

# Health, safety and developmental conditions of young asylum seekers in the Netherlands<sup>1</sup>

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## Summary

*In the light of the current uncertain position in the Netherlands of many asylum-seeker families and unaccompanied asylum-seeker children, a basic document to describe their situation is urgently needed. The reorganisation of refugee reception and the splitting of asylum seekers' centres into orientation/integration and repatriation centres, mean that many families and children have to move again and again. Many families are uncertain whether or not they may return. Although children and young people often are resilient, they are at the same time very vulnerable. The health of asylum-seeker children and youths has been under pressure for a long time. Because of their resilience they are overlooked, however, as regards health and welfare they deserve to be regarded as a high-risk group. Matters have gone so far that one could speak even of structural neglect. They are in real danger of suffering (permanent) damage. This means we need to develop a specific policy in which their health and welfare are central. It also means that the consequences for the health and welfare of this group deserve special attention in the development and execution of immigration policy. In addition we need to provide structural monitoring and screening for this group. These efforts must be made so that their upbringing, care and education are of such a high standard that they can develop as healthily and normally as possible. The present situation leads to great mental stress.*

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<sup>1</sup> UPDATE 2006:

This document was published in January 2005. Since then conditions are changing, like reception. The reception of UMA's is improving. But when they reach the age of 18 they are expected to leave the country. However thousands of them still remain illegal in the Netherlands. Medical staff in the centers generally is working hard to improve the health situation and the safety of children. Measures to prevent physical accidents have been taken. Small numbers of children of rejected parents stay in prison with their parents, waiting for deportation to their homeland. Recent research results fail in this document, so facts in this document can be out-of-date.

At the end of 2004 there were roughly 45,000 asylum seekers in asylum seekers' centres in the Netherlands. One third of these are minors. These 15,000 children and young people usually live with one or both parents, but there is also a large group of unaccompanied asylum-seeker children, internationally referred to as unaccompanied minor: 'URM'. A total of 5430 URM are wards of Nidos, the guardianship and family guardianship institution for refugees and asylum seekers. In addition 3764 ex-URM receive some form of further counselling and financial support (Nidos 2004). Increasing numbers of URM are obliged to live in reception centres until their majority, on the assumption that they will return to their country of origin.

On the basis of practical information, this data document provides a statement of affairs on the health, safety and developmental conditions of young asylum seekers, in the Netherlands. It is also a reaction to a report by the Dutch Advisory Committee for Immigration Affairs (Adviescommissie voor vreemdelingenzaken, ACVZ 2003): 'Kinderen in de asielpraktijk' (Children's experience of asylum).

This Pharos data document is based on (Dutch) research data available up to December now.

### **Scarcity of research data on young asylum seekers**

According to the Dutch government, the care of asylum seekers is basic but humane. In the Netherlands very little is known as yet about the effects on children and young people of having to live for some length of time in asylum seekers' centres. With the exception of research into URM, only very restricted (large-scale) research has been done in the Netherlands into the somatic and mental health of these children. There are no epidemiological data and it is difficult to keep records within the child health services.

In the above-mentioned ACVZ report, the position of underage asylum seekers is held up to the light and various recommendations are made to improve welfare and (access to) health care (ACVZ 2003).

- An inventory must be made of the pro-(or anti-) child aspects of care, with the aim of improvement.
- We need an international data bank, with information on care, education and health facilities (including psychosocial care).
- More attention should be paid to the safety and the psychosocial situation of URM.

This data document can be seen as a start on the inventory recommended by the ACVZ. The basic assumption is the principle that the health service should be just as accessible for young asylum seekers as for Dutch children. In the practice of the Dutch child welfare services reference is often made to developmental conditions which apply for all children (Bartels & Heiner 1994).

Children have a right to:

- adequate care
- safe physical environment
- continuity and stability in living conditions; uninterrupted development
- interest in their environment
- respect, security, support and understanding
- have their needs taken seriously
- structure, regularity, encouragement, limits and rules.
- possibility of acting on own initiative and a limited responsibility
- psychological security/safety
- someone to model themselves on and contact with contemporaries
- education
- knowledge of and contact with their own past

These developmental conditions are also used as touchstone to check whether the current immigration policy and its execution take sufficient account of the vulnerability of asylum seeker's children and young people.

## **General development and effects**

### ***Harsh political attitudes***

Dutch political attitudes towards immigrants in general and asylum seekers in particular are becoming harsher. Decreased asylum applications, cutbacks and economies are putting pressure on aid and services to this group. In the year 2001 the current immigration law was brought into operation, with much emphasis on (enforced) repatriation. For thousands of asylum seekers' families this meant a real threat of deportation and a blow to their hopes of legitimate residence in the Netherlands. Children and young people, like their parents, experience the increasingly negative views on asylum seekers in Dutch society.

Life in a reception centre is stressful. People are cooped up for long periods alongside other residents with very different backgrounds and customs. Living quarters are cramped. There is no privacy, parents and children often having to live together in one room. Asylum seekers are not allowed to work, they are forced to simply wait. They are often obliged to move, especially now that the decrease in asylum applications has caused the closure of many centres. That means that the continuity and stability of the lives of asylum seekers' children is more frequently interrupted. Because they have to change schools more often, the continuous development essential for children is repeatedly interrupted.

They seem to adapt easily, but their welfare depends to a large extent on the strength of their parents. As long as the latter give the impression that they stand firm as parents and offer protection, children seem to make the best use of their resilience. If the parents have serious problems, the children will suffer directly and indirectly from this. Directly because parental care falls short, indirectly because their parents' suffering affects the children profoundly.

### ***Continuity of care under pressure***

The mental health of adult asylum seekers is poor. One fifth suffers from anxiety disorders, a third has depressive disorders, and post-traumatic stress disorders occur in slightly more than a third of asylum seekers (Laban et al. 2002). There has been no research into the effect of parents' serious mental problems on the children of asylum seekers, but it is common knowledge that mental disorders in parents can have a disruptive effect on children's development (Unicef 2004). Social and health workers and others involved with children are very concerned and are protesting against the effects of the current immigration policy. The RIAGG Noord Holland (regional ambulatory institute for mental health) for children has sent an open letter to the minister of immigration, Ms R. Verdonk. In this letter they write that asylum seekers' children in their care, some of whom were born here, are often hardly able to speak their native language and have settled here 'with heart and soul' (Bastiaanse, 2004). According to them it is an impossible task to treat children who have lived in the Netherlands for a long time and who must now be deported. This is to ignore the rights of the child.

Staff members of the Medische Opvang Azielzoekers (Medical care of asylum seekers) (MOA) increasingly report that the quality of care in the centres has seriously deteriorated. As cause they cite, for example, that the closure of centres and constant changes in team personnel is placing the continuity of care under pressure (Koppenaar & Van Gogh, 2004).

### ***Living conditions URM in the Netherlands are getting worse***

The policy regarding URM has gone through drastic changes. It is the intention that all URM older than 15 years on entry into the Netherlands should remain in reception centres until they reach their majority. Meanwhile they are put under pressure to return home. A small-

scale survey among teachers, mentors and social workers into the effects of this policy reports that things are going considerably less well with these young people than formerly (Engelhard, 2003). Schools report unauthorised absence and problems with concentration. All respondents report anxiety, stress, headache and sleeping problems on the part of URM. According to the respondents, behavioural problems, suicide threats, isolation and aggression also occur more often since the implementation of this policy. These occupational groups do not oppose the repatriation of URM, but the way in which this policy is carried out. One element of this policy consists of an experiment, now discontinued, with two URM campuses. These half-open boarding schools started using a system derived from the Glen Mills re-education system for young delinquents.

Refugee pressure groups have opposed campus reception centres from the beginning. Youngsters commit acts of vandalism and violence against the staff. The youngsters rebel for example against the strict regime. They are unhappy and feel that they are treated without respect. There is not only vandalism and conflict with the management, but also enmity among the young people themselves. Research shows that these URM have considerably worse health than young people in other reception centres. (TNO 2003). Public safety however is greater on the Vught campus than in other reception centres. The experiment with the URM campuses was terminated at the end of 2004. The most important objective, to motivate young people to return to their countries of origin, appears to have failed. Of the 436 URM who stayed there, only six have returned to their own countries.

## **Health of asylum seekers and refugee children**

### ***Psychological complaints***

It is difficult to assess the health and welfare of young asylum seekers as there are insufficient objective data. Since the early 1990s large groups of asylum seekers have been coming to the Netherlands. The number of children and young people among them is usually between 30 and 35 per cent. These children clearly form a high-risk group which needs central registration. Only in the last few years information has been produced, largely from surveys by MOA staff, on the living conditions, problems and care of children in asylum seekers' centres. These are small-scale surveys which indicate that further research is necessary. One example is the survey in three reception centres among 154 children aged between 4 and 12 years, which shows that the children living there suffer from poor mental health (Sokal 2001):

- 53.9% has mental problems
- 4.5% has serious mental problems
- 30.5% has problems sleeping
- 27.3% has behavioural problems
- 14.9% wets the bed

This information is consistent with English research (Fazel & Stein 2003). More than a quarter of refugee children suffer from a 'significant psychological disorder'; three times more than English children. According to this research, refugee children are more hyperactive and have more problems with contemporaries than English children.

URM are being, and will continue to be, much more thoroughly documented than young asylum seekers who come here with their parents. A very exhaustive survey was carried out by Tammy Bean. URM reported having experienced many stressful life events. Moreover, in comparison with other adolescent populations, such as young parental accompanied refugees and migrants, URM report a very high severity level of psychological distress. The psychological distress is expressed in anxiety symptoms, depression symptoms and traumatic stress reactions. A strong relationship was confirmed between high levels of emotional distress and exposure to many traumatic life events. Moreover, there was a strong association between factors such as feeling safe, the type of residential setting in which the URM live, and the severity level of psychological distress. (Bean 2005).

### ***Somatic complaints***

Somatic problems of asylum seekers' children have been researched and described even less than mental problems. The paediatrician Tjon a Tjen feels that asylum seeker's children should be more exhaustively screened for health problems (Tjon a Tjen 2003). He draws a comparison with adopted children, who are extensively screened. On the basis of figures from other countries he assumes that parasitic infections are very common (20-40%). Owing to the origin of several groups of asylum seekers, relatively many children are infected with HIV.

A frequently occurring problem is hepatitis. Because 51 per cent of adult asylum seekers has suffered such an infection and a considerable number of them remain carriers of the virus, younger children in particular run a great risk of chronic infection. In spite of the advice of the Gezondheidsraad (National Health Council) to vaccinate all children of whom one parent at least comes from an area where hepatitis B is endemic, this does not happen with asylum seekers' children. Long-term risks are acute and chronic liver infections, resulting in liver failure and hepatoma (liver cell carcinoma).

Roughly 20,000 girls in the Netherlands come from countries where female circumcision is practised. It is estimated that every year roughly 50 girls are being circumcised. ( Raad voor Volksgezondheid, 2005)

Arrears in dental care also occur. Research in two reception centres has been carried out on, for example, the incidence of caries, fluorosis and dental plaque in children of 8 to 10 years. Compared to Dutch children the prevalence of caries seems generally high (Kalsbeek et al. 2001).

### ***Sexual and reproductive health***

Another field which shows lacunae is that of sexual and reproductive health. Pharos' research indicates that only a very limited section of 12 to 18 year-olds has had adequate sex education (Mouthaan & De Neef 2003), while a number of young people are fully sexually active. Some young female asylum seekers are pregnant on arrival in the Netherlands. A number of these have been sexually abused.

According to the asylum seeker centre nursing staff, a large number of teenage births occur among young female asylum seekers. These young single mothers, who usually do not know whether they will be allowed to stay in the Netherlands, find it very difficult to bring up their children alone. Unplanned and single motherhood is a high-risk factor in the upbringing of children. We know too little as yet about the shorter- and long-term effects on these mothers, and especially on their children. A number of women do not want the child and opt for an abortion. Dutch abortion registration is not sophisticated enough to show the exact number of (young) asylum seekers who have abortions.

In order to improve the sexual and reproductive health of these young women, much extra attention is needed. To make sex education successful, asylum seekers must be regarded as a high-risk group in national, regional and local policy. First reception schools are eager to give sex education but would appreciate support from local area health authorities. This is not yet the case (Tuk 2004).

It is known that URM have often undergone negative experiences in their sexual development and that they form a high-risk group for sexual violence. 22 per cent of URM has been the victim of sexual violence (Rots-De Vries 2002). But this percentage may be even higher. Bean's research shows that 12 per cent of boys and 43 per cent of girls report sexual abuse (Bean 2005). This survey does not go into the nature of this sexual violence, nor where it happened: in the land of origin, in transit, or in the Netherlands. In 2003 it

emerged that Dutch reception centres are often unsafe. Staff reported sexual violence, prostitution and the recruitment of URM girls for this purpose (Van Burik 2003).

### **Quality of life and safety for children in reception centres**

The quality of life and safety in reception centres leaves much to be desired. Children have many accidents in and around asylum seekers' centres. Hygiene inspection has been improved but there are many other environmental factors which pose a threat to children from 0 to 14 years. There is insufficient safety instruction. Without specific information it is difficult for parents to take adequate measures to prevent accidents to their children (A. Stellinga-Boelen 2004).

Children in reception centres often undergo unpleasant experiences. This is shown for example by the excess mortality of asylum seekers through unnatural causes. Accidents, drowning, suicide, murder and manslaughter occur often, compared with the Dutch population (Koppenaar 2001). In 1998/1999 nine people died violent deaths. There were also twenty suicides during that period (W. Amptmeijer, 2002). These are drastic experiences for children, not least because they have already experienced many drastic and sometimes violent events.

It is not known how many children die unnatural deaths; what is known is that more children (and adults) drown every year.

### ***Domestic violence and child cruelty***

Asylum seekers' children run a greater risk than Dutch children of becoming the victim of child cruelty. No research has been done as yet into the incidence of this problem, but there are many indications. Research into safety in the centres shows that one in twenty women in an asylum seekers' centre is the victim of domestic violence. It probably occurs more often, as staff in the reception centre do not consider it part of their duties to be on the watch for it (Van Burik 2003). And very often asylum seekers and their social workers fail to report it. Domestic violence between parents and adult family members is a good predictor of violence against children (Unicef 2003).

A survey in five centres shows that staff and social workers regularly see indications of child cruelty but often fail to report them (Mensinga Wieringa 2004). They are reluctant to take action, for example because they feel that this would conflict with professional secrecy and would damage their position of trust with the asylum seeker. 43 of the 50 care and social workers interviewed felt that life in an asylum seekers' centre 'endangered the development of children'. A Pharos telephone survey at the end of 2004, among a number of Advice and Complaints offices for Cruelty to Children (Advies en Meldpunt Kindermishandeling, AMKs), confirms the fear that these children are 'at risk'. All of the AMKs surveyed receive complaints from centres. Some of them accordingly provide instruction and/or training courses for centre staff. One of the AMKs reports that some social workers see no point in helping these children because of their specific living situation. Organisations working in the centre do develop activities to improve prevention and referral through protocols and co-operation agreements, for example. Staff are also trained to improve public safety. As there is no good overview of the seriousness of the situation, however, the effects of such improvements cannot be shown.

### **Health facilities in reception centres**

The above-mentioned report 'Kinderen in de asielpraktijk' (Children's experience of asylum circumstances) (ACVZ 2003) is supported by quick scan data (Van Willigen 2003). One section concerns the accessibility of health care. There are reports that the medical care of young asylum seekers in the centres, recorded in 'service level agreements', is improving. This conclusion was probably justified at the time of the survey, but the current situation does not confirm this optimism at all. In three of the centres surveyed, the quality of care

deteriorated in 2004 compared with the previous year (C. Pasibaru 2004). The required standard has not been achieved. Vaccination is administered too late and medical information is inadequately recorded (77% of medical cards are not properly recorded). The psychosocial care of children provokes criticism. With mental problems the three centres surveyed showed great differences, for example in connection with referral to a general practitioner or paediatrician. It is assumed that the centres differ greatly as to the level of attention devoted to psychosocial problems, and that this hampers referral.

### ***A practical example:***

Bedwetting is a relatively common problem with this group. This can be ascribed to the situation in which these children and young people are placed. For this group however it is difficult to remedy the situation because of poor living conditions and financial difficulties. There are all kinds of devices for children who wet the bed. The usual aids, such as incontinence pads, special sheets or pads and buzzers are hard to get; the costs are not refunded (Albadi 2004).

### **Child welfare**

The ACVZ report discusses poor access to child welfare services and recommends improvements. Pharos makes the same observations. Staff in the supervision and care sector are largely negative about the referral of young asylum seekers to child welfare. Pressure points are the waiting lists, and also young people's lack of motivation. The existing availability of care services does not meet the demand.

Although the new law on child welfare, one extra regulation in particular, seems to guarantee accessibility for this target group, pressure points remain. The daily supervisors appear to be insufficiently familiar with referral possibilities, and young people who are referred have to wait a long time for treatment (L. Gerritse 2003).

### **Illegal immigrant children and young adults**

In its report 'Ik ben er wel maar ze zien me niet (I'm here but they can't see me)' Defence for Children International discusses the position of illegal immigrant children in the Netherlands and concludes that these children have inadequate access to the health service (Braat 2004).

In the survey 55 children and young people were interviewed, 36 of which from an asylum seekers' background. Their living situation is characterised by instability because of their constantly moving house. Access to education is not a problem, but lack of money prevents children from taking part in social and sporting activities.

School holidays are therefore very dull and tedious for them.

Most children state that their physical health is reasonably good, but report problems with their mental health. One third has psychological problems (psychosomatic complaints, nightmares, sleeping problems). One or two report depressive complaints and suicidal tendencies. Some children receive medication, while others are told that illegal immigrant children cannot be given mental health care because of their uncertain residence situation. Access to the health service is often dependent on volunteers who show them the way and find sufficient financial means. They are unable to take out health insurance. Sometimes parents are unaware that they can nevertheless make use of the health service. This does not include preventive dental care.

Illegal immigrant children themselves feel that they are different from other children and are treated as such. They are ashamed of their position and are afraid of being discovered by the police and deported. Because of many movements they lose track of many friends. For many children, social isolation is threatening because of fear to make new friendships. Some parents deter their children from making social contacts.

Children often do not dare to think about the future, their lives seem to have temporarily come to a halt.

These findings agree with Pharos' observations and data. In 2004 Pharos arranged conferences in 5 Dutch towns for organisations concerned with the care of refugees. The more than 400 participants confirm the idea that children suffer greatly under illegality. The health of children of single mothers is particularly threatened. The FIOM (National organisation support unplanned motherhood) is getting disturbing reports of children being abandoned. Pharos' information and advice telephone line receives frequent calls about situations in which the health of these children is threatened. An important problem is that illegal immigrant parents regularly change their address, which makes continuity in supervision and care impossible. Not only asylum seekers but supervisory social workers too are often unaware of the 'koppelingsfonds', a financial emergency fund for health care for illegal immigrants.

Children suffer primarily from the fact that they can be 'picked up' and deported at any moment. In the summer of 2004 the newspapers reported that a Bosnian boy did hide himself in another town during school examinations, to avoid being picked up and deported. Schools increasingly report that children are being taken from their classrooms in order to be 'removed'. Those who remain are afraid that one day they too will disappear with their families, leaving everyone and everything behind. Teaching staff feels a great need for better supporting these children on this subject (Zdrinja 2004).

Expectations are that in the early months of 2005 the government will start to withdraw financial support from several thousand ex-URM. Although this will presumably happen one step at a time, social workers, counsellors, teachers and other professionals expect that this will lead to great problems, because many young people cannot or do not wish to return to their country of origin. On some occasions expulsion from reception centres has led to extreme situations. At the end of 2003 Vluchtelingenwerk (Refugee Council) Utrecht reported that an 18 year-old girl from Sierra Leone, expelled from a centre because she had reached her adulthood, had been sexually abused for three months by homeless people and drug addicts (Utrechts Nieuwsblad 2003).

## **Conclusions**

As stated in the introduction, this data document provides an overview of the information available in the field of health and welfare of asylum seeking children and young people. It does not paint a rosy picture. There is a great discrepancy between what is on paper and reality. Often, what seems to be formal legislation, policy, protocols and methodology is actually not offered to young asylum seekers. Not all of the developmental conditions mentioned at the beginning of this document have been tested. There is insufficient (research) data for this at present. What is clear is that several important conditions are not being met. Current policy interrupts the continuity and stability of living conditions. Both physical and psychological safety leave much to be desired. Parents in the first place are responsible for the care and upbringing of their children, but their living conditions influence their competence negatively. Because the parents are in a sorry plight, not all children are well cared for, nor do they get enough security, support and understanding. Illegal child immigrants are also badly off.

Roughly one third of all asylum seekers in the Netherlands is a child or young person. That is a large group. Their health and welfare are often damaged by the flight from their country and their prior experiences. Their resilience sometimes causes us to overlook them, but children and young people are a vulnerable group that need care and protection. That does not mean that they wish to be regarded as a problem case, but that the quality of reception, upbringing and education ought to promote the most healthy and normal development possible. There is no question of this at the moment. The effects of the current policy are to create a situation of structural neglect. Neglect in the sense that immigration policy

insufficiently considers the needs and developmental conditions of these children. The earlier quoted ACVZ report posits that the decreased inflow of refugees will lead to improved facilities for children and young people. With hindsight it appears to be wishful thinking. Reception centres are so becoming the new Dutch deprived areas. Children who have to grow up in these conditions, even for a short time, are harmed and perhaps even for their whole life. This is an undesirable situation that demands swift improvement.

What must be done?

1. Immigration policy. In developing and carrying out immigration policy the consequences of these measures on the health and welfare of this group ought to be considered.
2. The target group itself ought to be consulted, in order to involve it in the organisation of appropriate care and reception.
3. Quality. By means of education and further training the health care sector ought to possess the necessary skills, information and attitude to offer this group appropriate care. By regarding this group as high-risk, it ought to be possible to offer timely help where necessary.
4. Monitoring and screening. To improve the living conditions of asylum-seeker children and to safeguard preventive and curative treatment, we need a more concrete picture of their situation than this document can provide. There is insufficient epidemiological information, in the field of both somatic and mental health. To make policy measures testable and measurable, we ought to measure the health of this target group more exhaustively than is now the case. A more focused screening could then take place on the basis of such data.

## Literature

***The vast part of this literature has not been translated in English.  
Literature marked with \* has (partly) been translated in English.***

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