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Psychosocial Consequences of Armed Conflicts on Society

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This issue of the *Clinical Social Work and Health Intervention Journal* is devoted to the topic of psychosocial consequences of armed coonflicts on society. Social events of global significance, including military conflicts, cause serious psychosocial consequences for individuals, groups and communities. This involves, for example, restructuring or even destabilizing values, especially for those in whom armed conflict makes it necessary to change the current way of life. The loss of security is accentuated by the real threats posed by the ongoing armed conflict not only in the countries directly involved, but also in the surrounding countries, the whole continent or the world. The traumatic experiences of war are particularly dangerous for the psychosocial development of children, whose mental and social health can be seriously impaired as a result of these events. War conflicts also often reshapes boundaries, not only between countries, but also in a psychosocial sense between individuals, ethnic groups, or entire nations.

As a result of the war standardized social situations and processes also change their etiology, incidence, prevalence and possible solutions, such as housing, looking for a job, education of children and youth, or health and social care.

War conflicts, even after their end, have long-term consequences, for example in the form of mental and physical symptoms in war veterans and prisoners of war resulting from their direct involvement in combat operations.

A relatively new phenomenon of the society-wide reflection of public awareness of war conflicts is the determination of its relevance by global social media. Verification of the justification of the war conflict, information about the course of the fighting, or the war facts themselves in the global social media during the war conflict becomes a topic that goes beyond the national reference framework and requires a global society-wide commitment.

Identifying methodological approaches, theoretical background, as well as the possibilities of scientific interpretation of the psychosocial consequences of war conflicts on society is an important and current task of scientists in the social sciences and humanities.

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Concerning the Humanitarian Crises in Ukraine

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Abstract:

The humanitarian crises in Ukraine recall other armed conflicts that resulted in needless death, destruction and the flight of refugees in pursuit of safety.

In some ways, the international cable television network coverage of the conflict in Ukraine may have brought a greater sense of immediacy to the devastation being experienced by the people there. Foreign press coverage in the early weeks of the conflict utilized "on the ground" correspondents reporting in real time on the atrocities they were witnessing. Eventually, the intensity of the armed conflict, coupled with the death and serious injury of journalists, caused some media outlets to withdraw some of their personnel to safer locations.

The War in Ukraine might be further categorized as two humanitarian crises: the plight of citizens remaining in the country including the forces attempting to defend against the Russian invasion and more than 3.7 million so far who have become refugees. The displacement of civilians from Ukraine is now

the largest such exodus in Europe since World War II (Economist, March 19-25, 2022). However, the refugee flight is smaller than from the recent civil war in Syria.

Within the Country

The invasion of Ukraine has seriously hampered the provision of medical care to the nation's residents.

In a joint statement from the United Nations Children's Fund (UNICEF), the United Nations Population Fund (UNFPA) and the World Health Organization (WHO), the parties called for „an immediate cessation of all attacks on health care in Ukraine" (WHO, March 12, 2022).

The statement continued:

> „These horrific attacks are killing and causing serious injuries to patients and health workers, destroying vital health infrastructure and forcing thousands to forgo accessing health services despite catastrophic needs." (ibid)

Among the most heavily devastated cities in Ukraine is Mariupol. The International Committee of the Red Cross (ICRC) addressed the situation in Mariupol by stating:

> „Hundreds of thousands of the city's residents are now facing extreme or total shortages of basic necessities like food, water and medicine. People of all ages, including our staff are sheltering in unheated basements, risking their lives to make short runs outside for food and water… Lifechanging injuries and chronic debilitating conditions cannot be treated. The human suffering is simply immense". (ICRC, March 13, 2022)

The Washington Post (March 17, 2022) reported that the WHO had verified 43 attacks „including assaults on patients, health care workers, facilities and infrastructure". The Post also reported that the shelling of cities, supply routes and shipping ports had made it „nearly impossible for international aid including life saving medication to be delivered including cancer drugs, insulin and dialysis supplies".

The American Cancer Society formed a network of volunteer oncologists to connect virtually with physicians and cancer patients in Ukraine (Wall Street Journal, March 12-13, 2022). has been forced to suspend much of its work in the country, but is continuing to donate medical supplies and is setting up sites at the Ukrainian border (ibid).

Internally Displaced Persons and Refugee

Since the invasion of Ukraine began on February 24, 2022, there has been a large displacement of Ukrainian civilians. The United Nations estimate that approximately 6.5 million are Internally Displaced Persons (IDP) who left their homes because of the armed hostilities but still remain in the country and more than 3.5 million who have crossed international borders and are classified as refugees (UN News, March 21, 2022).

Since men between the ages of 18 and 60 were to remain in Ukraine as military or volunteer defense forces, the vast majority of IDP and refugees are women, children, and the elderly, many of whom require medical care including medication.

In the early days of the invasion, attempts were made to establish humanitarian corridors for the safe passage of hospitalized patients, IDP and refugees. But many of the corridors have been subjected to military attack and were unable to facilitate safe passage. Beehner & Spencer (2022) point out that despite anticipated benefits of the corridors to aid in the safe passage of non-combatants, their use can also lead to increased civilian deaths as happened in Grozny and Aleppo when the cities from which the corridors lead are presumed clear of non-combatants and military forces shell nonmilitary targets without limit.

The vast majority of the refugees from Ukraine have migrated to eastern European nations immediately adjacent to the war-torn country: Poland, Slovakia, Hungary, Romania and Moldova. From there, many have migrated further west into Europe and some have gone north to Estonia, Latvia and Lithuania. A small number migrated from the eastern provinces into Russia.

The European Union (EU) has given Ukrainians the right to live and work anywhere in the 27-member countries for up to one year (Dalton, 2022). The EU is also providing tens of billions of dollars from its budget for member states to provide housing, medical care, education and other support (ibid).

The Legal Implications

The International Court of Justice in the Hague, The Netherlands issued on March 16 „a preliminary but likely unenforceable order“ to Russia to cease military operations in Ukraine. The suit was filed by Ukraine which claimed that Russia justified the invasion on the false pretext „of stopping a purported genocide in Ukraine's Russian-speaking Luhansk and Donetsk regions“ (Bravin, 2022). Russia claims the court lacks jurisdiction in the dispute.

Courts in The Hague may also end up dealing with civil litigation or enforcement of a treaty to end the conflict. Ukraine has already suffered hundreds of billions of dollars in damage to its infrastructure. Assuming a negotiated resolution to hostilities, the issue of reparations will most likely be discussed. Might some of Russia's financial assets impacted by international sanctions remain out of reach of the Kremlin until there is some agreement as to how Ukraine is to be compensated for the damages it has suffered?

The International Criminal Court in The Hague has begun an investigation on whether Russia has committed war crimes in Ukraine. The Council on Foreign Relations has written that the invasion of Ukraine „constitutes the crime of aggression under International Law“ (Scheffer, 2022). He writes: …“all uses of armed forces by Russia on Ukrainian territory can be viewed as illegal“ (ibid). He argues further that Russian activity constitutes not only war crimes, but also crimes against humanity and genocide.

Conclusion

The invasion of Ukraine and the subsequent relocation of approximately ten and one half million people constitute two of the most significant humanitarian crises since the World War II. The destruction of health care facilities within country, combined with the health needs of IDP and refugees, are presenting an ongoing needs for international support for the Ukrainian people. That need for international support of health need may continue for years into the future.

References

1. BEEHNER L, SPENCER J (2002) „Russia's Humanitarian Corridors in Ukraine Endanger Human Life.“ Wall Street Journal, March 17, 2002, p. A21.
2. BRAVIN J (2022) „World Court Orders Russia to Suspend Military Action in Ukraine.“ Wall Street Journal, March 17, 2022, p. A13.
3. DALTON M (2002) „EU Pressed to Provide Haven For Refugees.“ Wall Street Journal, March 23, 2002, p. A7.
4. THE ECONOMIST „No End in Sight.“, March 19-25, p. 15.
5. INTERNATIONAL COMMITTEE OF THE RED CROSS (2022“Ukraine: ICRC Calls For Urgent Solution to Save Lives and Prevent Worst-Case Scenario in Mariupol.“, March 13, 2022. Retrieved March 15 at www.icrc.org.
6. COSTELLO M, DRGOVA J, BOZIK J, MURGOVA A, GALLOVA, A., BUJDOVA N (2020) Vaccine refusal *Clinical Social Work & Health Intervention*, 11 2020, 2, pp. 9-12.
8. OTRUBOVA J, KALATOVA D, KILIKOVA M, MURGOVA A, KOZON V, *et al*. (2019) Education on nursing and social work. *Clinical Social Work & Health Intervention*, 2019, 2, pp 10-11.
9. KHALED I, HAJ ALI PERI, KALATOVA D, GALLOVA A, BAK T, MURGOVA A, ZOLLER K, GIERTLIVOVA D, *et al*. (2018) Spectrum of infections in physiotherapy and rehabilitation ward for war victims. *Clinical Social Work Health Intervention*. 8, 2018, 2, 26-28.
10. SCHEFFER D (2022) „Can Russia Be Held Accountable For War Crimes in Ukraine?“ Council on Foreign Relations, March 17, 2022. Retrieved March 21, 2022 at www.cfr.org.
11. UNITED NATIONS (2002) „More Than 2 Attacks a Day on Ukraine Health Facilities; 6.5 Million Now Internally Displaced,“ UN News, March 21, 2002. Retrieved March 23, 2022 at www.news-un.org.
12. WALL STREET JOURNAL „Aid Groups Rush In as Health Crisis Emerges.“ March 12-13, p. 1.
13. THE WASHINGTON POST (2002) „At least 43 Attacks on Health-Care Facilities and Patients in Ukraine, WHO says.“, March 17, 2002.
14. WORLD HEALTH ORGANIZATION (2022) „Stop Attacks on Health Care in Ukraine. Joint Statement from United Nati-

ons Children's Fund, United Nations Population Fund and World Health Organization," March 13, 2022. Retrieved March 15, 2022 at www.who-int/news.

Spectrum of Humanitarian Help to migrants of War from Multi-ethnic vs. Mono-ethnic Regions (Note)

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Abstract:

After armed conflict due to invasion of Russian Fed forces to Ukraine, humanitarian help from neighboring countries emerged, mainly Poland, Slovakia, Czech Republic, Hungary,

Romania, Moldova, etc. The aim of this short research note is to compare the type of humanitarian assistance from a multi-ethnic area of Rimavska Sobota (multi-ethnic area with about one fifth of Hungarian; a third of Roma population; a district of highest unemployment; to the Bratislava area with lowest unemployment with Slovak nationals in majority.

Introduction

War conflicts have been fueling media especially when they emerged outside of Europe (Eritrea, Yemen, Libya, Syria, Iraq, Afghanistan) and the Middle East was considered as the most affected region. Therefore, so called small conflicts in Central Europe have unfortunately escaped from attention of major humanitarian HMO, starting from the Balkan War in Croatia, Serbia, Bosnia, Kosovo with about 200,000 victims; Karabakh, with 20,000 victims; and currently in Ukraine, with up-to-date about 5 million refugees of war, declared as the biggest migrant refugee and internal displacement event within last 80 years. The aim of this note is to compare humanitarian assistance collected from the less developed multi-ethnic district in Slovakia, Rimavska Sobota) to Bratislava, the highest financially developed mono-ethnic district within the first 3 weeks of war. (l-3)

Methods

Open label cohort comparison of funds per capita/per student and type of intervention was done comparing Rimavska Sobota with 50,000 (district) 3-ethnic population (Slovak, Hungarian, Roma) versus 10 times higher populated capital of Slovakia, Bratislava (500,000 inhabitants per district), between 24.2. to 6.3.2022, during first 2 weeks) Items were independently compared such as:

a. financial funds
b. food and drinks/water
c. clothing/shoes
d. medication
e. staff health care/social work

Results and discussion

As seen from Table l., the food and hygiene items per student/capita was surprisingly highest from Rimavska Sobota, followed by Michalovce, Presov and Skalica, in comparison to Bratislava which is economically the most developed district with highest per capita income. The student teaching centers situated closer to the border, Presov and Michalovce, were the earliest at the border; Rimavska Sobota and Skalica, contributed to humanitarian help concerning food and medicines. Bratislava contributed most massively with Michalovce and Presov to Health Care; Bratislava with doctors and rescuers; Michalovce and Presov with nurses.

Currently, Michalovce and Presov Centers, with Bratislava support, are covering most nursing

and health care services at both hotspots closest to the border. And, the Step In Group and John Paul II are on steam to the social mission inside of Ukraine. Even the team from Dept. of Social Work has its Ambassador in Melitopol inside of the occupied part of UA administrative regulated from the Donetsk Republic backed by

Table 1 Comparison of the amount and value of humanitarian assistance to refugees of war to UA/SK border and UA within first period of refugee wave due to the armed conflict (population of students in first column)

Student center / population		Timing / days from conflict		Staff	Food	Other/kg
Rimavska Sobota	185	Day	6	2 yes	1,250	
Skalica	288	Day	12	1 yes	1,500 plus med	
Michalovce	605	Day	1	8 yes	nursing/soc. workers	
Presov	420	Day	1	4 med	nursing staff	
Bratislava	2,025	Day	4	3 med	rescue, doctors	

Russian troops; taking care of wounded; performing food distribution. Surprisingly, there were no security events in any of those operations not even in Melitupol and other sites of UA to the humanitarian staff from the group of authors reported up-to-date.

Conclusion

Even students from poorest districts in Slovakia with lowest per capita income and highest unemployment rate have very rapidly showed their solidarity independently of nationality, race, and religion. Probably low socio-economic housing and lifestyle levels may positively influence the willingness to help with social work, food, assistance, and most rapid transport to affected areas.

References

1. HAMAROVA A *et al*. (2022) First week of mission and humanitarian assistance at the unkrainian border. *Acta Missiologica*, 12. 2022. 1. pp. 12-13.
2. SUVADA J, PALENIKOVA M, *et al*. (2021) Post Ttrauma Stress Syndrome is the commonest diagnosis in migrants to Greece. *Clinical Social Work and Health Intervention*,11.2021. 2. pp. 98-99.
3. TOPOLSKA A *et al*. (2020) Spectrum of humanitarian assistance in war affected South Yemen, *Medical Horizon*. 59. 2020. pp. 266-270.

Personal Journey through Memory in Ukraine (Letter to the Editor)

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Abstract:

The images of destruction in Ukrainian cities that we continue to see on television every day, and the dramatic reports done by journalists, reminded me of a visit I made to that tormented country more than 20 years ago that I want to share with this brief note. In particularly, I remember taking part in a series of meetings with Ukrainian colleagues in two cities, Lviv and Kiev as part of an initiative promoted by the Vicariate of Rome, in the person of His Excellency Monsignor Lorenzo Leuzzi which involved professors from the Catholic University such as myself, and from the University of Tor Vergata both from Roma, Italy. Obviously, colleagues from the University of Lviv participated, and Prof. Krcmery was also present representing at that time the University of Trnava, Slovakia. The title of the conference was '*Humanism in Medicine*'. The meetings were held on the occasion of the apostolic visit of Pope St. John Paul

II which took place in June 2001. I still have vivid memories of that unforgettable trip and the meetings I had with Ukrainian colleagues. The topics either dealt with the ethical and scientific aspects of responsible childbirth, the use of stem cells in medicine and theology, the ethical aspects of human genetics and lastly, medical culture as an opportunity for teaching humanism. Indeed, I was a speaker in this last session (see photo). I also enclose both the bilingual program, in English and Ukrainian, with the complete list of speakers and the poster advertising the event. The opening prayer was given by His Eminence Cardinal Harchbishop Marian Yavorsky.

Having lived this extraordinary cultural experience it gives me unspeakable sorrow to think that some of those colleagues with whom we shared this experience during the Congress and in the following days may now find themselves in a situation of objective danger.

Notably, I certainly appreciated the high scientific level of my colleagues and their extraordinary commitment both on the technical side and more generally on ethics and Medical Humanities. This was evident from the visits we made to the hospitals. What was quite evident to me at the time was that while there was excellent medical training, the same could not be said of the technological equipment and instruments which were objectively further behind than those to which I was accustomed. It is clear that my memories are crystallized to this brief but intense experience and many of the things I saw then have probably changed for the better. In fact, I am sure that after 20 years even the technical aspects have improved even if unfortunately the present war have brought destruction.

I am also pleased here to recall that following the diaspora that is taking place in these days, the Italian Ministry of Health, aware of the exceptional nature of the moment and the excellent professional preparation of Ukrainian doctors and nurses, has allowed them to temporarily practice their profession in Italy without further constraints.

Perhaps the most interesting aspect of the conference was not so much the focus on strictly scientific aspects as on the great attention paid, especially by Ukrainian colleagues, to ethical-moral aspects. I interpreted this aspect and their acute interest in retrospect as a desire to regain possession of those ethical-moral aspects that during communism had been overwhelmed by the so-called historical materialism.

In addition to the scientific meetings, I was exposed to Ukrainian culture and religion, and learned how different nationalities, languages, traditions and religions coexist in this country. In fact, there is an Orthodox majority but also the Uniate Catholic faith especially present and active in the western part of Ukraine, in particular in Lviv which was part of the Austro-Hungarian Empire. I am pleased to recall, because the memory is still alive among the faithful, the figure and personality of *Cardinal Slipyj*. The Cardinal had been the object of persecution in the Communist period and through John XXIII he was allowed to immigrate to Italy where he died in Rome in 1984. His body was subsequently transferred (1992) to Lviv where he is buried.

The highlight of the mission in Ukraine was the mass in Kiev of St. John Paul II which was sincerely attended by a very large number of faithful who were not at all frightened by the pouring rain. The memory I have of that memorable celebration was the huge number of people who attended and the strong words of the Polish Pope that resonated in his sermon. I have vivid memories of the days leading up to ceremony. In fact, the whole city was celebrating and dozens and dozens of people met up, who had travelled by all means to the capital to take part in this extraordinary event. To think today that the cities I visited, Lviv and in particular the capital Kiev, with its priceless heritage, such the St. Sophia Cathedral, are at risk of destruction, causes me great pain. No less serious is what is happening to individual citizens who have suddenly found themselves thrown from a peaceful third millennium into a war that in some ways recalls the 20th century with the Second World War and, in terms of violence against civilians, the wars of the ancient times. It is too early to draw conclu-

sions, but certainly whatever the outcome of this terrible war, it will leave an indelible memory of dead and wounded. In the immediate future, Europe will have to deal with a major influx of immigrants occurring during the COVID-19 pandemic. This can aggravate a situation which is already very difficult in itself and not only in terms of health. The percentage of people vaccinated against SARS-CoV-2 in Ukraine is unfortunately very low (30-40%), so there may be a risk that these refugees could be a trigger for a new outbreak of the virus.

This war brought not only a COVID-related health problem, but dissolved the entire hospital and public health network of Ukraine that had reached or was about to reach before the war levels equal to European standards.

In this serious moment that sees the pain of so many refugees, it is important that either at the borders of Ukraine or in the countries that will accept them, the health of people is taken into great consideration by ensuring the continuity of treatment for chronic diseases and by establishing Public Health criteria such as the restoration of vaccinations to prevent the spread of infectious diseases.

In this regard, it should also be remembered that during catastrophic events such as the earthquake in Haiti, even in this case, skipping all the preventive measures in the bombed cities, there could be an increase in infectious diseases of fecal-oral transmission. No less important is the focus on sexually transmitted diseases in relation to the episodes of violence that have been reported in recent days. As previously said, this war event follows another disastrous event that is represented by the COVID-19 pandemic that still persists today. The combination of these two disastrous situations makes helping the Ukrainian population extremely difficult and complicated. In spite of this, the help to Ukraine is an inescapable moral duty for everyone, especially for physicians and more generally for health care workers whose mission is to bring relief to people.

At the end of this short note, I would like to thank Prof. V. Krcmery and Tropicteam (1-4), with whom I have been sharing both scientific and international solidarity aspects for over 30 years, for having asked me to bring my small testimony contribution on the occasion of this Ukrainian crisis. This allowed me to recall the apostolic visit of the Holy Father St. John Paul II in 2001 and the scientific events parallel to this.

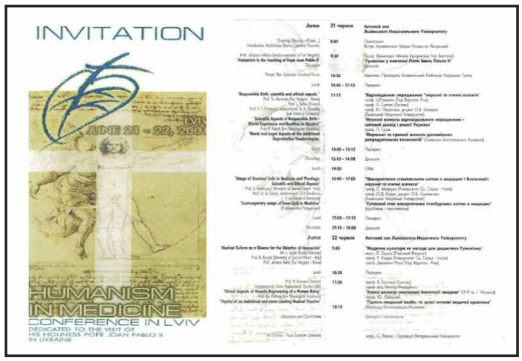

Photo: Invitation of conference 'Humanism in Medicine

References

1. COSTELLO M, DRGOVA J, BOZIK J, MURGOVA A, GALLOVA, A., BUJDOVA N (2020) Vaccine refusal *Clinical Social Work & Health Intervention*, 11 2020, 2, pp. 9-12.
2. OTRUBOVA J, KALATOVA D, KILIKOVA M, MURGOVA A, KOZON V, *et al*. (2019) Education on nursing and social work. *Clinical Social Work & Health Intervention*, 2019, 2, pp 10-11.
3. KHALED I, HAJ ALI PERI, KALATOVA D, GALLOVA A, BAK T, MURGOVA A, ZOLLER K, GIERTLIVOVA D, *et al*. (2018) Spectrum of infections in physiotherapy and rehabilitation ward for war victims. *Clinical Social Work Health Intervention*. 8, 2018, 2, 26-28.
4. BELOVICOVA M, MURGOVA A,VANSAC P, POPOVICOVA M (2019) Hepatitis C screening in Selected Social Rescue group facilities in Eastern Slovakia. *Clinical Social Work & Health Intervention* 10. 2019, 2, 5-28.

Unexpectedly low Incidence of COVID-19 among Refugees of War from Ukraine to Slovakia in First Month of Conflict (Original Research)

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Abstract:

Several armed conflicts and military troop interventions have been associated with minor pandemics, however, not always, and with the extent varied. e.g. during the most catastrophic loss of lives in the Bosnian Conflict in 1993-95 where 160,000 civilians and soldiers fell into mass graves, only one small epidemic of Hepatitis A was reported to the European branch of WHO.

In contrast, epidemics of cholera in Haiti, not related to war but associated with troop deployment (UN battalion from Nepal) in 2014, led to a devastating epidemic of cholera in the Artibonite River District with 1,000s of deaths. The same was reported during civil war and genocide in Rwanda in 1988-98 where hundreds died, and refugees of war-related exodus from Rwanda to the DRC in Goma. Finally, pipeline and water supply devastation during war in Yemen, led to the largest cholera outbreak in Yemen (1-3). Therefore, fear of epidemics, especially during COVID-19 Omicron wave is of concern mainly when the numbers of positive cases in Austria and other EU countries are increasing.

The aim of this study was to report the results of COVID-19 antigen testing in those escaping from war in Ukraine.

Methods and patients

Antigen testing for COVID-19 was performed by Standard Q Covid 19 Ag manufactured by Biosensor SD, var 3 Dusseldorf FRG, sampling by Shenzen Miraclean Technology, was voluntarily offered to those entering the border at Vysne Nemecke - Uzhorod checkpoint before entering buses, because bus transport companies required all adults be freshly tested by Ag test before the journey to CZ, AT or FRG was started. The test was not required by Slovak authorities for transit up to 8 hours nonstop but by bus companies and drivers to avoid the spread to other co-passengers during travel longer than 6 hours. This first group, (Gl) tested at the border were 101 individuals tested for this reason on days 10-13; a second group (GII) tested at point of entry of St. Elizabeth University Center for Refugees 5 minutes from the main Bratislava Rail Station. The building is used as a temporary shelter for transit up to 48 hours, to avoid transmission to other persons sleeping in the same room or admitted to a student guest house, where positively tested families can be quarantined in same room for those who planned to stay at the guest house for temporary residence for days, weeks or months.

Those who test positive and symptomatic are offered antipyretic novalgin and an antibiotic Azithromycin with oxygen less than 90 minutes, and supported with immuglucan pleuran or/and Zn, Se, Dvit tablets and quarantined until symptoms disappear plus 5 days. Those who are asymptomatic and positive were offered only compulsory isolation for 5 days, and a mask wearing regimen according to the *General Hygienist* bill valid in Slovakia until March 31. 155 of those from Group II were tested from day 5-30 after the conflict related crisis started.

Results and discussion

From the 101 refugees of war crossing the border in days 10-13 (on average about 9,500 crossing per day) requiring a test due to bus transport to FRG and CZ, nobody reported covid related symptoms; also because most of them reported to be vaccinated and primary health population transited (children and mothers, all aged below 40 apart with 4 seniors or less-minimum per day). Males younger than 60 were not allowed to leave Ukraine so 99%, were children and mothers on day 4-5. About 500 in total, foreign students from UA universities crossed the border. Zero test positivity was reported, however the limitation of the study is that only a small part of crossings were willing or had medical reason to be tested, and probably some of them denied having it for fear that they may be deported back or isolated.

However, concerning Group II, among 155 tested, 6 tested positive entering Bratislava by Rail Station and being sheltered in a University Building or Guest House. (4%) all being asymptomatic, requiring just 5 days isolation. 4% is less than the average number of Antigen tested positive in Slovakia in March (5.2% in average by Ag test and 51.8% among PCR RT test). All positives were adults: however only 2 were of Ukrainian nationality; one of Egyptian citizenship, being students leaving immediately to Vienna; 5 were Slovak humanitarian workers being infected possibly among all passengers (UA, Slovak, Czech, Hungarian, Austrian) crossing the Rail Station or counseling the refugees at information checkpoint.

Conclusion

In the first 4 weeks, positivity of Antigen testing for Covid 19 was minimal and represented

zero cases at the UA, SK border checkpoint; 4% at the Bratislava Rail Station checkpoint and those transiting or staying at the University Guest House or Main University building where everybody is tested. The explanation of zero positivity at the border is due either to a primary healthy population (young mothers with children); and/or also due to those denying any symptoms being afraid of deportation or isolation.

However, during Antigen testing after 8 hours travel and crossing at least 2 major rail stations, about 4% were detected. However. only a minority were UA refugees: and to a majority of humanitarian staff due to high exposure when assisting or counseling at railway station checkpoints. No symptomatic cases were detected.

For the future, we recommend increasing the testing capacity not only for those who require test for travel (bus train) but for all reporting any RTI symptoms explaining to them that tests cannot cause their deportation or isolation or any repression but only serves them to report this for next 5 days to their new housing sites (hotels, houses, guestrooms, shelters etc.) requiring separate management (isolation, or cohabitation with other positive refugees). In addition everyone should be compulsory tested: that means refugees; migrants, displaced, homeless; as well as humanitarian staff each day before service to avoid transmission to permanent housing facilities.

References

1. WHO ANNUAL REPORT (2020) WHO Genéve, 2022. pp. 155.
2. HYGIENIST GENERAL (2011) Lex corona. *National Institute of Public Health Bratislava* 2011. pp. 25
3. HAMAROVA A.*et al*. (2022) First week of mission and humanitarian assistance at the Ukrainian border. *Acta Missiologica*, 12. 2022. 1. 12-13.
4. SUVADA J, PALENIKOVA M, *et al*. (2021) Post trauma stress syndrome is the commonest diagnosis in migrants to Greece. *Clinical Social Work and Health Intervention*, 11.2021. 2. pp. 98-99.
5. TOPOLSKA A *et al*. (2020) Spectrum of humanitarian assistance in war affected South Yemen, *Med Horizon*. 59. 2020. pp 266-270.
6. COSTELLO M, DRGOVA J, BOZIK J, MURGOVA A, GALLOVA, A., BUJDOVA N (2020) Vaccine refusal *Clinical Social Work & Health Intervention*, 11 2020, 2, pp. 9-12.
7. OTRUBOVA J, KALATOVA D, KILIKOVA M, MURGOVA A, KOZON V, *et al*. (2019) Education on nursing and social work. *Clinical Social Work & Health Intervention*, 2019, 2, pp 10-11.
8. KHALED I, HAJ ALI PERI, KALATOVA D, GALLOVA A, BAK T, MURGOVA A, ZOLLER K, GIERTLIVOVA D, *et al*. (2018) Spectrum of infections in physiotherapy and rehabilitation ward for war victims. *Clinical Social Work Health Intervention*. 8, 2018, 2, 26-28.
9. BELOVICOVA M, MURGOVA A, VANSAC P, POPOVICOVA M (2019) Hepatitis C screening in Selected Social Rescue group facilities in Eastern Slovakia. *Clinical Social Work & Health Intervention* 10. 2019, 2, 5-28.

Comparison of Risk of Diseases and Humanitarian Help of Areas after Bombing and Shelling in Yemen and Karabakh Autonomous Region Armenia

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Abstract:

Several Yemenese towns had been shelled and bombed in the Karabakh Region in 2000-2001 by neighboring states. Bombing and/or natural disasters due to earthquakes and floods have been related to outbreaks of waterborne diseases due to destruction of water pipelines and damaging wells for individual water supply. We compare 2 Regions: 1 in tropical; the other in a mild climate afflicted by similar war intervention-shelling and bombing from neighboring countries, Yemen and Karabakh Arzach Autonomous Region of Armenia in 2020.

Introduction

History within the last 30 years of war, conflict and/or natural disaster, related with disruption of water pipelines, resulting in waterborne infections. Hepatitis A, leptospirosis but mainly Salmonella, Shigella and Cholera. Postwar cholera devastated the Rwandese DRC border, Hariri, and finally Yemen. Fortunately no waterborne outbreaks were reported from the Karabakh Autonomous Region within the last 2 years. Therefore, the spectrum of humanitarian help after similar types of destruction were different.(1-3). The aim of this communication is to compare the type of humanitarian help to both Regions: similarly affected but with very different climates.

Settings and Methods

Hodeidah was affected with bombing and shelling by Saudi forces for 4 years, however, very sporadically in last 2 years; Stepanakert and surrounding towns in Karabakh shortly within the autumn and winter of 2020 for approximately 3 months and with sporadic firing and shelling after thae period. Two member teams, composed of social workers were organizing food, water and medication from local pharmacies and shops within local marketing with funds transferred from the Humanitarian Center in Bratislava. A comparative 2 cohort approach was applied, and about 5,000 recipients in each city were served and compared.

Results and discussion

After initial help of team leaders from the Czech and Slovak Republic, the activity was performed by local social workers. This, due to security concerns because both European humanitarian groups were removed due to safety concerns leaving funds and maintaining money transfers, purchasing water and food in Yemen and medications in Karabakh. Because no waterborne diseases were noted in Stepanake during the winter season, most medications were imported via our centers for COVID-19 and pneumonia (antivirals, antibiotics, oxygenators, ceftriaxone, azithromycin, hydroxyquine, etc.) . Vice versa, due to cholera local outbreaks in Yemen, food and safe water were substances of humanitarian help in Yemen.

Conclusion

Despite similar types of war intervention-sporadic bombing and shelling, different approaches have to be applied due to different climate and spectrum of communicable diseases. In first case-Karabakh related with climate and local epidemics (pneumonia, Covid-19, influenza) and vice versa with waterborne infections due to Vibrio cholera, due to destruction of water sources and pipelines.

The spectrum of humanitarian intervention has to be therefore not adapted according to the type of conflict and destruction (similar in Karabakh and Yemen) but to local epidemiology and climate. Preparedness plans must be adapted for both waterborne and airborne outbreaks, and spectrum of stockpiled medication has to be prepared for those 2 major infections of war, in addition to wound infections due to direct war injuries.

References

1. COSTELLO M, DRGOVA J, BOZIK J, MURGOVA A, GALLOVA, A., BUJDOVA N (2020) Vaccine refusal *Clinical Social Work & Health Intervention*, 11 2020, 2, pp. 9-12.
2. OTRUBOVA J, KALATOVA D, KILIKOVA M, MURGOVA A, KOZON V, *et al*. (2019) Education on nursing and social work. *Clinical Social Work & Health Intervention*, 2019, 2, pp 10-11.
3. KHALED I, HAJ ALI PERI, KALATOVA D, GALLOVA A, BAK T, MURGOVA A, ZOLLER K, GIERTLIVOVA D, *et al*. (2018) Spectrum of infections in physiotherapy and rehabilitation ward for war victims. *Clinical Social Work Health Intervention*. 8, 2018, 2, 26-28.
4. BELOVICOVA M, MURGOVA A,VANSAC P, POPOVICOVA M (2019) Hepatitis C screening in Selected Social Rescue group facilities in Eastern Slovakia. *Clinical Social Work & Health Intervention* 10. 2019, 2, 5-28.
5. CARPO – Center for Applied Research in Partnership with the Orient & V (2018), ISSN 2364- 2467 Bonn, 2018.

Among Refugees of War from Ukraine, Yemen and Syria, Post Traumatic Stress Syndrome is the Commonest Diagnosis among Health CTR Visits

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Abstract:

War conflicts are not anymore located only to African and Asian subcontinent or to developing and less democratic countries, but after stopping the armed tensions: Zimbabwe in 2018; Ethiopia & Somalia in 2020; Libya in 2021; DRC in 2022, Middle east and Central Europe are surprisingly leading parts of the world with armed conflicts resulting to large numbers of internally displaced(l) war refugees (11) and subsequent unrest migrants(iii). The aim of this survey is to compare the commonest diseases reported by the migrants and refugees at Outpatient Departments (OPD) of clinics being served by SEUC tropic-team and migrant health teams at border spots within the last 6 years.

Introduction

Within the last 7 years, armed conflicts have moved from the Middle East and Sub-Saharan Africa to Central and Eastern Europe. Bosnia and Kosovo conflict ended with approximately 160 thousand dead victims; in Karabach 2 years ago; Georgia between 7-8 years; currently Ukraine is facing the largest refugee crisis replacing the migration exodus from Middle East to Turkey, Greece and the Balkans in 2015-16. The current number of all 3 groups escaping from war may reach 8 million in a few months, currently presenting 4-5 million legal and illegal refugees and migrants to Poland, Hungary, Slovakia, Czech Republic, Moldova and Romania. We have been active in Middle East and Africa conflicts in outbreaks of infectious diseases such as cholera (Somalia, Yemen, Rwanda; Poliomyelitis (Syria, Afghanistan) were results of war and refugee crises.

Fortunately, Syrian and Iraqi refugees, were escaping from organized health care system with high proportions of vaccinated populations, did not resulted to any major outbreak during the last refugee crisis into Central Europe in 2015-2018 when 879,000 migrants crossed the Balkan EU borders. (1-5)

Patients and Methods

Comparison of OPD visits and their spectrum of diseases in various hotspots is compared.

When low patient flow among refugees was detected, the diagnosis was easier (Lebanon, Lesbos), when large numbers of migrants appeared per day with a capacity of 2-20 HCW the diagnosis was comparable to time and to the acute situation (bombing shelling in Yemen, Syria, Iraq and Yemen) or peace (Balkan Crisis 2015-2018, Lesbos, etc.)

Results and discussion

In contrast to our experience in Rwanda, Haiti, Yemen, where major Infectious diseases outbreaks due to disruption of water supply was present due to cholera; or polio (Afghanistan, Syria); respiratory diseases (Balkan); scabies and other skin and soft tissue infections (Bosna, Lesbos), the current situation at border hotspots in Ukraine shows similarly to Lebanon and Iraq; countries with acceptable healthcare and high immunization level) majority of war (bombing and shelling) related disorders not related to infectious diseases, such as Post-traumatic Stress Syndrome; Acute Stress Syndrome; Hypertension; Insomnia; Psychiatric Reactive Disorders; diabetes; asthma), similarly to entities related with chronic stress in highly developed EU countries. Also, the number of Covid-19 infected persons in first month of war was low. Tuberculosis, having 10 times higher annual incidence (70-75 per 100.000 in UA) and 6.5 times average in EU, has also not been frequently seen in first month of war (2 cases). The reason is that active TB cases and COVID-19 symptomatic patients are unable to survive 36 hour travel and subsequent 18 hour waiting time at the border as seen in first 10 days. In addition, fear of deportation or isolation prevents symptomatic TB cases and other RTI patients to start the suffering travel.

Conclusions

The first month or war in Ukraine did not show any major outbreaks of infection historically related with war and refugees, such as cholera, shigella, pneumonia. Very few cases of TB and Covid-19 has been observed at the Slovak-Ukrainian border, however, the situation may be different in Romanian and Polish bound-

aries where many more refugees cross the border. Vigilant Covid-19, TB, measles surveillance and checking vaccination status may prevent the EU from entering or spread of classical ,,war" related pandemics, as seen in Yemen, Haiti, and Rwanda. Therefore, ECDC and WHO alert early warning systems shall be initiated ASAP mainly for early isolation of epidemic respiratory diseases (measles, Covid-19, TB) as well as waterborne infections in early summer.

References

1. WHO ANNUAL REPORT (2020) WHO Geneve, 2022. pp. 155.
2. HYGIENIST GENERAL (2011) Lex corona. *National Institute of Public Health Bratislava* 2011. pp. 25
3. HAMAROVA A.*et al*. (2022) First week of mission and humanitarian assistance at the Ukrainian border. *Acta Missiologica*, 12. 2022. 1. 12-13.
4. SUVADA J, PALENIKOVA M, *et al*. (2021) Post trauma stress syndrome is the commonest diagnosis in migrants to Greece. *Clinical Social Work and Health Intervention*, 11.2021. 2. pp. 98-99.
5. TOPOLSKA A *et al*. (2020) Spectrum of humanitarian assistance in war affected South Yemen, *Med Horizon*. 59. 2020. pp 266-270.

Acute Post Trauma Stress Syndrome (PSS) versus Chronic PSS after Armed Operations in Bosna, Yemen versus Lebanon and Syria

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Abstract:

Post Trauma Stress Syndrome has two forms, acute and chronic; depending on the interval and duration of stress, since this is a typically reactive psychosocial disorder with vegetative medical symptomatology evoked by acute or chronic stress.
The aim of this three cohort comparative study is to compare the position of PTSS between: victims of bombing in Yemen (air strikes only); combined war operations in Ukraine; and combined operations in Syria, and chronic military unrests in Lebanon.

Introduction

Armed conflicts within the last 10 years, have had severe consequences not only to housing trade and transportation infrastructure but to human lives directly, and indirectly, to poor status due to disrupted water and food energy supplies including sleep disturbances due to acute or chronic bombing and shelling.

The aim of this research is in a brief note to describe the position of acute and chronic post trauma stress syndrome (PTSS) in different types of conflicts in places served by the various emergency and refugees of war projects of the Tropicteam, Step In, Little Sisters and other NGOs operating in Eastern Europe and Middle east.

Methods

Frequency of acute versus chronic PTSS defined as:

1. Disturbances of sleep and or concentration
2. Fear, depression and other reactive psycho syndromes and symptoms
3. Psychomotoric disorders (hypertension, hyperglycemia, tachycardia, night sweats)

Acute syndrome was defined as signs and symptoms only during armed events;

Chronic PTSS was defined as persistence of at least 2 of 3 groups of symptoms (above) at least one week after an armed event (bombing shelling) or after leaving a risk area of war.

Results and discussion

Table 1. shows the distribution and percentage of visitors of particular either nutrition or health care projects.Yemenese and Ukrainian victims of war and refugees had all Acute PTSS and Lebanese and Syrian chronic PTSS: these required chronic medications against hypertension, diabetes and insomnia. In comparison to Post war areas with our projects in Rwanda and Burundi where war conflict apparently ended more than 25 years ago, infectious diseases of chronic origin such as malaria HIV and TB are prevalent and chronic PTSS is rare. (23).

Conclusions

Management of Acute Post Trauma Stress Syndrome requires a multidisciplinary team of: psychologist (psychological support and acute trauma management); social worker (travel and housing advice); nurse or doctor (acute health problems and medicamentous APTSS management); lawyer or UNHCR officer (ensuring safe migrant or refugee status).

Concerning chronic PTSS, patients need medical support with psychiatrists or trauma / war medicine specialist supported by pharmacists is advisable.

The best prevention is to avoid any armed conflicts or to remove the civilian population before bombing or shelling starts, like it was in Kuweit 1990, Baghdad 1998, Belgrade and other highly populated towns with prevalence of civilian population, where information of upcoming operations was announced by air dropping of maps and information about next day planned operations. However, this was not done in Yemen, Ukraine, and therefore, in management of migrants and refugees of war, we have to expect long systematic work with multidisciplinary socio-psycho-medical teams, and economic-financial rehabilitation of the whole country, as it was been done in Rwanda and Sudan, 25-60 years ago after genocide.

Table 1 Type and percentage of acute versus chronic PTSS-experience from Lebanon, Syria, Yemen, Ukraine by Tropicteam Refugee and Migrants Health Programs

	Tyoe of PTSS prevalent	Intervention	Time
Lebanon, Dayeeh/Beirut	Chronic 75-90%	Amb. services	45 years
Ukraine, border Uzgorod/Mukacevo	Acute 95%	Emergency, HC, PSS	30 days
Yemen, Hodejda	Acute 75%	Food and water suppl.	5 years
Syria, Alepo	Acute 25 / chronic 75%	Amb. Health service, food	8 years
Quaragosh, Kurdistan/Iraq	Chronic 90%	Amb. health	4 years

References

1. WHO ANNUAL REPORT (2020) WHO Geneve, 2022. pp.155.
2. HYGIENIST GENERAL (2011*)* Lex corona. *National Institute of Public Health Bratislava* 2011. p. 25.
3. HAMAROVA A *et al*. (2022) First week of mission and humanitarian assistance at the Ukrainian border. *Acta Missiologica*, 12. 2022. 1. pp.12-13.
4. SUVADA J, PALENIKOVA M et al. (2021) Posttrauma stress syndrome is the commonest diagnosis in migrants to Greece. *Clinical Social Work and Health intervention*, 11. 2021. 2. pp. 98-99.
5. TOPOLSKA A *et al*. (2020) Spectrum of humanitarian assistance in war affected South Yemen, *Med Horizon*. 59. 2020. pp. 266-270.
6. COSTELLO M, DRGOVA J, BOZIK J, MURGOVA A, GALLOVA, A., BUJDOVA N (2020) Vaccine refusal *Clinical Social Work & Health Intervention*, 11 2020, 2, pp. 9-12.
7. OTRUBOVA J, KALATOVA D, KILIKOVA M, MURGOVA A, KOZON V, *et al*. (2019) education on nursing and social work. *Clinical Social Work & Health Intervention*, 2019, 2, pp 10-11.
8. KHALED I, HAJ ALI PERI, KALATOVA D, GALLOVA A, BAK T, MURGOVA A, ZOLLER K, GIERTLIVOVA D, *et al*. (2018) Spectrum of infections in physiotherapy and rehabilitation ward for war victims. *Clinical Social Work Health Intervention*. 8, 2018, 2, 26-28.
9. BELOVICOVA M, MURGOVA A,VANSAC P, POPOVICOVA M (2019) Hepatitis C screening in Selected Social Rescue group facilities in Eastern Slovakia. *Clinical Social Work & Health Intervention* 10. 2019, 2, 5-28.

Holding Together for Curing This Wounded World

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Abstract:

The current crisis in Ukraine has not only caused endless human suffering, but also implies to the European Countries neighboring at Ukraine borders an important humanitarian task. However, currently in some journals concerns are raised against an immediate aid policy and towards uncontrolled receiving of refugees. These critics refer to the financial challenge of the European Community and raise concerns towards health hazards and public health risks probably linked to this humanitarian crisis.

Is there a health risk for European countries due to first aid programs supporting refugees from the Ukraine?

When a conflict like that occurring in Ukraine hits during a pandemic, the lack of global coordination of public health resources becomes more tragically obvious. The war in the Ukraine has indeed lead to incredible human suffering but the unity of the western states towards the refugees from the war regions is at the same time overwhelming and encouraging. Despite all positive aspects of these first aid social projects especially in countries close to the Ukraine e.g. Poland, Slovakia, Rumania and other countries, there might remain an increased risk for the health of the population in neighboring countries.

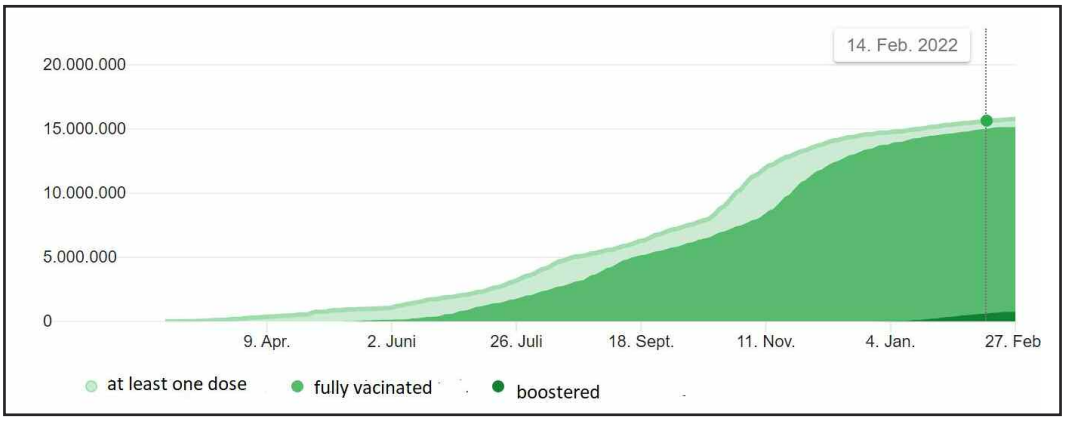
Reference has been made towards the fact, that 65% of major infectious disease outbreaks occurring in the 1990s were among refugee populations or in conflict zones according to World Health Organization (WHO)[1, 2, 3].

In Europe, the pandemic waves are now generally decreasing with only mild to none symptoms seen in infected ones and there is a strong tendency to reduce certain hygiene restrictions in these countries. In the same time, we realize that the Covid 19 pandemic is not over yet. Some countries of the European Union still register infection outbrakes and vaccination rates have not reached 100% nationwide. Even so-called vaccination breakthroughs in different areas prove that European Countries are still far from establishing a general stable immunity among their population[4].

Just before the invasion of Ukraine on Feb. 24, 2022 only about 35% of the Ukrainian population had been vaccinated against the Corona Virus. So, it has been questioned whether our background immunity in Europe is stable enough to absorb the infection pressure of millions of refugees. These low vaccination rates of the Ukrainian population are even in line with most of its neighboring countries, although some, including Poland and Hungary, have achieved higher vaccination coverage.While different health systems and varying attitudes about vaccination in those countries are contributing to those contrasting rates, Ukraine's relatively low vaccination rate could have implications for how large additional surges of cases, both in the country and in the region become as a result of the war. Like many other countries, Ukraine experienced a surge in cases due to the Omicron variant in November and another peak in the first week of February, most likely due to its low level of vaccination[5].

The increasing number of immigrants may indeed contribute now to a new health problem in Europe's unstable healthcare systems if we consider vaccination rates alone. On grounds of these numbers there may be a risk of an increasing new wave of Covid 19 infections in Europe due to the large number of refugees spreading into our countries without any health control[6].

Figure 1 Vaccination status of the population in the Ukraine at time of war beginning



Source: Reuters Covid 19 trackers. Comment: This vaccine role out data is projected by the numbers of doses vaccines administered and not by the number of people who have been vaccinated.

Critics of social first aid programs point to the fact, that by the middle of February 2022, 60% of COVID-19 tests conducted in the Ukraine were positive. And, as an official notice issued by the Robert Koch Institute in Germany on Friday 28 January 2022, Ukraine was listed as an international high-risk area implying that from 30 January 2022, a travel warning was issued by the Federal Foreign Office for Ukraine.

Source: Robert Koch Institute January 2022

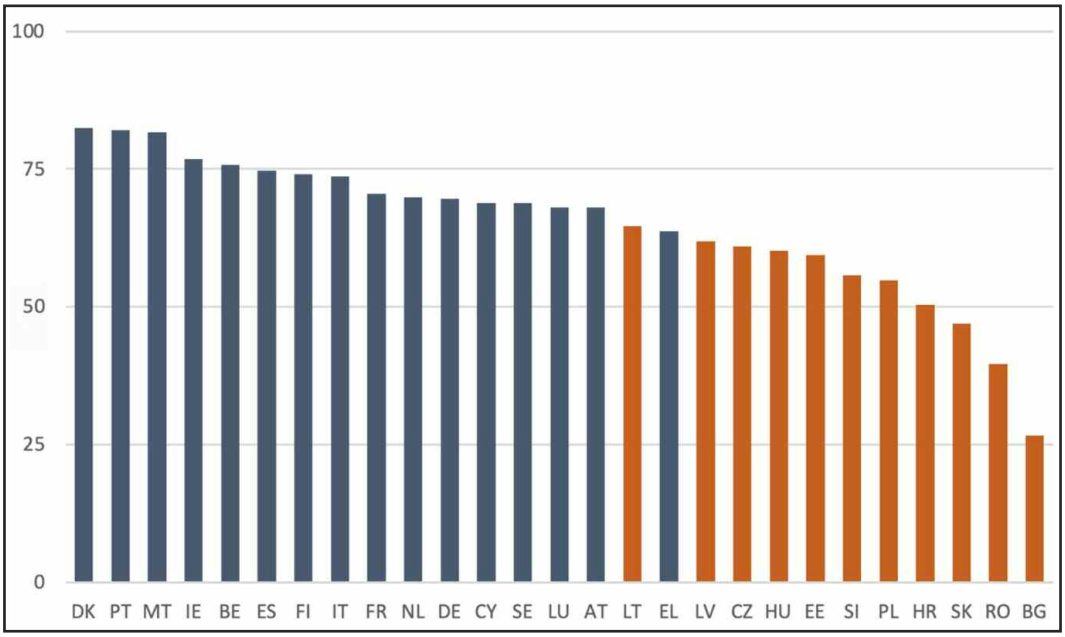
Such low vaccine coverage among Ukraine refugees does not seem to be enough in the eyes of critics to control a highly transmissible virus like SARS-CoV-2. They argue, that under war conditions with the political and social upheaval this situation may contribute to a potential emergence of new variant, which may put even our population at health risk. Hospitals might likely be hit hardest by the influx of refugees during the pandemic and war-related injuries will take precedence over COVID-19 care which will only make it easier for the virus to spread. That disruption may in turn lead to more infected health care workers who won't be able to perform their duties.

As a neighboring country, the Polish population is currently experiencing the strongest exchange with the refugees. It is just not for granted that surrounding countries have already reached a level of natural immunity in order to be able to take in refugees without risk to themselves. Prior to the influx, only 60% of Poland's population was vaccinated.

This situation exposes the weaknesses in the global biodefense network against threats like highly infectious coronaviruses according to critics. Even without a military conflict, gross inequities in health resources have led to profound differences in countries' ability to control COVID-19; developed nations have been able to purchase and distribute vaccines, while poorer countries, still struggle to contain the virus since they lack access to the shots. Eastern EU Member States (highlighted in orange in the figure below) have significantly lower vaccination rates than the EU average. This applies in particular to the tail lights in the EU: Slovakia (47.0%), Romania (39.6%) and Bulgaria (26.7%)[7, 8].

In fact, there is little doubt that the poor Corona immune status of refugees poses a direct

Figure 2 Percentage of fully vaccinated persons (without booster) in the total population of respective countries January 2022.



Source: Europäisches Zentrum für die Prävention und die Kontrolle von Krankheiten.

threat to our healthcare system as outlined before. The factors are obviously due to the fact that immunity to Covid 19 of the population in Europe is still vulnerable. Protective measures may not have been carried out in European Countries intensively enough to create a basic immunity in the population. There might remain a gap in the health prevention of the population. Should this fact impact social aid programs?

Humanitarian aid in the Ukraine at risk?

Presently, we already realizing an immense wave of willingness to help refugees both officially and in the private sphere which should not be reduced by any health concerns. In the end social aid programs are not only of help to refugees materially but also might be beneficial for helping countries.

Vaccination and mitigation measures such as mask-wearing, social distancing, and basic hygiene should be, of course, critical for curbing spread of SARS-CoV-2, but it is for granted that these measures are impossible to maintain when a country is under siege. War challenges every public health program. It limits the medical care available for those who might be seriously ill, and often fosters transmission when so many people are crowded into bomb shelter locations and on trains. This situation might turn indeed into a perfect storm of serious challenges even of our health system[9].

However, without downplaying this looming danger, we need to put the risk of infection emanating from the flood of migration into a proper perspective. From the view of Public Health including the understanding of the basics of Immunology and the course of the spread of the Sars Cov 19 Virus in different countries, there is hope that we will overcome this endemic threat under the ongoing aid program in Europe.

Epidemiological observations have taught us, that spreading of a contagious virus depends mainly on two factors: A) The pathogeny of the agent and B) the potency to resist the agent. The latter is referred to a proper immune response. Therefore, controlling refugees and selecting healthy from potential virus spreaders would be ideal from the point of view of Public Health. Unfortunately, there are still no easily recruitable immune parameters that can reflect such a reliable immunity[10].

Under these circumstances decision makers of Public Health need to continue a vaccination and booster campaign among refugees entering communal settings, especially those who are particularly vulnerable such as the elderly or people with underlying health conditions. Even in times of war with scarce vaccine supplies, this should be the primary goal. And, even if there are concerns arising that these programs will not be sustainable over a longer period this should not detract from the readiness to invest in active social aid programs.

Why should we remain positive towards the immunity of refugees?

Here we describe a hypothesis based on a deeper understanding of immunological principles, which in fact is in favor of the extension of more social aid programs despite the possible threat of increasing infections in our populations. According to our understanding, social aid programs and welcoming refugees do not have to lead to an increased infection rates in the population despite adverse circumstances.

For one, present data suggest that Omicron leaves less severe clinical cases in general[11]. And also we have to point to the fact, that resistance against virus exposure is not based merely on the specific adaptive immune system of humans alone[12]. This is why the vaccination status does not represent the entire immune status of refugees.

The specific immunity against corona virus is supported by *a non-specific immune system* considered also as *natural immunity*. The functioning of this innate immune system makes a decisive difference in viral attack. Especially with virus infections, it has been shown that the natural immunity of humans is a reliable factor for health even in cases of less active specific immunity. In the recent two years, people with poor health and a less active innate immune system have become victims of severe infections much more frequently than people in good health[13, 14, 15].

Although both the innate and the specific immune systems are closely related and act together in the defense of foreign germs these two different angles of the immune system are still subject to different stimulations and interactions.

The innate immune system acts as the body's first line of defense quickly against virus attack.

It consists of natural body barriers as well as humoral (proteins) and immune cell components such as scavenger's cells neutralizing germs. A third very essential role of innate immunity is related to Natural Killer Cells. Natural Killer (NK) Cells are lymphocytes which respond quickly to a wide variety of pathological challenges such as virus infections. Natural Killer Cell activity plays a decisive role in our immunity and protection against viruses as they recognize the lack of a self-tissue molecule on the surface of cells (characteristic of many kinds of virally infected and some cancerous cells) and lyse those cells by releasing toxic substances on them. Natural Killer Cells are therefore thought to be important in limiting the early phases of viral infections, before specific immunity becomes effective[16, 17, 18].

Current research from the new field of psychoneuroimmunology refers to interesting connections between stress and the human immunological response capacity. Obviously, duration of the emotional „challenge" or immunological stimulus has a strong impact on the human innate immune system[19]. However, it has been shown, that acute stress motivates the native immune response whereas constant stress reduces the effectiveness of this strong natural immunity[20, 21, 22, 23, 24].

On the grounds of these findings we hypothesize, that despite health concerns the immediate and constructive aid offered to refugees will facilitate the situation not only from a humanitarian and material point of view but it will also contribute to a certain stress relief among the refugees. The realization of such many helping hands may encourage refugees and will help improve their predicament. So, actually by reducing their stress, we also boost their immunity.

Conclusions

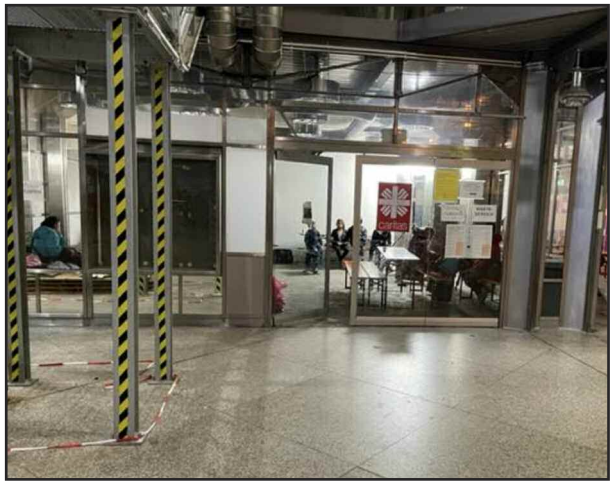
There are obvious and realistic concerns with reference to social aid programs under present pandemic conditions. However, we conclude, that charity programs not only benefit the refugees, but will also contribute to a better and more efficient immune system for refugees as it may help to reduce their stress impact. To improve the situation for refugees is therefore rewarding in two ways; for the refugees and for the helping population. Reducing the stress of refugees may in the end contribute a stronger immunity and a healthier population. Countries opening their borders for refugees will be rewarded for their gesture of humanity by a reduced infection pressure among refugees which in turn benefits the general population

Obviously there lies quite fundamental truth in the famous words: „Giving makes you happier than receiving." Supporting humanitarian aid projects to help refugees does not only correspond with Christian challenges but may be also rewarding in itself. We therefore should support the ongoing aid programs and expand our humanitarian aid wherever possible despite the possible health risks that these efforts may entail.

References

1. GAYER M, LEGROS D, FORMENTY P, CONNOLLY MA (2007) Conflict and emerging infectious diseases. Emerg Infect Dis. 2007;13(11):1625-1631. doi:10.3201/eid 1311.061093.
2. GAYER M, LEGROS D, FORMENTY P, CONNOLLY MA (2007) Conflict and emerging infectious diseases. Emerg Infect Dis. 2007;13(11):1625-1631. doi:10.3201/ eid1311.061093.
3. ALTARE,C. NGWA,M,GOLDSMITH,M, GOLDSMITH,A. HERING,H., BURTON,B, SPIEGE PL(2019) Infectious disease epidemics in refugee camps: a retrospective analysis of UNHCR data (2009-2017) Journal of Global Health Reports Vol. 3, 2019September 01, 2019 BST.
4. NAFIS IFTEKHARA E et al. (2021) A look into the future of the COVID-19 pandemic in Europe: an expert consultation. The Lancet 2021 (8) 2666-7762.
5. PARK A (2022) Times Magazine MARCH 2, 2022.
6. ROKSANDI ´C S, MAMI ´C K, MIKAC R (2021) Migration in the Time of COVID19—Policy Responses and Practices in Croatia Concerning the Western Balkan Routes and Readiness for the Post-COVID-19 Society in Which the Right to Health Care for the Most Vulnerable Is Guaranteed. Front. Hum. Dyn 3:595189. doi: 10.3389/fhumd.2021.595189.
7. ROKSANDI ´C S, MAMI ´C K AND MIKAC R (2021) Migration in the Time of COVID19—Policy Responses and Practices in Croatia Concerning the Western Balkan

Routes and Readiness for the Post-COVID-19 Society in Which the Right to Health Care for the Most Vulnerable Is Guaranteed. Front. Hum. Dyn 3:595189. doi: 10.3389/fhumd.2021.595189.
8. KYIV POST (2020) "Homepage: COVID-19 in numbers" (accessed 31 March 2020).
9. Jimenez D (2022) Ukraine: Russian invasion could cause spike in Covid-19 cases. Pharmaceutical Technology March 22.
10. JESENAK M, BRNDIAROVA M, URBANCIKOVA I, RENNEROVA Z, VOJTKOVA J, BOBCAKOVA A, OSTRO R, BANOVCIN P (2020) Immune Parameters and COVID-19 Infection - Associations With Clinical Severity and Disease Prognosis. Front Cell Infect Microbiol. 2020 Jun 30;10:364.
11. CDC ABOUT OMICRON AS A VARIANT OF SARS COV 19 - B.1.1.5 29 February 2022.
12. PACES J, STRIZOVA Z, SMRZ D, CERNY J (2020) COVID-19 and the immune system. Physiol Res. 2020 Jul 16;69(3):379-388.
13. KRAMMER F (2021) Correlates of protection from SARS-CoV-2 infection. Lancet. 2021 Apr 17;397(10283):1421-142.
14. CATANZARO M., FAGIANI F., RACCHI M., CORSINI E., GOVONI S., LANNI C (2020) Immune response in COVID-19: addressing a pharmacological challenge by targeting pathways triggered by SARS-CoV-2. Signal Trans. Target. Therapy. 2020;5:1–1.
15. ANANE LH, EDWARDS KM, BURNS VE, ZANTEN JJ, DRAYSON MT, BOSCH JA. (2010) Phenotypic characterization of γδ T cells mobilized in response to acute psychological stress. Brain Behav Immun. 2010; 24 (4):608–614.
16. BEUTLER B (2004) Innate immunity: an overview. Mol Immunol. 2004 Feb;40(12): 845-59.
17. YATIM KM, LAKKIS FG (2015) A brief journey through the immune system. Clin J Am Soc Nephrol. 2015 Jul 7;10(7):1274-81. doi: 10.2215/CJN.10031014.
18. TAEFEHSHOKR N, TAEFEHSHOKR S, HEIT B (2020) Mechanisms of Dysregulated Humoral and Cellular Immunity by SARS-CoV-2. Pathogens. 2020 Dec 8;9(12):1027.
19. D'ACQUISTO F (2017) "Affective immunology: where emotions and the immune response converge." Dialogues in clinical neuroscience vol. 19,1 (2017): 9-19.
20. BOSCH JA, BERNTSON GG, CACIOPPO JT, MARUCHA PT (2005) Differential mobilization of functionally distinct natural killer subsets during acute psychologic stress. Psychosom Med. 2005;67(3):366–375.
21. DHABHAR FS, MALARKEY WB, NERI E, MCEWEN BS (2012) Stress-induced redistribution of immune cells from barracks to boulevards to battlefields: a tale of three hormones - Curt Richter Award winner. Psychoneuroendocrinology. 2012;37(9):1345–1368.
22. SEGERSTROM SC, MILLER GE (2004)



Photos taken from the First aid station at Munich Central Station welcoming refugees from the Ukraine and offering first aid.

Psychological stress and the human immune system: a meta-analytic study of 30 years of inquiry. Psychol Bull. 2004;130(4):601-630.
23. AUBERT A (2008) Psychosocial stress, emotions and cytokine-related disorders. Recent Pat Inflamm Allergy Drug Discov. 2008; 2(2):139–148.
24. LOPES PC (2016) Why are behavioral and immune traits linked? Horm Behav. 2016 Sep 22. Epub ahead of print. doi:10.1016/j.yhbeh.2016.09.008.

Minimal Occurrence of Suspected Tuberculosis among Immigrants of War from Ukraine Shelters and Orphanage in Comparison to HIV Positive Cambodian Children from Orphanage

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Abstract:

Armed conflicts are connected with huge migration and refugees of war transfer at borders often without appropriate checks for vaccination, or immunization calendars. Within the last 10 years due to war, sporadic cases of measles and polio have been exported from Syria to Israel or from Afghanistan to Pakistan and vice versa (l2). The aim of this study was to compare occurrence of Tuberculosis in 2 shelters, 1 with refugees of war and 1 with orphans, 1 from Ukraine and the second in Cambodia and a shelter of homeless people in Jarna Slovakia (3 countries of different incidence of TB).

Introduction

Several outbreaks have followed: industrial; seismologic; armed conflict; related catastrophes or natural disasters. Floods are mostly related with ID outbreaks such as Hepatitis A, Leptospira spp and cholera; armed conflicts with measles (Syria) cholera (Yemen, Rwanda).

Due to large number of refugees, no time for accurate vaccination control and checks at the border is possible. In 2015, our teams when facing 20-28,000 refugees of war from Iraq and Syria at Health Post Nickelsdorf AT, were unable to check any data on vaccination.

Due to such events with large migration and travel emergencies (Kabul Dec. & Jan. 2021-22) subsequent checks for ID with rapid tests are performed, when exodus is regulated, e.g. in Italy and Greece after ship events when routine checks with rapid tests for HIV, HBV, HCV and malaria performed after emergency landings in Malta, Lampedusa, Sicily, Canaria, Lesbos, Chios and other EU border hotspots in the Mediterranean.(1-3). No real rapid test for TB is available, and closest to the ideal test is probably Gene X pert rapid test, when after 30 minutes results can be obtained and suspected cases are radiographed or tested with PPD. In such cases when no time or sources for Gene X pert test are available, a simple WHO recommended questionnaires is available.

Patients and Methods

Three settings with the simple WHO questionnaire or interview are:

1. Phnom Penh 101 children of Cambodian origin, 30 of them underwent also Gene X pert testing
2. Vyšne Nemecke Border, Pruske Guest House and Shelter, and the Bratislava Shelter (refugees of war from Ukraine in March 2022)
3. Jarna Homeless Shelter, Trnava District-and, Mea Culpa Homeless Shelter Bratislava (homeless population)

Results and discussion

1 Phnom Penh HIV orphanage setting

From 102 children 50 (about 50%) were treated for TB; from the rest all were negative for Gene X pert testing. However, the Kingdom of Cambodia is among SEA countries with overall incidence for more than 800 per 100.000 population.

2 Ukraine Border, and Shelter setting, migrants of war

Between Feb. 28 & March 28, 102 refugees of war were questioned, none of them reported positive answers to any of 5 questions (unexplained cough last 3 months; weight loss 10% and more; fever of unknown origin, previous diagnosis of TB or chronic lung disease; (contact or family presence with /of TB known positive persons). The reason for zero positive answers may be also the fear of a travel ban, or of a quarantine, or of deportation. However, Covid testing was negative. Also, the incidence of TB in UA is 10 times less than in Cambodia, and primary healthy population is escaping, with a small proportion of at risk individuals such as COPD, low SE status; homelessness; chronic lung disease; higher age; etc.

HIV is 10 times less frequent in Ukraine in comparison to Kingdom of Cambodia. In addition when checking 10 individuals in the Pruske Shelter and the Bratislava Main University temporary shelter for transit, none of 39 people transiting reported even one positive answer on any question of the WHO adapted test / questionnaire.

3 Slovak Shelter for Homeless Setting

In Jarna where 10 homeless and 21 low socio-economic status based families from the Roma marginalized community are located, only l case was noted without any coincidence with homeless, paradoxically in the only regularly employed and working person. In another homeless, elderly, non-migrant person, anamnestic receipt of anti TB drugs was noted.

Conclusion

Paradoxically, positivity of the questionnaire based screening for clinical check, or Gene X pert PCR based diagnostic sampling was highest in the community of orphans with HIV, where up to 50% were on anti TB triple therapy; however, none of them had confirmed active TB with the Gene X pert test.

The 2nd community with l confirmed and l suspected case was the homeless sheltered Slovak / Roma population from Jarna.

At the 3rd community, Ukrainian refugees of war, none responded positively to the WHO structured rapid questionnaire. The reason is, that a primary healthy population was escaping the conflicts, mainly children and young mothers; the proportion of males was 2%, and no at risk population was present among the Ukrainian cohort (HIV, smokers, homeless, low SE status, contacts etc.).

Another explanation of zero occurrence of TB among refugees of war from Ukraine is, that in UA still anti TB vaccine is administered routinely and is compulsory in children over last 70 years, in contrast to Slovakia, where the elderly population and children in last 10 years received no vaccine, since the incidence in SK dropped below 6 per 100.000, as it is in most EU countries.

Renewal of TB vaccination therefore is advisable, since sporadic cases have been observed in our study only in the Slovak population of homeless.

References

1. WHO ANNUAL REPORT (2020) WHO Genéve, 2022. pp. 155.
2. HYGIENIST GENERAL (2011) Lex corona. *National Institute of Public Health Bratislava* 2011. pp. 25
3. HAMAROVA A.*et al*. (2022) First week of mission and humanitarian assistance at the Ukrainian border. *Acta Missiologica*, 12. 2022. 1. 12-13.
4. SUVADA J, PALENIKOVA M, *et al*. (2021) Post trauma stress syndrome is the commonest diagnosis in migrants to Greece. *Clinical Social Work and Health Intervention*, 11.2021. 2. pp. 98-99.
5. TOPOLSKA A *et al*. (2020) Spectrum of humanitarian assistance in war affected South Yemen, *Med Horizon*. 59. 2020. pp 266-270.
6. COSTELLO M, DRGOVA J, BOZIK J, MURGOVA A, GALLOVA, A., BUJDOVA N (2020) Vaccine refusal *Clinical Social Work & Health Intervention*, 11 2020, 2, pp. 9-12.
7. OTRUBOVA J, KALATOVA D, KILIKOVA M, MURGOVA A, KOZON V, *et al*. (2019) Education on nursing and social work. *Clinical Social Work & Health Intervention*, 2019, 2, pp 10-11.
8. KHALED I, HAJ ALI PERI, KALATOVA D, GALLOVA A, BAK T, MURGOVA A, ZOLLER K, GIERTLIVOVA D, *et al*. (2018) Spectrum of infections in physiotherapy and rehabilitation ward for war victims. *Clinical Social Work Health Intervention*. 8, 2018, 2, 26-28.
9. BELOVICOVA M, MURGOVA A,VANSAC P, POPOVICOVA M (2019) Hepatitis C screening in Selected Social Rescue group facilities in Eastern Slovakia. *Clinical Social Work & Health Intervention* 10. 2019, 2, 5-28.

Review on Vietnamese Refugees, Resettlement and Mental Health: From Pulau Bidong, a Malaysian Experience

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Original Article

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Abstract:

War regardless of where it occurs, causes widespread devastation for everyone on the planet. Civilians who are directly affected by war are subjected to unspeakable atrocities. They cross national borders in search of safety. The total number of refugees in the world reached 26.4 million in 2020 and now with the Russia-Ukraine conflict, the number is escalating. As of May 2021 the United Nations High Commission for Refugees (UNHCR) in Malaysia has registered 179,570 refugees and asylum seekers. With the growing number of refugees around the world, the prevalence of their mental health disorders is significant for public health. These people are among the most vulnerable people on the planet. The purpose of this review is to look at the short and long term psychological impact on refugees, in particular the Vietnamese refugees who once fled their country for safety in Malaysia and

then resettled in other countries. From the review, recommendations for handling the growing number of refugees worldwide in the hope of reducing the impact their psychological problem in future. #SayNoToWar

Introduction

1.1 History of Vietnam War

The Vietnam War was a long, expensive, and contentious conflict that divided North Vietnam's communist government against South Vietnam and its main ally, the United States. Tensions were heightened by the ongoing Cold War between the United States and the Soviet Union. Nearly 3 million people were killed in the Vietnam War, including over 58,000 Americans with Vietnamese civilians accounting for more than half of those killed [1]. The greatest immediate consequence of the Vietnam War was the enormous death toll. During the conflict, a total of 2 million Vietnamese civilians, 1.1 million North Vietnamese military personnel, and 200,000 South Vietnamese troops were killed [2]. In 1975, Communist forces took control of South Vietnam, and the country was unified as the Socialist Republic of Vietnam the following year.

1.2 Temporary placement of Vietnamese refugees in Pulau Bidong

Following the fall of Saigon in 1975, Malaysia has its first substantial encounter with mass refugees and asylum seekers triggered by an American-led war in Indochina in the 1960s. The first wave of refugees consisted of 47 people; after that, they began to arrive in greater numbers, and Malaysia became the temporary home to over 250,000 people. This became known as one of the world's worst humanitarian crises, and the Vietnamese refugees were labelled the Vietnamese Boat People, or *Orang Vietnam Hanyut* (OVH) in Malaysia. According to researchers, Malaysia became the first safe haven for these boat people under the 1989 Comprehensive Plan of Action for Indochinese Refugees [3]. To keep up with the influx, the government established a temporary camp for them on Pulau Bidong, an isolated island in the East Coast of Malaysia on August 8, 1978 [4]. The island was designed to house 4,500 refugees, but by January 1979, there were 18,000 refugees on the island, and by June, the number had risen to 40,000, making it the most densely populated place on the planet [5].

The Vietnamese's journey as refugees is not easy, and they must confront danger before reaching a new destination. They frequently left Vietnam in overcrowded, derelict boats unfit for seafaring, and in addition to dehydration and starvation, the monsoon made their journey even more terrifying. Thai and Malay pirates were also a constant threat to the refugees, frequently raping and kidnapping female refugees and stealing their belongings. Even if they made it to land, local authorities would frequently deny them entry, sending their boats back out to sea. As a result, merchant ships that found them floating would frequently refuse to rescue them, fearing that they would not be able to unload them when they arrived.According to studies, refugees are at a high risk of developing mental disorders [6-9]. As Nieves-Grafals points out, "refugees are survivors by definition [10]." They are trauma survivors from a world "where they have knowledge of the vagaries of miserably bad luck and intimate experiences with evil [11]."

The impact of health and psychological trauma amongst refugee are a huge health problem around the world [12], and among forced displaced people, it may involve three levels: psychiatric problems that existed prior to fleeing their homeland; aggravation of their mental illness by the flight; and a new mental health difficulty caused by the entire process [13].

The challenges of adjustment continue for a long time in their lives in a new country: balancing a different environment, a new culture, their traditions and memories left behind with their current needs [14]. Learning another language, finding work and a place to live, homesickness, social isolation, and barriers to accessing social care, healthcare, and educational services are all common challenges [15].

In July 1979, Western countries finally agreed to increase the number of refugees they will accept for resettlement each year; to provide more funds to assist these refugees; to assist in the processing of their resettlement. The Orderly Depar-

ture Program, the Philippine Refugee Processing Center, and the Comprehensive Plan of Action were among the programs and facilities used to carry out resettlement.

To that end, officials from Europe, the United States, Australia, and Canada visited refugee camps in Southeast Asia to interview refugees and return the lucky ones to their home countries, and the number of refugees gradually decreased [16]. Thousands of people were resettled in the United States, Canada, Italy, Australia, France, Norway, and the United Kingdom. Several tens of thousands of people were either voluntarily or involuntarily repatriated to Vietnam.

Pulau Bidong was eventually closed down as a refugee camp in October 1991, and the remaining refugees were relocated to Kuala Lumpur's Sungai Besi Refugee Center, where they were either resettled or repatriated back to Vietnam [17]. On August 30, 2005, the last Vietnamese refugee left Malaysia.

Literature Review

The Grand Challenges in Global Mental Health initiative has identified the need to study the impact of violence, warfare, and migration as one of its 25 primary research priorities for the next 10 years in order to improve the condition of people worldwide suffering from mental health problems [18]. A critical question is whether psychological reactions to trauma persist over time and whether such reactions can become disabling in refugees. The majority of studies have been conducted very soon after refugee communities have been exposed to trauma, and usually in conditions of abnormal stressors, such as in refugee camps or shortly after arrival in resettlement countries. Only 3-year follow-up periods have been studied in a few longitudinal studies [19-20]. Although the findings of an epidemiological study conducted in a non-refugee setting suggested a steady decline in the risk of post-traumatic stress disorder during the 6 years following a traumatic incident, a subset of people experienced mental health problems that lasted beyond that time [21].

Another study [22] adds to previous research by demonstrating that a wide range of stressful events experienced by refugees throughout their lives are associated with poor mental health. There were significant differences in the direct and indirect effects of stress types on mental health among refugee groups. It was not surprising that non war related stress had both direct and indirect effects on both groups' mental health because these were events that almost always occurred prior to war related and migration stress. And, it has been established that prior trauma is a risk factor for adverse effects from later trauma [23]. Vietnamese refugee who are now dealing with stressors that are more distant in time from their war related and post migration stress.

Gender, age at resettlement/immigration, and pre- and post-migration trauma experiences were all linked to psychological distress among Vietnamese refugees. Women were more likely to report symptoms associated with psychological problems than men. As a result, it is not surprising that gender is a significant predictor of psychological distress in this group [24]. It is important to point out that the majority of refugees in most circumstance are female refugees and they may have experienced more pre-migration trauma, as well as trauma during the escape. Furthermore, among Vietnamese refugees, being older at the time of immigration was associated with a higher level of psychological distress.

Trauma-related mental disorder upon arrival, as well as the progression of symptoms over the first 3 years of resettlement, predicted mental health after even after more than 20 years. Longitudinal data support the importance of screening refugees in the early years of resettlement, because elevated levels of psychiatric symptoms during that time appear to indicate long-term risk [25].

Gender, military service, and other social statuses shape war trauma exposure and reactions to it [26]. Therefore, understanding the experiences of different sub-populations improves the ability to determine the nature of trauma exposure and design interventions that address the health and well-being of the entire population.

In summary, both pre and post-resettlement trauma experiences are linked to psychological distress in refugees. These findings have potentially significant policy and clinical implications, implying that clinical and support services should target psychological symptoms and interpersonal processes when fostering positive adaptation in resettled refugees. These refugees were most likely directly exposed to active war situations due to their refugee status, which could explain pre-re-

settlement trauma as a risk factor for subsequent psychological distress. Refugees are also more vulnerable to secondary traumatization, not only because of their prior trauma, but also because of the socio-environmental situation in which they have been resettled in another country.

Method

This review is based on keyword searches of medical and social science publication databases. These searches were supplemented by searches across databases containing information about the effects of war on Vietnamese refugees.

It included studies that met 2 criteria 1) only refugees who fled from Vietnam due to war and mass violence and 2) the articles which were published in English.

Results

After discounting duplicate articles and filter process, 6 publications were shortlisted and included in the review. As shown in Table 1, these publications present varied geographic emphases.

The overall findings show that Vietnamese refugees face increased risk of mental health problems both in short and long term assessments necessitating special attention from psychiatric services. According to the study results, refugees face more barriers and challenges in accessing adequate healthcare services than citizens. However, government responses did not succeed to take into account the specific needs and vulnerabilities of refugees.

Listed below are the several gaps in health responses to refugees uncovered from the studies undertaken in six publications.

- Baseline depression, age, language proficiency and ethnicity are identified as variables that predict future depression. Baseline depression and language proficiency can be potentially modifiable, making intervention studies particularly relevant.
- Females are more likely to be severely stressed.
- Mental health is worse for the ethnic minorities.
- Increased levels of trauma increased the risk of mental illness and associated psychosocial disability even after 10 years or more.
- Despite the fact that psychological distress among refugees has decreased significantly over time, even after more than 20 years of resettlement, a higher proportion of this cohort met threshold scores than native citizens.
- Early-life conflict exposure increases the prevalence of depressive symptoms in adulthood among affected cohorts. The impact of early-life war exposure on boys and girls reveals that both suffer similar negative consequences.
- Civilians, members of militias and other less formalized military organizations, and members of formal military organizations all have different reactions to war events, suggesting the need for various assessment approaches.
- Longitudinal data support the importance of screening refugees in the early years of resettlement.

Recommendation and Conclusion

Living under the constant threat of violence has a lasting effect according to studies, even long after the escape from danger. The insecurity that refugees face extends far beyond the guns and blasts of the war. A large proportion of studies used quantitative methods to test differences in psychological and well-being outcomes among Vietnamese refugees.

Some of the shortcomings identified in these studies included failure to pay attention to the needs of refugees in camps, lack of adequate public health information, lack of inclusive access to health and mental health services, and the exclusion of refugees from decision-making processes. After the basic health and welfare needs such as protection, warm meal, clothes and so on are met, there is a need for orientation and information about their exact location, legal status, and so on. It is important for the refugees to be placed in a suitable environment. National and regional strategies should include plans for reducing overcrowding and improving shelter and sanitation in refugee camps. From our Malaysian experience at Pulau Bidong, the Malaysian government took the isolation rather than rapid integration approach. This helped the refugee build their own community. With the assistance of volunteers, the island was gradually organized to the point where it had longhouses, schools, places of worship, and even a post office and coffee shops.

Second, public health messaging should be directed toward refugee communities, utilizing culturally sensitive and linguistically appropriate resources, as well as medical interpreters.

Third, the government should recognize refugees' potential as leaders and their contributions to their communities and host countries. Responses should allow refugee-led organizations to conduct communication campaigns, provide essential services, conduct contact tracing, and help shape social norms. It is noted that some enterprising refugees in Pulau Bidong had established small businesses such as bakeries and tailor shops even musical stage in the late 1980s, with regular performances by both refugees and volunteers which shows the active roles that refugees and refugee-led organizations can and do play in crisis response.

References

1. BARNETT A, STANLEY T, SHORE M (1992) America's Vietnam casualties: victims of a class war? *Operational Research* 40 (5), 856-866, 1992.

Table 1 Overview of Studies

Authors	Research Method	Population	Location of Study	Results
Hinton et al.[19]	Longitudinal	114	USA	Traumatic experiences prior to arrival (e.g., Veteran status) predict future depression.
Steel et al.[22]	Population-based	1,413 adult Vietnamese	Australia	Vast majority of refugees are unlikely to develop long-term mental illnesses. Nonetheless, there wasa strong link between increasing levels of trauma and an increased risk of mental illness, associated psychosocial dysfunction, and a natural tendency to seek both western and traditional health care.
Vaage et al.[25]	Longitudinal	80 Vietnamese refugees 1,946 Norwegian	Norway	Overall mental health of refugees improved since their arrival in Norway, but the mean scores remained higher than those of native Norwegians.
Hollifield et al.[23]	Cross section	252	USA	Various sources of stress in the lives of war refugees have direct and indirect effects on their mental health. Variation in the path of these effects across refugee groups suggests ways to understand the effects of past and ongoing stressors in different populations.
S. Singhal [24]	Review	1,421		Children aged 5 or younger during the American bombing campaign in Vietnam report higher depressive symptoms in adulthood.
Young et al.[26]	Mixed	2447	Vietnam	Civilians, members of militias and other less formalized military organizations, and members of formal military organizations all have different reactions to war events.

2. GR SHAW, I (2016) Scorched atmospheres: The violent geographies of the Vietnam War and the rise of drone warfare. *Annals of the American Association of Geographers*. 2016 – Taylor&Francis.
3. AHMAD A A, RAHIM Z A, MOHAMED A M H B (2016) The refugee crisis in Southeast Asia: The Malaysian experience. *International Journal of Novel Research in Humanity and Social Sciences*, 3(6), 80-90.
4. MOOREHEAD C (2006) *Human cargo: a journey among refugees*. New York: Picador; 2006.
5. BADD (In 1975) (2018) How did a tiny Terengganu island become the most populated place in the world? *Cilisos.my 2018*.
6. BUHMANN CB (2014) Traumatized refugees: morbidity, treatment and predictors of outcome. *Dan Med J*. 2014;61(8):1-29.
7. CRAIG T, JAJUA PM, WARFA N (2009) Mental health care needs of refugees. *Psychiatry*. 2009;8(9):351-4.
8. HARRELL-BOND B (1999) The experience of refugees as recipients of aid. In: Ager A (Ed.). *Refugees: perspectives on the experience of forced migration*. London: Pinter; 1999. p. 137-68.
9. WARFA N, CURTIS S, WATTERS C, CARSWELL K, INGLEBY D, BHUI K (2012) Migration experiences, employment status and psychological distress among Somali immigrants: a mixed-method international study. *BMC Public Health*. 2012;12(749):1-12.
10. NIEVES-GRAFALS S (2001) Brief therapy of civil war-related trauma: a case study. Cultur Diver *Ethnic Minor Psychol*. 2001;7(4):387-98.
11. SCHULZ PM, MAROVIC-JOHNSON D, HUBER LC (2006) Cognitive-behavioral treatment of rape- and war- related posttraumatic stress disorder with a female, Bosnian refugee. *Clin Case Stud*. 2006;5(3):191- 208.
12. ROSENBAUM B, VARVIN S (2007) The influence of extreme traumatization on body, mind and social relations. Int J Psychoanal. 2007;88(Pt 6):1527-42.
13. CROSS S, CRABB J, JENKINS R (2010) International refugee policy. In: Bhugra D, Craig T, Bhui K (Eds.). *Mental health of refugees and asylum seekers*. Oxford: Oxford University Press; 2010. p. 87-103.
14. WOJCIK W, BHUGRA D (2010) Loss and cultural bereavement. In: Bhugra D, Craig T, Bhui K (Eds.). *Mental health of refugees and asylum seekers*. Oxford: Oxford University Press; 2010. p. 211-23.
15. CRAIG T, JAJUA PM, WARFA N (2009) Mental health care needs of refugees. Psychiatry. 2009;8(9):351-4.
16. WC ROBINSON (1998) Terms of refuge: The Indochinese exodus and the international response. *Zed Books*, 1998
17. HAUFF E, VAGLUM P (1995) Organised violence and the stress of exile: predictors of mental health in a community cohort of Vietnamese refugees three years after resettlement. Br *J Psychiatry* 1995; 166: 360–67.
18. COLLINS PY, PATEL V, JOESTL SS, MARCH D, INSEL TR, DAAR AS (2011) Grand challenges in global mental health: a consortium of researchers, advocates and clinicians announces here research priorities for improving the lives of people with mental illness around the world and calls for urgent action and investment. Nature. 2011;475(7354): 27-30.
19. HINTON LW, TIET Q, TRAN CG, CHESNEY M (1997) Predictors of depression among refugees from Vietnam: a longitudinal study of new arrivals. J Nerv Ment Dis 1997; 185: 39–45.
20. MOLLICA RF, SARAJLIC N, CHERNOFF M, LAVELLE J, VUKOVIC IS, MASSAGLI MP (2001) Longitudinal study of psychiatric symptoms, disability, mortality, and emigration among Bosnian Refugees. JAMA 2001; 286: 546–54.
21. KESSLER RC, SONNEGA A, BROMET E, HUGHES M, NELSON CB (1995) Posttraumatic stress disorder in the national comorbidity survey. Arch Gen Psychiatry 1995; 52: 1048–60.
22. STEEL Z, SILOVE D, PHAN T, BAUMAN A (2002) Long-term effects of psychological trauma on the metal health of Vietnamese refugees resettled in Australia: a population-based study. Lancet 2002
23. HOLLIFIELD M, WARNER T D, KRAKOW B, WESTERMEYER J (2018) Mental Health Effects of Stress over the Life Span of Refugees. *J. Clin. Med*. 2018, *7*(2), 25;

24. COSTELLO M, DRGOVA J, BOZIK J, MURGOVA A, GALLOVA A, BUJDOVA N (2020) Vaccine refusal *Clin Soc work Health Intervention* ,11 2020, 2, 9-12.
25. BELOVICOVA M, MURGOVA A,VANSAC P, POPOVICOVA M (2019) Hepatitis C screening in Selected Social Rescue group facililities in Eastern Slovakia. *Clin Soc Wrok Health Intervention* 10. 2019, 2, 5-28.
26. SAURABH SINGHAL (2019) Early life shocks and mental health: The long-term effect of war in Vietnam. *Journal of Development Economics* 141 (2019) 102244
27. AINA BASILIER VAAGE, PER HOVE THOMSEN, DERRICK SILOVE, TORE WENTZEL-LARSEN, THONG VAN TA AND EDVARD HAUFF (2010) Long-term mental health of Vietnamese refugees in the aftermath of trauma. The British Journal of Psychiatry (2010) 196, 122–125. doi: 10.1192/bjp.bp.108.059139
28. YOUNG Y, KORINEK K, ZIMMER Z, KHANH TOAN T (2021) Assessing exposure to war- related traumatic events in older Vietnamese war survivors. Conflict and Health 15(1), 1-16, 2021.
29. REFUGEE CAMPS: Pulau Besar and Pulau Bidong. The Chao Tom Journal July 12, 2012.

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