Health of refugees and migrants

Practices in addressing the health needs of refugees and migrants

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Contents

In response to a request, in World Health Assembly resolution 70.15, the World Health Organization issued a global call for information, including case studies, on current policies, practices and lessons learned in the promotion of refugee and migrant health. This document is based on information gathered from the contributions from Member States, the International Organization for Migration, Office of the United Nations High Commissioner for Refugees, International Labour Organization, other partners and WHO regional and country offices in response to that global call, as well as from literature searches and reports available in the public domain. It is, therefore, presented without any claim to completeness. Furthermore, WHO has not independently verified the information from the contributions unless otherwise stated. This is a "living" document which will be updated periodically as new information becomes available.

Abbreviations

EEA	European Economic Area
EU	European Union
NGO	nongovernmental organization
UNFPA	United Nations Population Fund

AUSTRIA

CONTEXT: In 2017, there were 1 660 283 international migrants in Austria, constituting 19% of the total population. The number of migrants has increased at an annual rate of 5.3% since 2015. Of these migrants, 165 446 were refugees and asylum seekers (10%). Since 2015, there has been a significant increase in the number of refugees, particularly asylum seekers, with an annual rate of increase of 37%. Between 2010 and 2015, the number of refugees and asylum seekers increased 12.3% per year *(1)*. The number of asylum seekers in 2016 (42 285) was almost half of that of 2015 (88 300) but was nevertheless significantly higher than the numbers in 2012 and 2013 (each around 17 500) and 2014 (28 100). Most of the asylum seekers came from Afghanistan (11 800), Iraq (2900) and the Syrian Arab Republic (8800). In 2016, about 174 300 people immigrated to Austria, while 109 700 people left the country. This resulted in a net immigration rate of around 64 600. Of the 174 300 immigrants, 15 600 were returning Austrian citizens, while almost 85 700 came from European Union (EU) and European Economic Area (EAA) countries and Switzerland. The largest group of immigrants came from Romania (16 700), followed by Germany (16 100) and Hungary (13 300). Total immigration from developing countries (73 000) made up about 42% of all arrivals due to refugee migration, especially from Afghanistan (11 700), Iran (4700) and the Syrian Arab Republic (9000). Compared with the previous year (107 000), this was a decline of 34 000 (32%). Apart from refugee migration, immigration was most significant (14 700) from countries of the former Yugoslavia (countries outside of the EU). At the beginning of 2017, there were about 1 342 000 foreign citizens residing in Austria (15.3% of the population). On average, approximately 1 898 000 people with a migration background were living in Austria in 2016 (22% of the population), 85 000 more than in 2015: about 1 415 000 who had been born abroad (forming the first migration generation) with the remainder born in Austria as the children of foreign-born parents (second generation). Among foreign nationals, Germans remain by far the largest group. On 1 January 2017, more than 181 600 German nationals lived in Austria, followed by nationals of Serbia (118 500), Turkey (116 800), Bosnia and Herzegovina (94 600) and Romania (92 100). This is followed in decreasing numbers by nationals from Afghanistan, Croatia, Hungary, Poland and the Syrian Arab Republic.

Improving the health and well-being of women, children and adolescents living in refugee and migrant settings; promoting gender equality and empowering refugee migrant women and girls

PRACTICES. Sexual violence as well as female genital mutilation and cutting may define persecution under the Asylum Act. Migrant, refugee and asylum-seeking women are provided support services free of charge. As migrant women often go to hospitals rather than local doctors, hospitals of a certain size are obliged to set up victim support groups, and smaller hospitals must cooperate with larger ones if they do not set up one themselves. These victim support groups are responsible for early detection of sexual, physical and psychological violence (particularly in women) and for raising awareness among hospital staff of violence as a cause of injury or ill being. Some hospitals also have specialized units to perform necessary operations to help victims of genital mutilation/cutting, and training programmes are offered to medical staff. Other services to promote gender equality and promote the health of migrant women and girls include more than 50 violence-specific aid facilities and protection centres for women and children affected by domestic and sexual violence, including a specific shelter for those exposed to forced marriage; many of these centres offer support in relevant foreign languages to accommodate the high percentages of migrant clients. There is specialized training for staff of the Office for Immigration and Asylum on traumatism and interculturalism, and the Austrian Integration Fund also provides training to Muslim women as peer educators, including on the prevention of violence.

(Source: Federal Ministry of Health and Women Affairs)

BELGIUM

CONTEXT. In 2017, there were 1 268 411 international migrants in Belgium, constituting 11.1% of the total population. The number of migrants has increased at an annual rate of 0.6% since 2015. Of these migrants, 61 780 were refugees and asylum seekers (4.9%). Since 2015, there has been a decrease in the number of refugees and asylum seekers, with an annual decrease of 3.9%. However, between 2010 and 2015, the number of refugees and asylum seekers increased by 26.3% per year *(1)*.

In a 2015 study about labour market and origin, in which two variables (origin and migration background) were taken into account, it was found that, in 2012, 29.3% (1 874 076 people) of the Belgian population between 18 and 60 years of age were of foreign origin (i.e. either the individual or one of the parents was a foreign national or born as a foreign national). For 7.4% of this population, origin could not be determined. The largest group of people of foreign origin (43.6%) originated from the EU14 countries (Austria, Denmark, Finland, France, Germany, Greece, Ireland, Italy, Luxembourg, Netherlands, Portugal, Spain, Sweden and the United Kingdom); the second largest group (16.2%) originated from Maghreb countries. Other important groups originated from the EU12 countries (Bulgaria, Cyprus, Czech Republic, Estonia, Hungary, Latvia, Lithuania, Malta, Poland, Romania, Slovakia and Slovenia) (8.5%), other African (non-Maghreb) countries (7.5%), candidate EU countries (7.3%) and other European countries (6.0%). The composition of the population of foreign origin in Belgium stems from the relatively old history of immigration from the beginning of the 20th century. Among Belgians who have acquired Belgian nationality during their lifetime (first generation), 62 844 (15.7%) previously had an EU nationality, while 338 678 (84.3%) previously had a non-EU nationality. In the first group, 61.9% acquired Belgian nationality after five years and 38.1% acquired Belgian nationality in up to five years. In the second group, these percentages were 47.2% and 52.8%, respectively.

Promoting the right to the enjoyment of the highest attainable standard of physical and mental health, equality and non-discrimination of refugees and migrants

PRACTICES. Access to medical care is ensured from the moment of central registration of the asylum application as well as for the duration of the entire asylum procedure. Each collective reception centre has its own medical service and offers access to mental health care. All medical costs including psychological consultations are covered by the Federal Agency for the Reception of Asylum Seekers (FEDASIL) for both beneficiaries in the collective reception centres and asylum seekers residing at private addresses. The medical costs for the asylum seekers residing in individual reception structures are paid by the public service of social integration. Intercultural mediation in hospitals and via video remote intercultural mediation is now also available in a number of primary care centres and the medical services of the Federal Agency.

Lessons learned and recommended future priority actions. The existing free access to health services, including mental health services, for asylum seekers is a good and effective way to attain the highest possible standard of physical and mental health for this group. The restrictions on urgent medical care for irregular migrants remain an obstacle. Intercultural mediation, on site as well as remote, is an effective strategy to reduce health care inequities among migrants and ethnic minorities. Intercultural mediation is only effective when it is part of a larger systematic strategy to provide equitable care to a diverse population. A sufficient number of intercultural mediators, and sufficient financing, is necessary to cover needs, not only in hospitals but also in primary health care, mental health care and preventive services. Further implementation of video mediation is required in order to be able to respond to increased diversity among migrants and ethnic minorities. It is also important to develop a systemic approach to the management of diversity in health care (e.g. through the implementation of tools such as the Equity Standards for Health Care for Migrants and Other Vulnerable Groups, developed by the MED Task Force), to ensure access and to include migrants in the existing health insurance system of the country.

Preventing and controlling communicable and noncommunicable diseases, including mental health, for refugees and migrants

PRACTICES. With the aim of providing free vaccination services and promoting the importance of vaccines among people in vulnerable situations, Flanders launched mobile vaccination teams in 2014. Focusing on children falling through the safety net of the School Health Service or the Flanders Agency for Child and Family, the mobile vaccination teams provide services free of charge to all people who cannot access medical care. Potential target

groups include Roma, victims of trafficking and homeless people. Vaccination data are recorded in a centralized system, where they are then available to all other vaccination services. Moreover, since 2016, all asylum seekers receive vaccinations and tuberculosis screening at the time of their asylum application. Those coming from countries with polio also receive an extra polio vaccine in line with WHO recommendations. Further priority is given to vaccination against measles, mumps and rubella (WHO elimination goal for measles and rubella) and combined diphtheria, tetanus and pertussis, the latter group especially for pregnant women. Catch-up vaccination is also carried out in well-baby clinics, by the School Health Service for children and adolescents and by doctors in local refugee-receiving centres. Where necessary, the mobile vaccination team can help. All vaccines provided are free of charge, including for refugees, migrants and asylum seekers.

Lessons learned and recommended future priority actions. Using the opportunity of tuberculosis screening to vaccinate as soon as possible may help to prevent outbreaks and spread of infectious diseases such as measles. Early vaccination at entry points is of utmost importance.

Providing equitable access to universal health coverage, including access to quality essential health services, medicines and vaccines, and health care financing for refugees and migrants

PRACTICES. The ETHEALTH (Ethnicity & Health) expert group was created to formulate recommendations for public health authorities on how to reduce ethnic and migrant health inequalities and for targeting irregular migrants and migrants with a precarious legal status. These recommendations included ensuring a clear framework of reimbursement and applying the existing legislation on urgent medical aid; providing a voucher entitling irregular migrants to request assistance; extending the use of medical cards to all irregular migrants, entitling them to urgent health care; diversifying the health professionals and health services available to treat migrants; and providing a temporary residence permit for irregular migrants affected by infectious diseases in order to ensure a full course of treatment.

Promoting people-centred, gender-, refugee- and migrant-sensitive health policies and health systems and programme interventions

PRACTICES. In Belgium, a team of 80 cultural mediators working in 60 hospitals acted as interpreters and accompanied patients to the doctor. These mediators were often recruited among migrant communities to facilitate dialogue and inclusion. Such presence helped to overcome possible misunderstandings and conflicts and was judged useful by health practitioners. The incorporation of training on cultural competence into the education of health professionals, or provision of separate training, is another method to bridge cultural barriers for migrants accessing health care services.

Culture-sensitive aid workers are more and more often confronted with people of a foreign origin (e.g. refugees, migrants, asylum seekers, irregular migrants, expatriates and international students) and the current flow of refugees will only increase the need for culturally sensitive care. However, culturally sensitive care needs to go further and extend to encompass people with the same ethnicity but different cultural backgrounds, for example because of differences in socioeconomic status or being part of a specific target group such as the homeless, adolescents or the elderly. Currently, three centres for mental health care (in Ghent, Antwerp and Brussels) receive funding to support culturally sensitive care. Their goal is to create mental health care that takes into account social–ethnic–cultural diversity.

Lessons learned and recommended future priority actions. Capacity specifically aimed at serving the mental health needs of refugees is being well used and appreciated. Registration data show that there is still increased need for specialized mental health care for this target group of vulnerable people. Embedding teams in the local area gives added value, but a central intersectoral collection and use of expertise for stronger support coverage for culturally sensitive help would be advantageous.

(Source: FPS Health, Food Chain Safety and Environment)

BOSNIA AND HERZEGOVINA

CONTEXT. In 2017, there were 37 100 international migrants in Bosnia and Herzegovina, constituting 1.1% of the total population. The number of migrants has decreased at an annual rate of 1.9% since 2015. Of these migrants, 5324 were refugees and asylum seekers (14.4%). There has been a significant decrease in refugees and asylum seekers particularly, with an annual rate of decrease of 12.2% since 2015. Between 2010 and 2015, the number of refugees and asylum seekers increased 0.6% per year *(1)*.

In 2016, 11 519 temporary residence permits were granted to aliens in Bosnia and Herzegovina, which was 8.82% less than in 2015 (12 633). The annual overview since 2007 shows a constant increase trend in the number of granted temporary residence permits in Bosnia and Herzegovina, except in 2011 and 2016, when there was a slight decline. Of the total number of permits issued for temporary stay in 2016, the highest numbers were for citizens of Turkey (2727), Serbia (2239), Croatia (1038), Montenegro (718), the former Yugoslav Republic of Macedonia (629) and China (503), accounting for 68% of the total number of permits issued.

Aliens in Bosnia and Herzegovina were granted 799 permanent residence permits in 2016, which is a slight decrease of 1.11% compared with 2015, when 808 permanent residence permits were approved. The most common countries of origin of aliens who have obtained permanent residence in Bosnia and Herzegovina in 2015 and 2016 were China, Croatia, Montenegro, the former Yugoslav Republic of Macedonia and Turkey.

According to data provided by the Sector for Asylum of the Ministry of Security of Bosnia and Herzegovina, a total of 66 applications for asylum for 79 people were submitted in 2016. However, in addition to unresolved applications from preceding years (13 applications for 16 people), the Sector for Asylum had to review 79 applications for 95 people in 2016. The largest numbers of asylum seekers in Bosnia and Herzegovina in 2016 were from Turkey (13 applications for 19 people), followed by citizens of the Syrian Arab Republic (17 applications for 18 people), Pakistan (11 applications for 12 people), followed by Serbia (six applications for eight people) and Iraq (four applications for six people). In the last two years, no applications for asylum were submitted by unaccompanied minors.

(Source: Ministry of Civil Affairs of Bosnia and Herzegovina)

CYPRUS

CONTEXT. In 2017, there were 188 973 international migrants in Cyprus, constituting 16% of the total population. The number of migrants has decreased at an annual rate of 0.8% since 2015. Of these migrants, 16 165 were refugees and asylum seekers (8.6%). The number of refugees and asylum seekers has shown the largest increase, with an annual rate of 2.7% since 2015. Between 2010 and 2015, this number increased 30.2% per year *(1)*.

In 2008, the Ministry of Interior estimated that there were approximately 40 000 irregular third country nationals (not citizens of the Member States of the EU, the EEA or the Swiss Confederation) in Cyprus. However, during that