric, and start embracing the realities of migration.

¹ Seedat F, Hargreaves S, Nellums LB, Ouyang J, Brown M, Friedland JS. How effective are approaches to migrant screening for infectious diseases in Europe? A systematic review. *Lancet Infect Dis* 2018. doi:10.1016/s1473-3099(18)30117-8

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V. WATER, SANITATION, AND HYGIENE (WASH)

LOW- AND MIDDLE-INCOME COUNTRIES

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HIGH-INCOME COUNTRIES

N/A.

VI. MENTAL HEALTH, PSYCHOSOCIAL ISSUES, AND SUBSTANCE ABUSE

LOW- AND MIDDLE-INCOME COUNTRIES

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HIGH-INCOME COUNTRIES

N/A.

II. NON-COMMUNICABLE DISEASE

N/A.

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

LOW- AND MIDDLE-INCOME COUNTRIES

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IV. NUTRITION AND FOOD SECURITY

LOW- AND MIDDLE-INCOME COUNTRIES

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HIGH-INCOME COUNTRIES

N/A.

V. WATER, SANITATION, AND HYGIENE (WASH)

LOW- AND MIDDLE-INCOME COUNTRIES

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N/A.

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LOW- AND MIDDLE-INCOME COUNTRIES

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N/A.

VIII. MULTI-CATEGORY

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HIGH-INCOME COUNTRIES

N/A.

Technological Disasters

I. COMMUNICABLE DISEASE

N/A.

II. NON-COMMUNICABLE DISEASE

LOW- AND MIDDLE-INCOME COUNTRIES

N/A.

HIGH-INCOME COUNTRIES

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

IV. NUTRITION AND FOOD SECURITY

V. WATER, SANITATION, AND HYGIENE (WASH)

III.-V, N/A.

VI. MENTAL HEALTH, PSYCHOSOCIAL ISSUES, AND SUBSTANCE ABUSE

LOW- AND MIDDLE-INCOME COUNTRIES

N/A.

HIGH-INCOME COUNTRIES

Suzuki Y, Takebayashi Y, Yasumura S, et al. Changes in risk perception of the health effects of radiation and mental health status: the Fukushima Health Management Survey. *Int J Environ Res Public Health* 2018; **15**. doi:10.3390/ijerph15061219
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Nukui H, Midorikawa S, Murakami M, Maeda, M, Ohtsuru A. Mental health of nurses after the Fukushima complex disaster: a narrative review. *J Radiat Res* 2018; **59** (suppl 2): ii108–13. doi:10.1093/jrr/rry023
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VII. HEALTH SYSTEMS

N/A.

VIII. MULTI-CATEGORY

LOW- AND MIDDLE-INCOME COUNTRIES

N/A.

HIGH-INCOME COUNTRIES

Fukushi Y, Nakamura A, Itaki C, Tokonami S, Yamada M, Mariya Y. Mental and physical stress of the Fukushima disaster evacuees as estimated by the measurement of urinary 8-hydroxy-2'-deoxyguanosine. *Exp Ther Med* 2018; **16**: 231–35. doi:10.3892/etm.2018.6165
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