



Offering care for victims of torture among a migrant population in a transit country: a descriptive study in a dedicated clinic from January 2017 to June 2019

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Background: Médecins Sans Frontières set up a clinic to provide multidisciplinary care to a vulnerable migrant population experiencing torture. We describe the population accessing care, the characteristics of care provided and patient outcomes.

Methods: A descriptive retrospective cohort study of patients enrolled in care during January 2017–June 2019 was conducted.

Results: Of 2512 victims of torture cases accessing the clinic, the male: female ratio was 1:1. About 67% of patients received medical care, mostly for chronic pain treatment. About 73% of patients received mental health care, 37% received physiotherapy and 33% received social support care; 49% came to the clinic upon the recommendation of a friend or family member. The discharge with improvement rate ranged from 23% in the mental health service to 9% in the sociolegal service. Patients retained in care had a median IQR of 3 (2–4) follow-up visits for medical care, 4 (2–7) for mental health, 6 (3–10) for physiotherapy and 2 (1–4) for sociolegal.

Conclusion: Care for victims of torture cases among vulnerable migrants is complex. For those who did receive care that led to an improvement in their condition, their care models have been described, to allow its implementation in other non-specialised settings.

Keywords: migrants, multidisciplinary services, SORT IT, victims of torture.

Introduction

The United Nations' High Commissioner for Refugees (UNHCR) reported that in 2015 nearly 1% of the world's population was a refugee, asylum-seeker or internally or forcibly displaced person.¹ Displaced populations, including asylum-seekers and refugees, are often exposed to repetitive violence and often carry a high prevalence of torture, which can be perpetrated in both the country of origin (often as a triggering factor for departing the country of origin) and along the migration route, often in situations of trafficking or detention.^{2,3} UNHCR has estimated that among refugees alone, 5–35% are torture survivors.⁴

Torture, as defined by the International Committee of the Red Cross, is 'Severe pain or suffering, whether physical or mental, inflicted for such purposes as obtaining information or a confession, exerting pressure, intimidation or humiliation'.⁵ This definition is

often expanded to 'torture and inhuman treatment', which also includes acts that cause serious pain or suffering, whether physical or mental, or that constitute a serious outrage upon individual dignity. Unlike torture, these acts do not need to be committed for a specific purpose. In this paper, we will use the term 'torture' to refer to the broader 'torture and inhuman treatment'.⁵

Torture has long-term physical and psychological consequences,⁶ which exist in a complex interplay of social, political, cultural, economic and biological factors.^{5,7} Nearly all survivors of torture have symptoms of chronic psychiatric disorders.⁸ There is limited information about the types of services provided to torture survivors and the outcomes of such services.⁹ These services can include the provision of psychological interventions (at individual, family or group level) aiming to change cognitive, emotional or behavioural outcomes, which have been reported to improve the psychological distress of torture survivors.⁹

Care for victims of torture (VOT) is complicated by barriers to seeking care, due to social isolation, social vulnerability, stigma, legal challenges and a lack of awareness of healthcare services among torture survivors,¹⁰ as well as by challenges at the level of care provision. Care for VOT is necessarily complex and requires long-term, multidisciplinary support at medical, psychological, social and legal levels. While all signatory countries of the United Nations Convention Against Torture are obliged to provide torture rehabilitation care, few countries have managed to set up services that allow prompt and sensitive identification of VOT and comprehensive, long-term rehabilitation care.

The humanitarian medical organisation Médecins Sans Frontières (MSF) has set up a dedicated clinic for victims of violence, including torture, among displaced populations in an unnamed country that acts as both a transit and a destination country. Due to the sensitivity of tackling torture, especially (in the case of refugees and migrants) in the country where the clinic is located, the authors opted to anonymise the location of the clinic and the nationalities of the patients. The clinic provides multidisciplinary care, which includes medical examination and emergency treatment, mental healthcare (psychological and psychiatric care), physiotherapy and sociolegal services. Most models of care for torture rehabilitation are provided in destination countries and/or in settings where many options exist for social support (e.g. social support referrals, protection services). The MSF multidisciplinary model of care provided in this type of context has not been described in its entirety elsewhere, although some specific aspects of the multidisciplinary approach have been highlighted in a previous MSF study.¹¹

Focused projects for VOT, such as the MSF clinic in this context, may not be necessary or possible in all humanitarian settings. The model of care in this clinic can serve as a template for projects aiming to offer care for VOT in non-specialised settings. We will describe and define a package of activities that have been shown to be successful in supporting this particularly vulnerable and difficult to treat group. We therefore aimed to (1) describe the characteristics of VOT patients who sought multidisciplinary care in the MSF clinic during January 2017–June 2019, (2) the care provided by each department (medical, mental health, physiotherapy and sociolegal) and (3) patient outcomes per department among all patients and among those patients who had positive outcomes.

Methods and Resources

Study design

This is a retrospective quantitative analysis using routine programmatic data.

Study setting

The MSF clinic is a specialised facility for victims of violence (including sexual violence and torture), accepting both old and recent cases. It offers a comprehensive, free-of-charge model of care that includes medical, psychological/psychiatric, social-legal and physiotherapy care.

When a new patient is admitted to the clinic, they are generally assessed in triage by a trained nurse to assess whether the patient's needs are within scope of the clinic's treatment capacities and to identify emergency cases (with severe acute symptoms and signs requiring immediate care such as acute physical conditions like bleeding or fractures or severe mental health symptoms such as anxiety attacks or suicidal ideation requiring immediate protection services [for incidents occurring at the home of the victim]).

After triage, a joint intake session is performed by a medical doctor and a psychologist, using a structured assessment tool, to assess the medical and mental status of the patient and whether the case is an emergency (red case) or not (Figure 1). The assessment tool includes basic personal history (demographic information), a brief history of the incident, physical and mental symptoms and signs. A fast, basic physical examination of the patient is carried out (anthropometric measures, vital signs), as well as assessing their mental/psychological state and consequences of the incident using a simple 10-item questionnaire. Based on the intake assessment results, the healthcare needs of the patient are defined. The patient is then allocated to a specific multidisciplinary team and a first tentative treatment plan is discussed.

The patient then accesses the different services required (medical, psychological, psychiatric, physiotherapy and/or social care), either directly after the intake or following an internal referral when a specific need is identified. Each service initiates its care through a detailed/in-depth assessment session, using a detailed assessment tool, according to the type of service. All the assessment tools and treatment plans are developed based on MSF guidelines, which were adapted from the consensus treatment guidelines, according to the patient's diagnosis and needs.^{12,13} The tool includes questions on the patient's demographics, a history of the incident in the patient's own words, an assessment of their needs, any further investigations required, an assessment of the need for internal or external referral, diagnosis and the treatment plan. The assessment will also involve a discussion with the patient in simple language. The patient will be set a variable number of follow-up sessions, as required. In every follow-up session, the patient's progress is measured and registered in a separate follow-up form, one for each session. Each patient has their own file with all their assessments, treatment plans and investigation results; all the forms are labelled with a unique patient ID with only their first name to maintain the patient's confidentiality.

There are four multidisciplinary teams in the clinic, each including members of all disciplines, so that if the patient is treated within one team, their treatment plans and progress are discussed at regular intervals within the multidisciplinary team.

The treatment of all VOT patients starts with medical and mental health components. Physiotherapy and sociolegal services are provided if needed. The cultural mediator's team, who speak around 12 different languages among them, are present most of the time to provide support to the clinicians.

The medical component consists of a physical/clinical assessment of the patient and the consequences of torture by a trained physician. The patient will then receive medical treatment and any required investigations (labs and imaging) and referral to physiotherapy if needed; the patient's progress is then monitored at each visit.

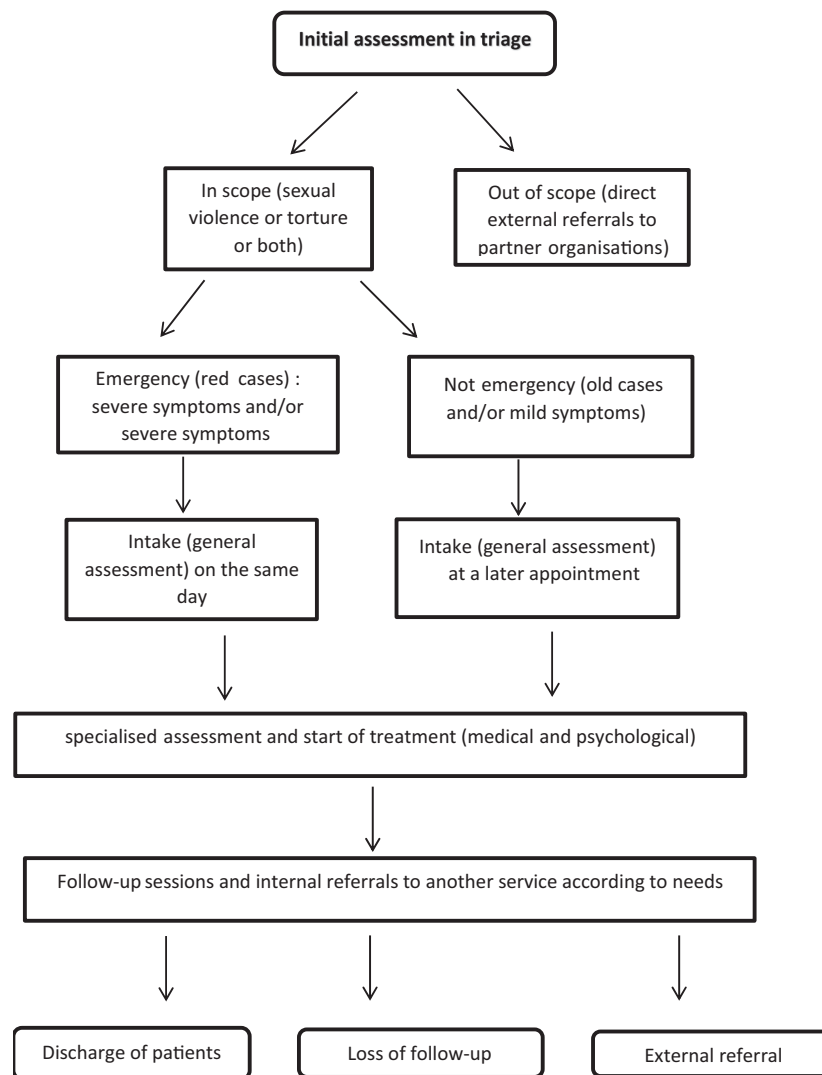


Figure 1. Flow of patients in the clinic.

The mental health component in VOT care starts with a basic mental assessment by a trained psychologist using the structured assessment tool, including assessment of symptoms (e.g. sleep quality, fears, anxiety symptoms, flashbacks), assessment of speech coherence, perception, cognition, orientation of the patient and a functional assessment using the Global Assessment of Functions scoring system.¹⁴ All the assessment results are registered in specific forms, each identifying the session number at which those results were recorded. The scores are compared to monitor progress over the course of treatment.

Mental health treatment for VOT patients mainly involves therapeutic rapport techniques (active listening and empathy), then different evidence-based techniques (e.g. cognitive behavioural therapy, narrative therapy, eye movement desensitisation and reprocessing [EMDR]) are applied according to the main diagnosis and severity of the symptoms and signs.

Psychopharmacotherapy is available from the beginning of treatment in cases of severe mental states such as depression and post-traumatic stress disorder (PTSD).

Treatment over the various disciplines is mainly provided through individual sessions, assuring the maximum privacy and confidentiality of the patients. Group therapy techniques started to be applied in January 2019, in both mental health and physiotherapy. Every group session includes 10–12 patients, each with similar complaints and diagnoses, coordinated by a trained psychotherapist or physiotherapist in a safe and confidential setting. The aim of the group therapy sessions is to facilitate the healing process through helping patients to rediscover their inner resilience, in addition to educating them about physical exercises and healthy coping techniques to alleviate their physical and/or psychological symptoms. The groups allow socialisation with patients who have similar problems and for patients to receive feedback and support from other group members in the presence of the therapist.

Different techniques are used in group sessions, such as art therapy and drama therapy (in mental health), exercises and health education about the physical consequences of torture in physiotherapy sessions.¹⁵

The clinic is a primary healthcare facility that only provides outpatient services. If hospitalisation is needed then a patient can be referred externally through coordination with a dedicated referral liaison officer and the supervision of a specialist. During the external referral period, each patient is followed up by their MSF specialist and their treatment and progress are registered in their file as a part of the treatment.

The time a patient spends in care differs from one patient to the next: patients are discharged when improvement is observed and the treatment course per service is complete. The decision to close a patient's file is taken after multidisciplinary discussions across the teams and a consensus is reached that the optimum recovery and rehabilitation has been achieved.

However, given the transient nature of the setting, patients may opt to discontinue treatment and leave of their own volition; patients who have not been seen for ≥ 90 d are classified as lost to follow-up (LTFU). The flow of patients in the clinic is illustrated in Figure 1.

Study population and period

The study was conducted using data from all individuals admitted to the clinic who disclosed being VOT within the last 10 y of their presentation to the clinic, from January 2017 to June 2019.

Data collection and data sources

Study data were extracted from the standardised, pseudo-anonymised routine database of the clinic. This is a relational EpiData database, developed for use across all MSF-Operational Centre Brussels projects for VOT and sexual violence.

Data storage, data management and quality assurance

A rigorous system for routine data management has been set up in the clinic, with a strong emphasis on data/identity protection. Patient files are labelled with a clinic ID and no names or identifying information are recorded in the patient files; a 'golden book' linking the clinic ID with the name, address and telephone number of each patient is stored in a secure safe and is kept under strict surveillance.

The clinic ID is used throughout the clinic for patient identification. Clinical data for monitoring and evaluation are recorded in each service (including the intake service) on a specific proforma (also only labelled with the clinic ID) and sent to the data team (consisting of two data officers, supervised by an epidemiologist) for encoding in the EpiData project database. Monthly analysis of the project database includes automated checks for internal consistency.

The routine data required for this study were extracted into a study database, from which the clinic ID and all direct and indirect identifiers were removed.

The specific outcomes used in the clinic are described in Box 1.

Box 1. Possible patient outcomes

- 1 - Discharged with improvement: the patient completes their treatment and shows improvement according to the clinician's opinion
- 2 - Out of scope/single orientation
- 3 - Patient referred externally to other organisations
- 4 - Patient migrated/detained/died
- 5 - Lost to follow-up: patient does not show for >90 d after last visit
- 6 - Patient was either not improved or non-compliant to treatment

Abbreviation: LTFU, lost to follow-up.

Data analysis

A descriptive analysis of data was conducted, using frequencies and proportions for categorical variables. Continuous variables were summarised using means and SDs and medians and IQRs as appropriate. Box and whisker plots were created to display continuous follow-up variables. All analysis was conducted using EpiData 2.2.3 Odense, Denmark. Stata 15: Texas, USA was used to generate graphs.

Results

Patient characteristics

Table 1 shows the characteristics of the 2512 VOT enrolled during the study period, with an average of 84 new cases per month. Nearly half of the patients (1220 cases; 48.6%) attended the MSF clinic upon a recommendation from friends or family and the majority of the remaining patients were referred from other organisations (996 cases; 39.6%). The female to male ratio was approximately equal, with 51.4% (n=1249) female VOT.

Approximately 46% (n=750) of the 1629 VOT who reported physical consequences at admission suffered from chronic pain. Soft tissue injuries (13.9%; n=221) and fractures (5.9%; n=96) were also common.

About 70.7% (n=1770) displayed mental health symptoms at admission. Of those, 588 (33.2%) displayed general mental health symptoms (e.g. feeling down, worried, frightened, confused or unable to concentrate), 511 (28.9%) showed symptoms of PTSD, 256 (14.5%) displayed major depressive symptoms and 122 (6.9%) exhibited symptoms of anxiety.

Financial needs were stated as the primary reason for seeking social services for 413 VOT, which represents 16.4% of those arriving at the clinic and 49.2% of those receiving social/legal support.

Services in the MSF clinic

Table 2 shows the number of and types of services provided to patients in the MSF clinic. Most patients (1837; 73%) were admitted to the mental health department providing psychological care: these cases received a total of 6401 counselling sessions, including individual counselling sessions and 50 group sessions.

Approximately 1682 (67%) of the patients were admitted to the medical department. About 37% (n=939) of the cases

Table 1. Sociodemographic and clinical characteristics of VOT patients seen at the MSF clinic, January 2017–June 2019

Characteristics		N (%)
Total number of patients		2512
Gender	Female	1290 (51.4)
	Male	1207 (48.0)
	Unknown/not registered	15 (0.6)
Age groups (y)	16–19	242 (9.6)
	20–45	2064 (82.3)
	>45	206 (8.2)
Recurrent events		322 (12.8)
Referrals to MSF	Family/friends	1220 (48.6)
	Referral from other organisations	996 (39.6)
	Community leaders	180 (7.1)
	Unknown	70 (2.7)
Delay in seeking care	MSF presence	46 (1.8)
	(Time between the event and seeking care) in months (median ± IQR)	21.5 (2.4–45.9)
Delay in seeking care	Yes	1021 (40.6)
	No	203 (8.1)
	Unknown	1288 (51.3)
Cause of delay*	No knowledge	757 (74.1)
	No access	243 (9.7)
	Scared	21 (2.1)
	Unknown	1654 (65.8)
Primary reason for seeking care**	Mental symptoms	1654 (65.8)
	Physical symptoms	393 (15.6)
	Sociolegal issues	736 (29.2)

*Causes of delay: The denominator is the cases who stated in the questions before it that they were delayed in accessing care in MSF center.

**Mental: anxiety disorders, depression, psychotic episodes, behavioural problems and others.

Physical: pain, soft tissue injury, deformity, broken bones, urogenital injury, damage to eyes and/or ears, amputation, breathing dysfunction and others.

Sociolegal: housing, financial aid, food and non-food items, birth certificates and others.

were admitted to the physiotherapy department. These patients received 2224 individual sessions in addition to 55 group sessions. Finally, 838 (33.4%) cases received sociolegal services; more than half of them (431, 51.4%) were referred to external organisations for further investigation of their needs.

Patient outcomes

Table 3 shows the outcomes for patients receiving care in each department: 1851 (34.8%) of those seen in the mental health department, 1682 (31.6%) in medical, 939 (17.6%) in physiotherapy and 838 (15.7%) in social support services were classified as LTFU. The rates of successful discharge of patients (i.e. discharged with improvement) ranged from 23.5% in the mental health service to 8.5% in the social support service.

Around three-quarters of patients received mental health services and two-thirds required medical care. Physiotherapy and social legal services were required for about a third of patients. The following number of sessions were needed for a successful outcome from each department: psychology, five sessions (IQR: 3–7) usually lasting 2.5–6 mo; psychiatry, six sessions (IQR: 3–10), usually lasting 2.5–6 mo; medical, three sessions (IQR: 2–4), usually lasting 0.5–3 mo; physiotherapy, five sessions (IQR: 3–7),

usually lasting 0.5–3 mo; sociolegal, three sessions (IQR: 2–5), usually lasting 1–4 mo. The median number of visits required to achieve a discharge with improvement, and duration of follow-up vs other outcomes, was calculated for all services (Figures 2 and 3).

Discussion

This study provides the first description of the MSF multidisciplinary care model for migrant VOT in a context that is both a transit and a destination setting.

Although the LTFU rate was high, a reasonable proportion of patients completed their treatment and showed improvement on discharge. The package of activities (in terms of the number of visits and duration of treatment) provided to these patients was described. The treatment plans and number of follow-up visits to different services/departments for the patients who showed improvement on discharge could be used to guide similar projects that aim to provide a comprehensive package of care to VOT.

Mental health services, including psychological and psychiatric care, represented the bulk of the care provided in the clinic. This

Table 2. Components of care provided by department to VOT patients seen at the MSF clinic, January 2017–June 2019

Service received overall		N (%) 2512 (100) [†]
Patients referred for medical care:		1682 (67.0)
Patients referred for mental health services:		1837 (73.1)
Type of mental health service provided		
	Individual sessions	2229 (97.8)
	Group sessions	50 (2.2)
Patients referred to physiotherapy:		939 (37.4)
Type of physio service provided		
	Individual sessions	2224 (97.6)
	Group sessions	55 (2.4)
Patients referred for social care:		838 (33.4)
SW service provided		
	External referral*	431 (51.4)
	Internal referral**	17 (2.0)
	Unknown/no action	390 (46.5)

*External referral to other non governmental organizations (NGOs) concerned with the non-medical needs of the patients (housing, legal needs, food and non-food items, birth certificates and education).

**Internal referral to other services inside the MSF clinic depending on the patient's expressed needs or social worker (SW) assessment

[†]Numbers in parentheses represent column percentages (IQR).

Table 3. Clinical and programmatic outcomes by department among all VOT at the MSF clinic, January 2017–June 2019

Department	Total	Patient outcomes					LTFU, n (%)	Non-compliant/ not improved, n (%)
		Improved, n (%)	Referred externally, n (%)	Out of scope/ single orientation, n (%)	Migrated/ detained/ died, n (%)			
Medical department	1682	276 (16.4)	32 (1.9)	351 (20.9)	0 (0)	1011 (60.1)	12 (0.7)	
Mental health department	1851	435 (23.5)	30 (1.6)	119 (6.4)	1 (0.1)	1262 (68.2)	4 (0.2)	
Physiotherapy department	939	185 (19.7)	0 (0)	183 (19.4)	21 (2.2)	545 (58.0)	5 (0.5)	
Social department	838	71 (8.5)	69 (8.2)	28 (3.3)	1 (0.1)	663 (79.1)	6 (0.7)	

Abbreviation: LTFU, lost to follow-up.

is consistent with the literature on torture, which shows that the psychological and mental consequences represent the bulk of morbidity associated with these events.¹⁶ The methods used for mental assessment and treatment are in line with the guidelines for patients having experienced trauma and/or torture living in humanitarian settings in low- and middle-income countries and MSF's clinical and programmatic guidelines.^{12,15,17}

Treatment plans were decided, taking into consideration patients' needs and expectations, and each patient was briefed about the treatment plan including the treatment methods and duration of treatment. The patient's case, treatment plans and prognosis were discussed once per week by the team providing care to the patient. Options for mental health treatment available included narrative exposure therapy, EMDR and inter-personal therapy.¹³

Group sessions also formed a vital part of the care package, both for mental health and for physiotherapy, as these can help

deal with a high number of patients while offering peer support to victims. Group psychotherapy has been shown to be a promising technique for working with traumatised populations, including refugees and torture survivors.¹⁸ Models for group therapy with torture survivors that have been described in the literature range from integrated models of combined individual and group therapy to time-limited groups to non-traditional activity groups developed by different torture treatment centres.^{19,20} Time-limited group models are used in the clinic. During group activities members share issues and support each other while conducting group-coordinated tasks such as art therapy, movement, drama and storytelling. These activities serve to facilitate talking about painful experiences and to support victims expressing their feelings.^{18,19} Patients are grouped together based on having similar experiences of torture in similar sociopolitical contexts.²⁰ These groups provide members with empathy, hope, acceptance and social solidarity. They also allow for information sharing

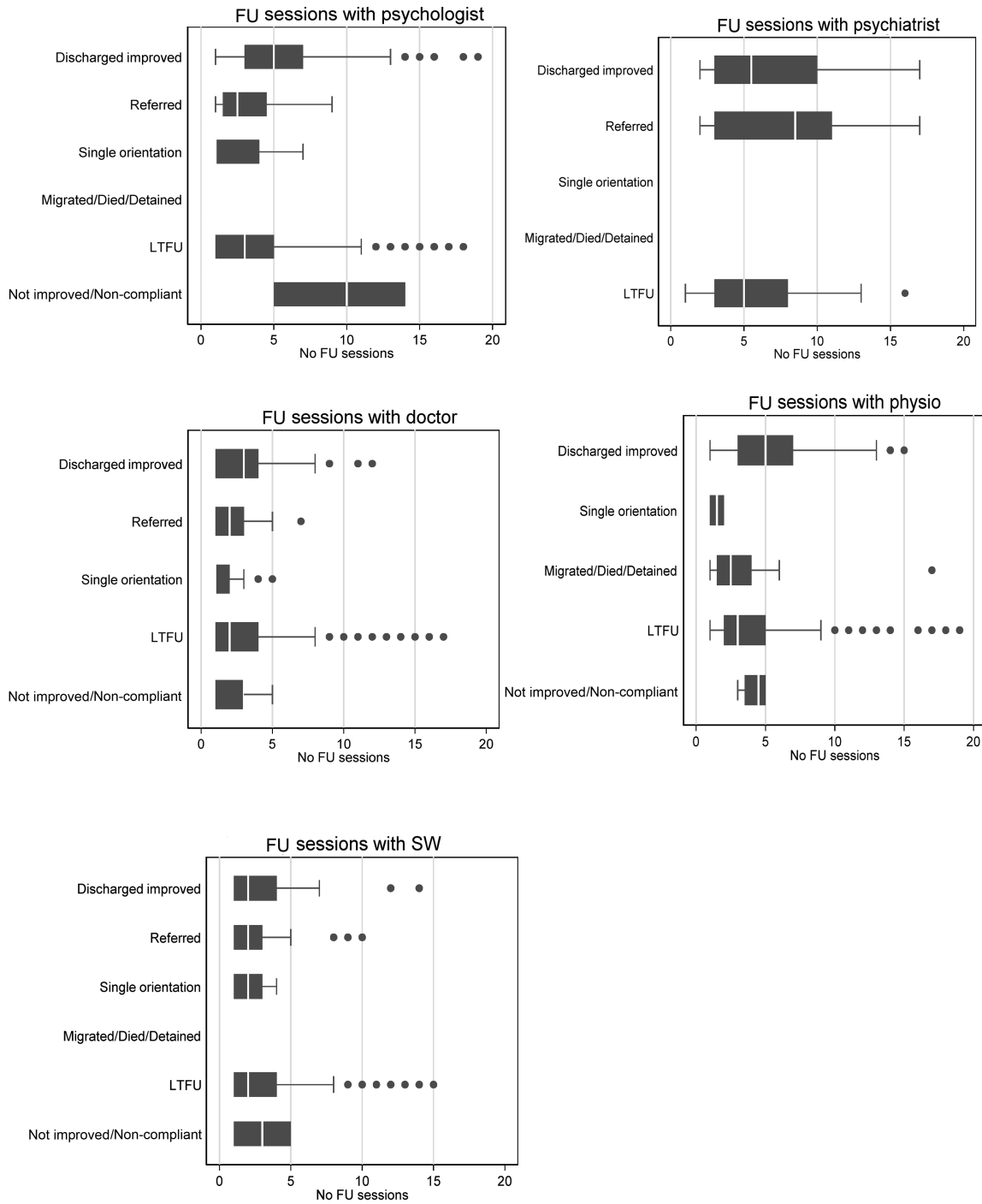


Figure 2. Median and IQR to show the number of follow-up (FU) sessions by patient outcome per department seen at the MSF clinic, January 2017–June 2019. Outliers are removed.

and can help patients place their experiences within a broader sociopolitical context, thus helping patients feel optimistic about improvement.^{18,20}

Patients were discharged as improved based on the clinician's subjective judgement of patients' needs and feelings, but most of the patients were involved in this decision-making process.

Patients would then be instructed on self-care and home programmes. In addition, discharged patients were encouraged to contact the hotline of the clinic or to come directly if they experienced similar or other problems.

The proportion of patients who were discharged with improvement by the care provider was low and the most common

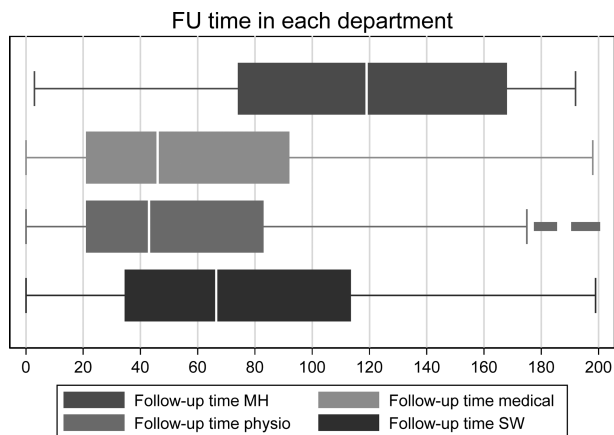


Figure 3. Median and IQR to show the duration of follow-up (FU) time by patient outcome per department seen at the MSF clinic, January 2017–June 2019. Outliers are removed.

outcome was LTFU. While cases of LTFU reflect incomplete care and possible dissatisfaction with the service, most of the LTFU cases received only slightly fewer or a similar number of sessions as those patients who were successfully discharged. This may suggest that a proportion of patients ceased attending the clinic of their own volition following some improvement. Nevertheless, measures to avoid cases of LTFU are urgently required. Anecdotal information from the clinic suggests that LTFU may be attributed to many reasons, such as money issues (an inability to pay for transportation to and from the health centre), difficulty finding transportation, feeling healthy and no need for further treatment and a desire to focus on work. These causes were similar to those found in a study conducted in India looking at causes of LTFU with treatment in cases of chronic diseases or health conditions, attributed by default to financial and social causes.²¹

The sociolegal department had the worst outcomes compared with other services. This may be because the social-legal needs of the patients are not easy to fulfil, especially as the services are provided through coordination with external organisations. Therefore this can take longer to follow up and there is often a lack of feedback from these organisations about the outcome of cases. To improve retention in care, this clinic has put in place a number of initiatives to support patients. First, in 2019, the social and legal needs assessment was performed upon a patient's admission to the clinic, rather than about 1 mo after admission. Also, in 2019, the MSF clinic started to provide food coupons for 1 mo of food for each patient, as well as distributing non-food items (e.g. clothes, hygiene kits) to patients in need at their first visit. As of June 2019, two-way transportation costs are now covered for patients. The project is currently planning to evaluate the effectiveness of this policy in decreasing the LTFU rate. In addition, we will look at patient satisfaction and other reported reasons for LTFU to try and improve the retention in care and services provided.

In the future, the project plans to implement a treatment plan with a standardised discharge criterion. This will be created based on a standard number of follow-up sessions and a given duration of treatment, using the results from this study. On top of this, research and testing are needed for the development of

culturally relevant medical, psychological and social assessment tools, including a scoring system to follow up each patient's progress. Standardised tools (e.g. visual analogue score, depression scale score) are available at the clinic, but some are currently underused by clinicians due to their lack of suitability for the population and context. Finally, the project will implement an appointment reminder system, which will be carefully created and implemented with feedback from patients, to ensure that every patient's confidentiality is maintained.

This study also described some characteristics of the patients who had experienced torture. Unfortunately, we were not able to elaborate on many of the details, due to the sensitivity of the information available, which may jeopardise the safety of the patients and the ability of the clinic to provide services.

Counter to initial expectations of a higher volume of male cases, the male to female ratio was nearly equal. This is similar to results of a study among Somali and Oromo refugees, which estimated that males and females, in this modern era, are VOT at nearly a 1:1 ratio. Civilians are now increasingly exposed to modern warfare and terrorism, and therefore women are now as likely to experience torture as men.⁴ The current study supports this observation.

In the current study, a high percentage of cases came to the clinic upon word of mouth advice from family, friends or community members. Self-referrals based on direct knowledge of the MSF services were low, although much credit for the high number of cases presenting overall can be given to the efforts of the health promotion team attached to the clinic, who conduct regular health education sessions among migrant communities to decrease the stigma associated with torture and to make migrant communities aware of the treatment available to them. These results indicate the importance of social networks for ensuring access to care for VOT, as demonstrated elsewhere.²²

The strength of the study is that it included a large number of patients and followed them up over a long period of time. In addition, the data source is routine data collected from a clinic, providing a good overview of on-the-ground activities. Also, areas for operational improvement are highlighted, including those outwith the study's parameters.

The use of routine programmatic data can also be a limitation as it may lead to problems with regard to its completeness and accuracy. Moreover, outcomes were based upon the subjective opinion of the clinician, with little objective information regarding whether the primary needs with which that patient initially presented were either met or not.

Conclusions

Care for VOT among vulnerable migrants is complex and a majority of patients discontinued treatment before being discharged after observed improvement. For patients who received care that led to an improvement in their condition, the care modalities have been described, to allow implementation of similar care in other non-specialised settings.

Authors' contributions: Study design: MK, RH, WK, CT, GDM and RVdB. Study implementation: MK, RH, MMC, HS, AM and RVdB. Analysis and

interpretation of data: MK, RH, CP, PO and RVdB. Major contribution to writing: MK, RH, CP, PO, HS, AM and RVdB. Read and approved final version: all authors.

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Data availability statement: The datasets used and/or analysed during the current study are available from the corresponding author on reasonable request.

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