

Health of refugees and migrants

Practices in addressing the health
needs of refugees and migrants

WHO European Region
2018

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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 time the economy was stronger and many jobs were available. Currently, estimations reduce the number to fewer than 20 000. The main countries of origin of irregular immigrants in Cyprus are Georgia, Iran, Iraq, Jordan, Pakistan, the Syrian Arab Republic and Turkey. The majority of irregular migrants are either those who have overstayed their visa or work permit or those who are rejected asylum seekers. More recently with the further deterioration of the humanitarian situation in the Syrian Arab Republic, asylum seekers are now arriving by sea (1607 people between September 2014 and November 2017). The largest arrival by sea happened in September 2014, when 345 migrants, mainly refugees from the Syrian Arab Republic, were rescued by a search and rescue operation conducted by the Joint Rescue Coordination Centre of the Ministry of Defence, followed by 115 in September 2015 and 114 in October 2015. It is also worth mentioning that, during the Israeli-Lebanon war in 2006, a massive evacuation plan was implemented to welcome and organize the departure of approximately 70 000 foreign citizens in transfer from Lebanon to their native countries.

Addressing the social determinants of health and health inequality for refugees and migrants

PRACTICES. Interventions are in place to ensure migrants' health rights, reduce excess mortality and morbidity among migrant populations, minimize the negative impact of the migration process on migrants' health outcomes and avoid disparities in health status and access to health services between migrants and the host population. These interventions include a systematic risk assessment undertaken in order to identify the relatively few epidemic-prone diseases that have the potential to cause the greatest amount of morbidity and mortality in the affected population. Findings of the risk assessment are used to prioritize surveillance efforts and identify interventions that will be most effective in mitigating the increased risk. Risk factors that influence disease transmission in emergency settings are also assessed systematically, grouped and viewed by disease category (waterborne diseases, vector-borne diseases and diseases associated with crowding or malnutrition) to link interventions with specific risks. Specific health services targeting these groups (e.g. triage and delivery of services for acute disease on the frontline, medical examination of all migrants, screening tests for communicable diseases (HIV, hepatitis B, hepatitis C, syphilis, tuberculosis)), medications for all patients with chronic diseases and immunization programmes are available at reception centres, with appropriate follow-up.

(Source: Ministry of Health)

CZECH REPUBLIC

CONTEXT. In 2017, there were 433 290 international migrants in the Czech Republic, constituting 4.1% of the total population. Currently, there are approximately 511 000, most commonly citizens of the Russian Federation, Slovakia, Ukraine and Vietnam. This number has increased at an annual rate of 2% since 2015. Of these international migrants, 4529 were refugees and asylum seekers (1%). There has been an increase in the number of refugees and asylum seekers since 2015, with an annual rate of increase of 2.6% since 2015. Between 2010 and 2015, the number of refugees and asylum seekers increased 11.3% per year (1).

Promoting continuity and quality of care for refugees and migrants

PRACTICES. The Policy for the Integration of Foreign Nationals includes raising awareness of foreign nationals and overcoming language barrier between patients and health care providers. In order to achieve this goal, the Ministry of Health created a patient guide and communication cards for foreigner patients and health professionals in various languages. Centres for the support of the integration of foreigners provide professional social consulting on various problems, including health care and health insurance, to migrants free of cost. Centres may also provide interpretation services and even accompany foreign national to the health care provider. Similar services are provided to refugees who participate in the state Integration Programme for Beneficiaries of International Protection.

Lessons learned and recommended future priority actions. Foreign patients need to be well informed in order to fully benefit from the Czech health care system and take proper care of their health.

Improving communication and countering xenophobia to dispel fears and misperceptions among refugee, migrant and host populations on the health impacts of migration and displacement

The intended goal of the integration policy is to communicate with the general public about the issues of migration and integration in relation to citizens and immigrants. The migration reality of the last few years brings a risk of certain adverse effects such as xenophobia, islamophobia, racism, extremism or other expressions of negative attitudes of individuals or groups towards immigrants. Crimes with racial undertones are still very few and isolated, but in some areas with higher concentrations of immigrants, negative attitudes from the majority population towards foreigners have been registered. The integration policy aims to consistently oppose xenophobic tendencies in society and to intervene actively against manifestations of hatred towards immigrants, while adhering to the requirements laid down by legislation. Emphasis is placed on the principles and tools of integration, on intensive promotion of governmental integration measures, on activities of organizations supporting integration and on clarifying the meaning of integration in the process of building harmonic coexistence

with immigrants. A variety of projects from the Centres for the Support of the Integration of Foreigners and nongovernmental organizations (NGOs), such as multicultural festivals and defence against hate crimes, are subsidized from the state budget and EU funds.

Lessons learned and recommended future priority actions. Integration policy has to tackle potential hostility of majority towards migrants and refugees.

(Source: Ministry of Health of the Czech Republic, Ministry of Interior, Consortium of Migrants Assisting Organizations in the Czech Republic)

FINLAND

CONTEXT. In 2017, there were 343 582 international migrants in Finland, constituting 6.2% of the total population. The number of migrants has increased at an annual rate of 4.4% since 2015. Of these international migrants, 30 133 were refugees and asylum seekers (8.8%). There has been a marked decrease in these numbers since 2015, with an annual rate of decrease of 10.4%. However, between 2010 and 2015, the rate increased by 28.9% per year (1).

The largest groups of refugees and migrants are people born in the Russian Federation or the former Soviet Union (approximately 70 000), Estonia (approximately 45 000) and Somalia, Iraq and China (approximately 10 000 each). In addition, there are asylum seekers (Finland received 5651 in 2016, 32 476 in 2015 and 3000–5000 during the previous years, mostly from Afghanistan, Iraq, Somalia and the Syrian Arab Republic) and irregular migrants (number unknown). The proportion of people of foreign origin in the Finnish population has been growing rapidly since the early 1990s (6.2% in 2015 compared with 0.75% in 1990).

Creating health monitoring and health information systems for refugees and migrants

PRACTICES. Current guidelines for the voluntary initial health assessment for asylum seekers focus on screening for infectious diseases. There is, however, an increasing awareness of noncommunicable diseases, in particular mental health issues. The National Institute for Health and Welfare launched the TERTTU project (Developing the Health Examination Protocol for Asylum Seekers in Finland: a national development project 2017–2019) in collaboration with the Finnish Immigration Service to improve the current national health examination protocol for asylum seekers. The project aims at evidence-based development of the current national health examination system towards a standardized protocol to be used in migrant reception. It also aims at improving health monitoring for asylum seekers in Finland through systematic data collection on the health and service needs of newly arrived adults and children. This will result in an improved health record system and increased knowledge and understanding of the relevant health concerns and needs of asylum seekers at the local, regional and national levels.

Promoting continuity and quality of care for refugees and migrants

PRACTICES. The PALOMA (Developing National Mental Health Policies for Refugees) project (2016–2018) works to develop a national model for mental health work with refugees and individuals from comparable backgrounds. The project aims to provide guidelines and build capacity among professionals working with refugees on the prevention, recognition and treatment of mental health problems. The project model is targeted to different levels of administration and different contexts and will be implemented nationally to ensure mental health services are better and equally organized throughout Finland. The model covers primary and specialized care, as well as preventive initiatives outside of the social and health service sectors.

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

PRACTICES. Evidence-based information is given to each pregnant family with the document We're Having a Baby: Guidebook for Expecting and Looking after a Baby. This is available in various languages, currently English, Finnish, Russian, Somali and Swedish. The Multicultural Women's Association of Finland (MONIKA) is an NGO operating in the field of social affairs. It develops and provides specialized services for immigrant women and their children who have been subjected to violence; acts as an expert and advocate in issues related to ethnic non-discrimination and

violence; and promotes integration by supporting civil society activities for immigrants. Its Resource Centre provides a low-threshold service with the possibility of receiving help anonymously. Services include psychosocial support, guidance, peer support groups and supportive housing. MONIKA also runs Shelter Mona, which is located at a secret address. Migrant women and their children from all over the country have access to this service.

Lessons learned and recommended future priority actions. Universal services (frequent health examinations and health counselling) are important to reach the migrant population. According to research evidence, health monitoring helps to identify support needs in the early stages and to provide tailored support to those who need it. Universal services that are free of charge (scheduled appointments and health counselling) are needed for families expecting or having small children in order to help, support and empower those with migrant backgrounds.

The universal access to well-baby clinics should be monitored, especially among asylum seekers. The services at the well-baby clinics should be migrant sensitive.

Addressing the health of migrant workers, occupational health and safety measures, including improving working conditions; addressing workforce strategies

PRACTICES. The National Institute for Health and Welfare runs a project called Cope that examines the current state of migrant health, social care workers' integration and education, and existing bottlenecks in integration. Cope examines the function, challenges and management of culturally diverse work teams, and how organizations take into account the diversity of work teams and clients. Cope aims to find out how both migrant clients and culturally diverse work teams impact on the learning and educational needs of health care personnel. Ways are explored to solve challenges to competence, work teams and leadership resulting from diversity. Cope seeks to find means for lifelong learning to prepare workers to encounter migrant clients with greater ease and to develop professional competence. It also introduces and launches good practices to improve migrant education and the means by which they can utilize their knowledge and skills in the Finnish work life.

(Source: Ministry of Social Affairs and Health)

FRANCE

CONTEXT. In 2017, there were 7 902 783 international migrants in France, constituting 12.2% of the total population. This number has decreased at an annual rate of 0.1% since 2015, although it increased by 1.9% per year between 2010 and 2015. Of this total, 354 880 were refugees and asylum seekers (4.5%). The number of refugees and asylum seekers has increased annually by 2.7% since 2015. Between 2010 and 2015, this increase was 10.3% per year (1).

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. The French health system is inclusive and accessible to migrant patients (2). Benefits and principles apply equally to legal residents and French citizens. Asylum seekers are also covered by the universal free health insurance system (Couverture Universelle Maladie Protection Complémentaire; CMU-C). Low-income irregular migrants are covered by state medical aid (Aide Médicale d'Etat) but with certain conditions and restrictions. Exceptions to this are made for vulnerable and at-risk groups such as people with infectious diseases and pregnant women, who are granted a temporary permit to access health care. Anyone falling outside the system can access emergency services and care. Newcomers to France receive an initial orientation to the health system, information on which is provided in 23 languages. Practitioners are also being trained in guaranteeing equal quality services for migrant patients and the need to protect migrants' privacy.

(Source: WHO Regional Office for Europe)

GEORGIA

CONTEXT. In 2017, there were 78 218 international migrants in Georgia, constituting 2% of the total population. This number has increased at an annual rate of 1% since 2010. Of these, only 2692 were refugees and asylum seekers (3.4%). The number of refugees and asylum seekers has decreased at an annual rate of 0.4% since 2015. However, between 2010 and 2015, the number increased annually by 28.9% (1).

(Source: Ministry of Labour, Health and Social Affairs, Head of Health Policy Division)

GERMANY

CONTEXT. In 2017, there were 12 165 083 international migrants in Germany, constituting 14.8% of the total population. This number has increased at an annual rate of 8.7% since 2015. Of this total, 1 256 828 were refugees and asylum seekers (10.3%). There has been a significant increase in refugees and asylum seekers since 2015, with an annual rate of increase of 26.7%. Between 2010 and 2015, the increase in number of refugees and asylum seekers was much lower at only 4.3% per year. This was still the second highest level of net immigration amongst countries globally, at approximately 355 000 immigrants per year (1).

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

PRACTICES. Access to tuberculosis care is often prevented by structural barriers. The project Together against Tuberculosis aims at supporting patients with tuberculosis to successfully finish treatment under the WHO-recommended directly observed therapy strategy. A pair of medical students partner with one patient to provide support throughout the whole therapeutic process, promoting quality and continuity of care at the highest standard. Students also assist the treating physician in explaining the disease and treatment to the patient and the patient's family. Students establish a personal relationship with the patient and provide support in organizing the management of medicines and medical check-ups after leaving the hospital. Patients are completely free to participate and provide written informed consent. Students receive supervision and support by their medical school and receive recognition within their medical curriculum when the patient successfully finishes treatment. The goal, of supporting patients to successfully treat tuberculosis, is combined with the didactic purpose of improving the social and cultural skills and competencies of future physicians. Students learn how the well-developed and equipped health system of Germany is perceived by particularly vulnerable individuals, and how social, practical, structural, cultural and linguistic barriers can be overcome.

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

PRACTICES. The pilot project Pregnancy and Flight targets pregnant women and aims to inform them of German pregnancy-counselling services. At its heart is the concept of a visiting pregnancy conflict-counselling service to make these tried-and-tested services available to pregnant refugees. A helpline for pregnant women in need is provided, giving anonymous, secure and refugee-sensitive assistance over the telephone. The helpline is available 24/7 and in 17 languages. The pilot project Pro Familia is a specialized dialogue network for pregnant refugees that aims to network specialist services for them. In eight federal states, special information and networking centres have been established that focus upon pregnant refugees' special needs for help and support, cooperating with multiple partner organizations.

Improving communication and countering xenophobia to dispel fears and misperceptions among refugee, migrant and host populations on the health impacts of migration and displacement

PRACTICES. The online portal zanzu.de provides simple explanations in 13 different languages covering sexual and reproductive health and rights, including the human body, pregnancy and birth, contraception, HIV/AIDS, other sexually transmitted infections, sexuality and relationships. Importantly, there is detailed information available on the respective rights and laws in Germany, as well as on existing support and counselling structures. The website is

not just multilingual but also utilizes illustrations and integrated text-to-speech functions and special icons in order to be easily accessed by immigrants who have recently arrived in Germany and may not yet have the adequate language skills to obtain quality information on issues of sexual and reproductive health. Based on a human rights approach, the online portal provides comprehensive information enabling people to live self-determined lives and make informed and responsible decisions. It is also accessible to practitioners and intermediaries who either advise or treat adult immigrants professionally, such as physicians and counsellors. According to such professionals, the need for information and adequate materials is enormous. This portal can supply them with valuable tools to advise or treat their patients. The portal was set up by the Federal Centre for Health Education in cooperation with the NGO Sensoa. A combined national and international advisory council that includes WHO has also actively supported this project.

Enabling participation and social inclusion of refugees and migrants

PRACTICES. To improve support for refugees, asylum seekers and those designated as tolerated individuals (where deportation has been temporarily suspended) in accessing the labour market, the Federal Employment Agency has developed programmes with a focus on the special needs of these groups. For example, programmes such as Prospects for Refugees, Prospects for Young Refugees and Prospects for Female Refugees help these groups to gain occupational orientation combined with practical work experience in companies. The goal of these programmes is to offer help with access to the labour market and vocational training in Germany, the mapping of skills, skills assessments and qualification checks, as well as teaching job-related German. Young refugees can obtain information about access, structure and functionality of the dual vocational training system and the labour market. This helps to empower them to make an independent choice for an occupation, preferentially for dual vocational training. In 2016, about 7500 young refugees started just within the Project for Young Refugees. With the measuring system for skill assessment, early activation and language acquisition (Kompetenzfeststellung, frühzeitige Aktivierung und Spracherwerb), participation in an activation measure is combined with participation in an integration language course. In this way, language skills are immediately and successfully used in practise, which increases learning effectiveness. Furthermore, participants become better acquainted with the requirements of the labour market. German language courses for those with good prospects of remaining in Germany have been further expanded for both people who want to acquire basic German language skills and those in need of vocational language skills. On 1 July 2016, the Ordinance for Vocational Language Training Support became effective, installing a language training support tool exclusively financed by the Federal Government for the first time.

(Source: Federal Ministry of Health)

GREECE

CONTEXT. In 2017, there were 1 220 395 international migrants in Greece, constituting 10.9% of the total population. This number has decreased at an annual rate of 0.9% since 2015. Of these, 94 630 were refugees and asylum seekers (7.8%). There has been a significant increase in refugees and asylum seekers particularly, with an annual rate of increase of 30.9% since 2015. Between 2010 and 2015, this increase was higher at 71.3% per year (1).

Ensuring provision of short- and long-term public health interventions to reduce mortality and morbidity among refugees and migrants, including bridging short-term emergency and humanitarian health assistance with long-term health programmes and vaccination

PRACTICES. The Greek Ministry of Health created the programme PHILOS (Emergency Health Response to the Refugee Crisis) to provide a new approach to the refugee crisis, by fulfilling the sanitary and psychosocial needs of people living in the open camps (3). The programme is implemented by the Hellenic Centre for Disease Control and Prevention and is funded by the Asylum, Migration and Integration Fund of the EU's Directorate-General for Migration and Home Affairs. The programme introduces a comprehensive approach to provision of health services

to refugee populations and also reinforces the capacity of the national health system to respond to the extra demand upon health services as a whole. The programme works towards consolidating the urgent needs of the Ministry of Migration Policy, the Ministry of National Defence, the National Centre for Emergency Care and the health districts to address the usage of primary health services by refugees and migrants. Its main objectives are further reinforcement of the capacity of the public health system; the enhancement of the epidemiological surveillance structures, which are struggling with the stranded migrant population; the provision of onsite health care and psychological services to the target population through coordinated and well-targeted operational actions; the strengthening of the national health system's task force, the primary health structures and the National Centre for Emergency Care; and the provision of a system of recording for hospitalization and health service provision to nationals of other countries.

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

PRACTICES. The migrants and refugees who arrived in Greece during 2016 were mainly children (under 18 years of age) from countries with a lower vaccination coverage rate. This led to the organization of tailored vaccination programmes in the form of mass vaccination campaigns, with the coordination and supervision of the General Secretary of Public Health of the Ministry of Health.¹ Priority vaccines for migrants and refugees in Greece have been defined and provided through a specific programme: in infancy for measles, mumps and rubella; combined diphtheria, tetanus, pertussis and polio; and tuberculosis. More than 30 000 vaccines have been administered under the programme, with estimated vaccination coverage (first vaccine dose) for children appropriate to age of 83% for measles, mumps and rubella; 82% for combined diphtheria, tetanus, pertussis and polio; 76% for pneumococcal vaccine; 75% for *Haemophilus influenzae* type B; and 79% for hepatitis B virus. Vaccination was mainly conducted by NGOs with considerable experience and expertise in mass vaccination campaigns, as well as by some health services within the national health system and the Institute of Public Health. Specific mass campaigns have been organized to implement the priority vaccination programme in all refugee and migrant accommodation, including children living in residential centres and in other urban areas (e.g. hotels, apartments) or atypical structures. In addition, emphasis has been placed on the implementation of established good practices in the vaccination campaign.

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. Together with the Hellenic Centre for Disease Control and Prevention, the United Nations Population Fund (UNFPA) started a programme called Boys on the Move (life skills programmes for unaccompanied and separated male adolescents displaced by conflict and poverty). The Hellenic Centre has now completely taken over the programme. The programme is particularly dedicated to empowering and strengthening the resilience and competencies of the many boys and young men who, while making an already difficult journey, experience situations of violence, abuse and insecurity. The life skills presented in the programme can be delivered in stages along this journey to help adolescents to identify risks, cope with difficulties and solve problems in a positive and constructive way. Delivered in 10 sessions, and integrating cross-cutting protection concerns related to adolescent sexual and reproductive health and prevention of violence and trafficking, the programme addresses health and hygiene, emotions, coping strategies, sexuality, relationships, communication, cultural awareness, money, connectivity and planning. It ultimately aims to provide potentially life-saving information and build competencies in young men and boys experiencing changing and challenging circumstances.

(Source: WHO Regional Office for Europe)

¹ Report on vaccination in refugee/migrant accommodation sites from the WHO Country Office Greece, February 2017.

ITALY

CONTEXT. In 2017, there were 5 907 461 international migrants in Italy, constituting 10% of the total population. This number has increased at an annual rate of 0.9% since 2015. Of these, 216 027 were refugees and asylum seekers (3.7%). There has been a significant increase in refugees and asylum seekers, with an annual rate of increase of 9.9% since 2015. Between 2010 and 2015, this number increased at a far higher rate of 22.9% per year (1).

Since 2014, the growing crisis in Africa and the Middle East increased the so-called landing phenomenon, and this continued to increase until mid-2017 when 23 526 migrants arrived on the Italian coast in June alone according to data from the Ministry of the Interior. Following this, the number of landed migrants then dropped dramatically due to agreements with Libya; 11 459 and 3914 in July and August of 2017, respectively. A specific aspect of this complex phenomenon is the arrival of unaccompanied minors. According to the Department of Public Safety of the Ministry of the Interior, 13 026 unaccompanied minors landed in 2014, accounting for 50% of all minors landed. In 2015, the total number of unaccompanied minors increased to 16 478, while in 2016 there were 25 846, accounting for 16% of total migrants landing on Italian coasts.

Addressing the social determinants of health and health inequality for refugees and migrants

PRACTICES. The impact of social determinants on the health status of individuals in terms of prevention, emergence and healing of diseases and on disabilities has been widely demonstrated in both high- and low-income countries. Nonetheless, there is still debate on which sources of information are best suited to encourage and support the adoption of effective intervention policies. To meet some of these information needs, a surveillance system, the Italian Behavioural Risk Factor Surveillance System (known as PASSI), has been developed. This system has regular data collection and investigates aspects related to the state of health (perceived health, prevalence of cardiovascular risk factors and depression symptoms), lifestyle habits (nutrition, physical activity, smoking and alcohol), the availability and use of prevention programmes (oncological screening, rubella vaccine and influenza vaccine) and road and domestic safety. A sample of 18–69 year olds was randomly extracted from lists of health records, stratified by sex and age and contacted through monthly telephone interviews during which a questionnaire was administered by specially trained staff. Such population surveillance systems are now considered important sources of information and indications of change over time in social inequalities. They are of particular interest for shaping regular policy implementation and for designing interventions to reduce health inequalities.

Lessons learned and recommended future priority actions. The factors that most affect the state of health, apart from genetic heritage, are access to high-quality socio-sanitary systems; level of education, income and employment; and the daily environment in which people work and live. These factors are defined as social determinants of health, and it has been shown that by acting on these factors it is possible to improve the health of both individuals and a population, while also reducing the health inequalities that penalize the most disadvantaged population groups. Consequently, innovative public health should reflect a multisectoral approach to health promotion policies through higher levels of education, support for income and employment, improved housing and transport, and improved recreation facilities and the surrounding natural environment.

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. In recognition of the importance of providing equitable, affordable and acceptable health care to the large number of incoming migrants and asylum seekers, health authorities in Italy have implemented a creative approach to guarantee access to health care for all. Irregular migrants are able to obtain a code to access urgent and essential health care (Stranieri Temporaneamente Presenti). This code identifies the migrant to all health services and is anonymous and free of charge. The code can be applied for at any time and can be renewed. Children are included on their parents' code. Irregular migrants are also entitled to preventive care, including both maternity care and care for diseases that could progress and become dangerous. As access to health is not simply related to entitlements but is also impacted by barriers to receiving health care, Italy has also ensured policies are in place to overcome such barriers. These include the use of targeted health promotion campaigns, interpreters and cultural mediators in some regions, and the dissemination of information regarding health care entitlements

at national and regional levels to different groups and in different languages. National law also explicitly prohibits health services from reporting irregular migrants to officials, except under very restrictive conditions, which also apply to Italian citizens. The Italian response to the health needs of irregular migrants is an example of policies enacted to ensure the equitable provision of health care for irregular migrants, and the elimination of key barriers to such provision.

Ensuring provision of short- and long-term public health interventions to reduce mortality and morbidity among refugees and migrants, including bridging short-term emergency and humanitarian health assistance with long-term health programmes and vaccination

PRACTICES. The Sicily Region in Italy, in collaboration with the WHO Regional Office for Europe, conducted an assessment to develop expertise and capacity and to identify and fill potential gaps in health service delivery, including the prevention, diagnosis, monitoring and management of disease. The assessment was conducted using the WHO Toolkit for Assessing Health System Capacity to Manage Large Influxes of Refugees, Asylum Seekers and Migrants (4). This work has been supported by policy-makers, health planners, local health professionals and others who are responsible for providing reception services to migrants. On the basis of these assessments, Sicily has become the pioneer in the WHO European Region in the development of an operational strategy to respond to the public health implications of sudden and large arrivals of immigrants (5). As search and rescue operations changed the geographical origins of the arrivals, a need arose for enhanced coordination among all actors involved within and beyond the health sector. From the beginning of 2014 until the end of 2015, more than 280 000 migrants arrived in Sicily, crossing the Mediterranean Sea to access European territory. In the same year, the WHO Regional Office for Europe, through the Public Health Aspects of Migration in Europe (PHAME) project, started to work with the Health Regional Councillor of the Sicily Region on a regional contingency plan for the management of massive influxes of migrants. With the start of the military operation Mare Nostrum, the geographical distribution of migrants in Sicily radically changed, thus challenging the capacity of the regional health authorities throughout the whole area. To address this challenge, the contingency plan identified all actors involved in the public health response to migration, integrating their roles in a coherent process and establishing a homogeneous procedure to improve the organizational aspects of the public health response by increasing the efficiency of both logistical and human resources. Owing to the complex and intersectoral nature of this issue, a wide diversity of stakeholders was involved. Authorities from the Ministry of Health and Internal Affairs of Italy (at both national and regional levels), NGOs and other important stakeholders were present during the launch of the contingency plan. The operative framework of the Sicilian contingency plan was published on 7 July 2017.

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. In Italy, local authorities also implemented a creative approach to guarantee access to health care for all migrants. In 2009, the Regional Government of Puglia introduced legislation granting irregular migrants full access to health care as well as the right to select a family doctor and a paediatrician for their children. Effective responses were put in place to overcome the practical and cultural barriers faced by irregular migrants. In cooperation with the NGO Emergency and the local health care unit of Foggia, a mobile clinic (Polibus) was launched that delivered health care services throughout the region. Between June and November 2012, Polibus reached 1709 patients. This initiative has had a relevant and positive impact and serves as an important tool for raising awareness on infections and HIV among both irregular migrants and health care professionals.

(Source: Ministry of Health)

KAZAKHSTAN

CONTEXT. In 2017, there were 3 635 168 international migrants in Kazakhstan, constituting 20% of the total population. The number of migrants has increased at an annual rate of 1.2% since 2015. Of these migrants, only 1566 are refugees and asylum seekers (0.4%). While this number increased at a rate of 1.4% since 2015, it decreased significantly at a rate of 21.2% between 2010 and 2015 (1).

Promoting continuity and quality of care for refugees and migrants

PRACTICES. With reference to the Wolfheze Consensus Statement on the minimum package for cross-border tuberculosis control and care in the WHO European Region, the Government of Kazakhstan in collaboration with the International Organization for Migration has implemented a project to enhance its operational and institutional mechanisms to fully deliver tuberculosis-related health services to migrants. The project aims to promote migrant-sensitive health policies, legal and social protections, and interventions to provide equitable, affordable and acceptable access to tuberculosis services for migrants. It is also focused on improving health monitoring and health information systems. Key practices have included the development of a legal framework for migrants' access to health care with a focus on tuberculosis services; training on tuberculosis and migration for immigration officials, including border guards; development of a predeparture orientation package for migrants, with a focus on health; and public information campaigns through the distribution of information material on migrants' rights in Russian, Tajik and Uzbek languages. There has also been advocacy for regional cooperation with United Nations agencies and development partners in central Asia, and exchange during high-level meetings of experiences on prevention, control, diagnosis and treatment of tuberculosis. As a result of such activities, two bilateral agreements on cross-border control, prevention and treatment of tuberculosis in the central Asian region have been established together with a protocol for medical escorting of migrants with tuberculosis during their return. There has also been extensive capacity-building for project partners, state officials and medical professionals in the predeparture orientation of migrants.

(Source: Ministry of Healthcare)

LATVIA

CONTEXT. In 2017, there were 256 889 international migrants in Latvia, constituting 13.2% of the total population. This number has decreased at an annual rate of 1.6% since 2015. Of these, only 396 were refugees and asylum seekers (0.2%). However, this still represents an increase in the number of refugees and asylum seekers since 2015, with an annual rate of increase of 1.1% between 2015 and 2017 following a much higher rate of increase of 34.8% between 2010 and 2015 (1).

Promoting continuity and quality of care for refugees and migrants

PRACTICES. Interpretation or translation services are provided within the project Information Centre for Immigrants, which is implemented by the NGO Shelter "Safe House" (Patvērums "Drošā māja") within the framework of the Asylum, Migration and Integration Fund and co-financed by the EU. To receive interpretation or translation services to communicate with legal immigrants, including asylum seekers, refugees and people granted subsidiary protection status, an individual must fill in the interpretation request and send it to the interpreters' coordinator at the NGO.

Interpretation and translation services are available to third country nationals (i.e. not citizens of the Member States of the EU, the EEA or the Swiss Confederation):

- for asylum seekers only for the purpose of implementing the socioeconomic inclusion plan in cooperation with social workers and social mentors (interpretation services);
- for those with refugee and alternative status for assistance for various integration-based purposes (interpretation and translation services) over the 12 months after receiving status;

- for legal immigrants for assistance in various integration-based situations (interpretation and translation services); and
- for different representatives of organizations, institutions, employers, landlords and so on to ensure communication among professionals and third country nationals (interpretation and translation services).

There are technical resources (e.g. Skype, WhatsApp, Facebook, Viber, WeChat) used by those outside Riga.

Daily and emergency interpretation is available in Arabic, Azerbaijani, Chinese, Dari, Farsi, French, Hindi, Kurdish, Pashto, Punjabi, Tajik, Urdu and Uzbek.

(Source: Republic of Latvia)

LUXEMBOURG

CONTEXT. In 2017, there were 264 073 international migrants in Luxembourg, constituting 45.3% of the total population. This number has increased at an annual rate of 0.7% since 2015. Of these, 4066 were refugees and asylum seekers (1.5%). The number of refugees and asylum seekers has increased annually at a rate of 4.4% since 2015. Between 2010 and 2015, the number of refugees and asylum seekers increased 2.7% per year (1). Many asylum applicants arriving in recent years are from African, eastern European and Middle Eastern countries.

(Source: Ministry of Health)

MALTA

CONTEXT. In 2017, there were 45 539 international migrants in Malta, constituting 10.6% of the total population. This number has increased at an annual rate of 3.5% since 2015. Of these, 8126 were refugees and asylum seekers (17.8%). Since 2015, there has been an increase in the number of refugees and asylum seekers at an annual rate of 2.9%. Between 2010 and 2015, the number increased 4.4% per year (1).

Improving communication and countering xenophobia to dispel fears and misperceptions among refugee, migrant and host populations on the health impacts of migration and displacement

PRACTICES. To attend specifically to the health needs of migrants as well as assist health professionals working with migrants, Malta has established the Migrant Health Liaison Office, a special unit within the Department of Primary Health Care. The office has developed training for cultural mediators to facilitate communication between migrants and health care providers and to overcome some of the cultural and linguistic barriers experienced on both sides during the health care encounter. The role of a cultural mediator is greater than that of an interpreter, aiming to explain and negotiate the cultural beliefs and behaviours related to health, illness and medical care. Mediators have been recruited from several migrant communities in Malta, including Congolese, Eritrean, Ethiopian, Nigerian and Somali communities. Moreover, half of the cultural mediators with the Migrant Health Liaison Office are women and provide assistance during prenatal and gynaecological appointments at the women's clinics within the health centres. The Office has also conducted community outreach on sexual and mental health and on how to navigate the health system. Materials have been published in many languages, including Arabic, French, Somali and Tigrinya. This experience in Malta is a further example of innovative measures taken to strengthen health systems and their capacity to respond effectively to the particular needs of refugees and migrants.

(Source: Ministry of Health)

MONACO

CONTEXT. In 2017, there were 21 255 international migrants in Monaco, constituting 54.9% of the total population. This number increased at an annual rate of 0.5% since 2015. Of these, only 32 were refugees and asylum seekers (0.2%). There has been no change in the rate of arrival of asylum seeker and refugee numbers since 2015 (1).

(Source: WHO Regional Office for Europe)

THE NETHERLANDS

CONTEXT. In 2017, there were 2 056 520 international migrants in the Netherlands, constituting 12.1% of the total population. The number of migrants has increased at an annual rate of 1.5% since 2015. Of this number, 114 303 were refugees and asylum seekers (5.6%). There has been a decrease in the number of refugees and asylum seekers since 2015, with an annual rate of decrease of 1%. However, between 2010 and 2015 the number of refugees and asylum seekers increased by 8.8% per year. The majority of asylum seekers arriving in recent years were Afghan, Eritrean or Syrian (1). In 2015, 19 000 children under 18 years of age entered the Netherlands.

Enabling participation and social inclusion of refugees and migrants

PRACTICES. With regard to promoting the participation and social inclusion of refugees and migrants, good practices are seen in many municipalities; for example, the municipality of Leiden's 24 x 24 programme is a tailored approach aimed at helping migrants integrate into Dutch society and the labour market. It recognizes the talent and contribution of migrants and is designed to enable them to be both socially and economically independent, and fully engaged in the Leiden community. The programme is made up of four 24-week periods in which a minimum deployment of 24 hours per week is required and includes several components, such as mentoring by volunteers, discussions on cultural differences and Dutch culture, language instruction, civic integration activities, internships and work and training mediation. The long-term programme empowers new residents to create their own place in Dutch society (6).

(Source: Rijnstate Hospital, Ministry of Health, Welfare and Sport)

NORWAY

CONTEXT. In 2017, there were 798 944 international migrants in Norway, constituting 15.1% of the total population. This number has increased at an annual rate of 3.4% since 2015. The largest groups of immigrants living in Norway are from Poland, Lithuania and Somalia. Of international migrants, 70 674 were refugees and asylum seekers (8.8%). The number of refugees and asylum seekers has been decreasing since 2015, at an annual rate of 3.4%. Between 2010 and 2015, however, the number of refugees and asylum seekers increased 12.6% per year (1). The population of Norway includes people with backgrounds from 223 different countries and autonomous regions. The largest groups of immigrants are from Lithuania, Poland and Somalia. There are major disparities in how long various immigrant groups have lived in Norway. Some groups, including those from Morocco, Pakistan, Turkey, and Vietnam, have lived in Norway for a long time, while immigrants from newer EU countries (particularly Lithuania and Poland) have lived there for a shorter period, mostly under five years. Refugees from Afghanistan, Iraq and Somalia have also lived in Norway for a relatively short period of time. Immigrants move to Norway for reasons of work, family or study or as refugees. Since 2007, work has been the most common reason for immigration, followed by family.

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. Systematic health education and promotion for migrants does not exist in Norway, but there are some initiatives (see below). A limited number of brochures with health information are translated, most into 10–15 languages. Some topics are thoroughly covered (e.g. diabetes and basic mental health care), while other topics (e.g. cancer and coronary heart disease) are barely covered. No single actor has responsibility for ensuring the quality and distribution of information. Consequently, information can be hard to find and neither patients nor health care personnel can be sure that information has been correctly translated. An extensive overview of translated material is given by MIGHEALTHNET (7). The following are examples of ad hoc initiatives currently active.

- Municipalities are recommended to have a local community health coordinator. Some of these have initiated public health campaigns directly targeted at different migrant groups.
- Workshop of Primary Health Care, an activity of the Church City Mission in Norway, runs various information, support, self-help and activity groups, and provides cultural mediation and training of cultural mediators.
- Caritas Norge provides information on health and access to services. During office hours, migrants can visit and receive counselling on practical matters.
- Patient associations have received funding to translate information material into different languages. Ammehjelpen (Breastfeeding Association) has translated films on breastfeeding. The Diabetes Association has a hotline, radio campaign, does outreach work and translates written material into several languages.
- Mosjon på Romsås (MORO) is a cooperated project between different public health institutions, the municipality and the educational sector.
- SOMAH is a cooperated project between researchers at the Oslo and Akershus University College and health institutions in Oslo and Akershus. It provides counselling on nutrition and food to families with children aged under-5 years in a culturally diverse population.
- STORK Groruddalen is a community project focused on better health for mothers and children in a culturally diverse population.

The majority of campaigns and projects on relevant topics are carried out by NGOs. Campaigns often have a limited and arbitrary selection of topics and/or geographical coverage; they are also limited in time, topics, intervention methods, target groups and areas. There is no systematic prioritization of topics covered, so some topics are widely covered and others not at all (8).

Addressing the social determinants of health and health inequality for refugees and migrants

PRACTICES. The purpose of the Public Health Act is to contribute to societal development, promoting public health and reducing social inequalities in health. The Act states the responsibilities for public health at local (municipality), regional and national level. Each level is required to have an overview of the health of its population and the positive and negative factors that influence this. This overview forms part of the basis for the whole-of-government policy-making and planning process, leading to comprehensive strategies and measures aiming to improve public health and reduce health inequalities. The Norwegian strategy to reduce social inequalities in health (2007–2017) has four priorities: reduction of social inequalities that contribute to inequalities in health; reduction of social inequalities in health behaviour and use of health services; targeted initiatives to promote social inclusion; and the development of knowledge and cross-sectoral tools. The combination of universal measures with more targeted initiatives requires a comprehensive and cross-sectoral approach; housing, employment, social inclusion and participation, and healthy living conditions for immigrants and refugees are mainstream issues within public health policy.

Particular efforts have been made to integrate migrants in Norway, and most live within municipalities rather than in isolated settings. However, in some areas, there has been an accumulation of migrants and it has been necessary to take additional measures. The Planning and Building Act (2009) and the Public Health Act (2012) are relevant legislation. The 2017 White Paper Sustainable Cities and Strong Districts also highlights the importance of urban regeneration in vulnerable areas, including strengthening focus on health care, education, employment and the physical and social qualities in neighbourhoods. As an example, the Grorud Valley Urban Regeneration Project 2006–2016, now prolonged until 2026, is an intervention aimed at improving the environment and living

conditions in Groruddalen (9). Groruddalen has a population of nearly 140 000 people, with strong cultural diversity including over 140 nationalities. Migrants are, therefore, a particular target group of the project, with a strong focus placed on cultural inclusion.

Improving communication and countering xenophobia to dispel fears and misperceptions among refugee, migrant and host populations on the health impacts of migration and displacement

Interpreters are available free of charge. The official web page for the health services in Norway (with translations into 24 languages) states that "it is your right to get information about your condition and treatment options in a language you understand". Official guidelines state that health care personnel are obliged to assess the need for a qualified interpreter and provide one if needed (it is illegal in the public sector to use children as interpreters, except in life-threatening emergencies). Despite these clear-cut policies, it is well documented that there is underuse of interpreters and that, contrary to what is prescribed, relatives and children are sometimes used as interpreters; in addition, the use of interpreters without formal qualifications is widespread. Norway has a national web page (www.tolkeportalen.no) where interpreters with formal competence are registered, which is administered by the Directorate of Integration. It also displays advice and e-learning programs on the use of interpreters in health care. Information about basic rights to health care for irregular migrants is available on the Directorate of Health's web pages. The brochure entitled Information Regarding Rights and Access to Healthcare for Irregular Migrants in Norway is available in 20 languages (www.helsenorge.no and <http://www.bymisjon.no>) (8).

(Source: Ministry of Health and Care Services)

POLAND

CONTEXT. In 2017, there were 640 937 international migrants in Poland, constituting 1.7% of the total population. The number of migrants has increased at an annual rate of 2.3% since 2015. The migration situation is characterized by labour migration (67% of applicants for temporary stay in 2017), as well as an increased influx of Ukrainian citizens specifically who are seeking legal residence. Of migrants in Poland, 12 912 were refugees and asylum seekers (2%). There has been a significant decrease in refugees and asylum seekers particularly, with an annual rate of decrease of 14.8% since 2015. However, between 2010 and 2015, the number of refugees and asylum seekers increased 2.2% per year. In 2017, most applicants for foreign protection came from countries of the former Soviet Union, mainly Armenia, Belarus, Georgia, Kyrgyzstan, the Russian Federation, Tajikistan and Ukraine (1). The current migration situation in Poland is characterized by an increased influx of Ukrainian citizens seeking legal residence, with the vast majority preferring the legalization of stay as this allows them to take up work (there is no such possibility during the first six months of the proceedings for international protection) and independently support their families.

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

PRACTICES. In the field of health services, the Office for Foreigners implements epidemiological protection procedures that provide for a thorough check of the health status of those crossing Polish borders and applying for international protection; this is aimed primarily at diagnosing, isolating and providing immediate treatment for patients suffering from infectious diseases presenting an immediate epidemiological threat. Implementation is made through the sanitary–epidemiological filters operating in the reception centres in Biala Podlaska and Debak–Podkowa Lesna. Any migrant, whether admitted to Office-owned centres or placed in rented accommodation, undergoes a special three-stage preliminary procedure within the sanitary–epidemiological filter, which includes a survey with medical questionnaire, medical examination, blood and urine laboratory tests (for viral hepatitis B and C, HIV, venereal disease) and thoracic radiology.

The Early Detection of Infectious Diseases Programme has more rigorous diagnostic procedures and increased patient observation from the moment of their arrival in epidemiological filters in Biala Podlaska and Debak until

the risk of infection with the infectious agent has been excluded. The aim of the Programme is to ensure proper and effective sanitary and epidemiological protection for all people living in filtered areas, early detection and isolation of people suspected of having infectious diseases and minimization of the risk of spreading infectious agents among both the incoming migrants and the Polish population.

In order to increase effectiveness of epidemiological protection procedures, the Office for Foreigners in the framework of co-financing from the Swiss–Polish Cooperation Programme has built a special facility for health services exclusively for this purpose. This facility is located in the centre for foreigners in Biala Podlaska, and is used to provide epidemiological protection to the eastern border of the EU. Creation of this modern facility allowed for development and further professional support for the programme for the detection of infectious diseases, among other things by providing additional medical staff and implementing more effective medicologic solutions to allow verification of the health status of migrants in epidemiological and sanitary areas. Specialized medical equipment is also provided, which includes not only the necessary diagnostic equipment but also a modern wastewater chemical disinfection station to ensure efficient and complete disposal of impurities from the whole building.

Lessons learned and recommended future priority actions. The experience of the Office for Foreigners is that there is visible scepticism in relation to vaccination and generally understood health prevention among migrants entering the country. Accordingly, the Office for Foreigners and the Chief Sanitary Inspector of the National Institute of Hygiene conduct periodic actions to raise awareness among migrants of the risks of infectious diseases. To this end, information leaflets on measles, as well as infectious diseases transmitted by ticks, have been created and disseminated in all centres for migrants in Poland. In addition, similar information campaigns are organized on a regular basis at individual centres. It seems appropriate to continue the education of foreigners as needed in the field of health prophylaxis and prevention of infectious diseases.

Enabling participation and social inclusion of refugees and migrants

PRACTICES. The Office for Foreigners considers that it is important to allow refugees and migrants to know the principles of Polish society and the state, even while at the stage of waiting for a decision on the provision of international protection. The Act on Granting Foreigners Protection in the Territory of the Republic of Poland guarantees them off-centre assistance, consisting of cash benefits to cover their costs of stay in the territory of the Republic of Poland. This ensures that everyone can choose the form of aid for their specific needs. There are also open days organized regularly in centres for refugees and migrants, which aim to educate local communities about the conditions of stay for those applying for international protection and the work performed by the centre staff. Residents, journalists and representatives of public institutions may enter the centre freely and talk to residents. All the guests of the open day can expect many attractions, including ethnic dishes prepared by the residents, dance shows and other games and activities. Centres also organize trips and holidays. Some centres cooperate periodically with nearby animal shelters where fund-raising and charity work is organized, including walking dogs, and participate in other local actions.

Promoting continuity and quality of care for refugees and migrants

PRACTICES. In order to preserve the continuity of treatment, as well as to comply with legal regulations regarding limitation of access to patients' medical records by entities not providing medical services, regulations have been introduced to govern the procedure for handling the medical records of refugees and migrants with accepted applications for international protection. The medical record of each person applying for protection in Poland is forwarded by the medical centre of the border guard or personally by the migrant to the medical operator providing health services to foreigners applying for international protection under a civil law agreement concluded with the Office for Foreigners. In the case of unaccompanied minors, the medical records are forwarded to the educational care facility to which the minor is sent, which serves as a substitute custodian. The electronic registration system of medical services greatly facilitates medical communication between centres, coordination of medical services of the medical operator when a refugee or migrant is transferred to another centre or for private benefits. It provides the migrant with continuity of treatment and allows doctors at medical centres dedicated to refugees and migrants to immediately view the patient's disease history.

(Source: Office for Foreigners)

PORTUGAL

CONTEXT. In 2017, there were 880 188 international migrants in Portugal, constituting 8.5% of the total population. The number of migrants has increased at an annual rate of 0.9% since 2015. Of these migrants, only 1806 were refugees and asylum seekers (0.2%). However, the number of refugees and asylum seekers has increased particularly, with an annual rate of increase of 11.5% since 2015. Between 2010 and 2015, the number of refugees and asylum seekers increased 26.4% per year (1). Portugal is currently receiving refugees from the United Nations Refugee Agency and within the European Agenda.

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. Since 2016, the Ministry of Health has been providing several training sessions to health care and administrative professionals working in local health units and hospitals across the country on the rights and duties of refugees in accessing the national health system. The training presents practical cases for discussion and provides legal documentation. The training sessions are of two types: one is in cooperation with the High Commission for Migration, and the other is part of the interministerial training package led by the Ministry of Work, Solidarity and Social Affairs and developed in the framework of the cooperation protocol in support of applicants and beneficiaries of international protection.

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

PRACTICES. Bué Fixe is a youth organization that aims at encouraging migrants from the community of Portuguese languages living in deprived neighbourhoods of Amadora, in the outskirts of Lisbon, to adopt safer attitudes and behaviour regarding HIV and AIDS. Through the programme Youth Media, Our Response to HIV/AIDS, initiated in 2009, Bué Fixe works to attain this goal by scaling up existing and effective HIV prevention initiatives in order to reach other young migrants; expanding adequate support and opportunities to people living with HIV in the community; empowering youth (especially young women) so that they can mitigate HIV risks through safer attitudes and behaviour; and developing community-based initiatives focusing on reducing stigma and discrimination towards people living with HIV. Bué Fixe trains young community leaders through workshops, conferences and debates in order to increase their knowledge and skills on HIV- and AIDS-related matters. It distributes condoms in places commonly frequented by the targeted population (e.g. night clubs, hairdressers and public spaces); circulates informative material in schools, shopping centres and libraries; and provides information and services on HIV and AIDS through text messages and a participative radio broadcast. The programme uses media outlets (i.e. radio programmes, a magazine, a Facebook page and a blog) to distribute information on HIV and AIDS for young migrants. Members regularly participate in European dialogues and engage in partnerships with other organizations to exchange practices and collaborate on HIV prevention strategies. In the first year of the programme, Bué Fixe produced 40 radio programmes on HIV and AIDS, five editions of its magazine, distributed 10 000 condoms, sent weekly text messages to around 600 young migrants, and distributed informative leaflets.

(Source: Directorate General of Health)

REPUBLIC OF MOLDOVA

CONTEXT. In 2017, there were 140 045 international migrants in the Republic of Moldova, constituting 3.5% of the total population. The number of migrants has decreased at an annual rate of 1% since 2015. During 2017, most requests for temporary and permanent residence permits were from countries of the Commonwealth of Independent States and the EU, followed by India, Israel and Turkey. The main reasons for migration were family reunification, employment and education. Of the total number of migrants, 560 were refugees and asylum seekers (0.4%). The number of refugees and asylum seekers has increased annually by 0.1% since 2015. However, between 2010 and 2015, the number increased by 26.5% per year.

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. Migrants and refugees benefit from medical services (primary, secondary and specialized) through the mandatory health insurance system and also benefit from preventive and disease prevention services (e.g. immunization, communication/information, screening, prophylactic treatment for infectious diseases). In addition, the Ministry of Interior has issued guidelines for referral, reception, medical examination and treatment of asylum seekers, refugees, beneficiaries of humanitarian protection and of foreigners placed in the Centre for the Temporary Placement of Foreigners, as approved by a Minister's Order. Asylum seekers arriving in the Republic of Moldova and foreigners placed in the Centre for Temporary Placement should be subject to a minimum of medical examinations for the purpose of prophylaxis of diseases that might be a threat to public health (e.g. tuberculosis, syphilis, HIV, viral hepatitis).

Improving communication and countering xenophobia to dispel fears and misperceptions among refugee, migrant and host populations on the health impacts of migration and displacement

PRACTICES. Ongoing training is provided to national authorities involved in the asylum system and the integration of foreigners, public authorities as well as civil society representatives. For example, the Bureau for Migration and Asylum, in partnership with the Office for Democratic Institutions and Human Rights of the Organization for Security and Cooperation in Europe (based in Warsaw, Poland), organizes a biannual workshop on migrants' rights. The workshop aims at strengthening the functional capacities of authorities in the field of migration, with a particular emphasis on ensuring respect for migrants' rights. The workshop contains several basic modules, including the right to health, international standards for migrants' rights, fundamental civil rights of migrants (with a focus on arbitrary arrest and detention), migrants' access to the labour market, social and economic rights, access to the social security system, access to education and the right of migrants to family life and family reunification. Each module is discussed in detail with the involvement of the participants, using case studies to examine the issues of migrants' access through to the enforcement of their rights in the Republic of Moldova. Discussion also includes avoidance of discrimination and xenophobia, presenting the experience of the Organization for Security and Cooperation's Member States, approaching the legislation and practice by each concerned institution, presenting successful cases and practices and outlining existing deficiencies and analysis of case law.

Lessons learned and recommended future priority actions. Promotion actions should be carried out at both the central and the territorial level, ensuring ongoing dialogue with local authorities in the communities where the migrants live.

(Source: Bureau for Migration and Asylum of the Ministry of Interior)

SERBIA

CONTEXT. In 2017, there were 801 903 international migrants in Serbia, constituting 9.1% of the total population. Due to its geographical location, Serbia has been a key transit route for migrants travelling to western Balkan countries. The number of migrants has decreased at an annual rate of 0.3% since 2015. Of these migrants, 31 314 were refugees and asylum seekers (3.9%). There has been a decrease in the number of refugees and asylum seekers particularly, with an annual rate of decrease of 6.2% since 2015. Between 2010 and 2015, the number of refugees and asylum seekers decreased 14.6% per year (1).

Ensuring provision of short- and long-term public health interventions to reduce mortality and morbidity among refugees and migrants, including bridging short-term emergency and humanitarian health assistance with long-term health programmes and vaccination

PRACTICES. With WHO support, Serbia is developing three local contingency plans for border regions that are on migrant routes. Expected to be completed and adopted by the end of 2018, these plans will improve capacity of

health authorities and local governments in these regions to respond in a timely and adequate mannerly to heightened new waves of arrivals. Contingency planning is a primary example of the coordinated and collaborative work being done within Europe to consolidate regional capacity and improve health system planning and development to adapt and manage the increasing number of migrants to Europe.

Creating health monitoring and health information systems for refugees and migrants

PRACTICES. The Migrant Health Information System, supported by WHO, was established in 2015. All health care providers in the country, both state institutions and NGOs, provide data on a weekly basis about the number of health conditions registered and services provided. This system set the basis for timely monitoring of the situation and response planning.

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. In Serbia, migrants living in reception and transit centres are provided with access to health care. Centres have rooms for the provision of health care, including 24-hour medical teams, gynaecologists and international organizations that provide health information. In cooperation with civil society organizations and international organizations, migrants also have access to psychosocial support. In cooperation with local health care centres, conditions and resources have been secured for the provision of health care in order to adequately respond to the needs of migrants present in the territory.

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. While sexual and reproductive health is an essential component of human development and well-being and is inextricably linked to notions of human dignity and autonomy, it is easily overlooked during emergencies. Supporting the Ministry of Health, the UNFPA Country Office Serbia is putting considerable effort and advocacy into strengthening the preparedness of the country to respond to needs linked to sexual and reproductive health and gender-based violence. One particular initiative is the development of the Minimal Initial Services Package for reproductive health among relevant actors, including working with cultural mediators to bring service providers and beneficiaries closer and overcome stereotypes to ensure adequate responses to the sexual and reproductive health needs of migrants. It will also provide training to empower both health and non-health workers involved in this area. Furthermore, UNFPA Country Office Serbia has worked to provide essential health services that are more than primary medical care, including ensuring access to gynaecological services. This is done through donation of mobile clinics for gynaecological examination of migrant women, donation of medical consumable materials and provision of support for humanitarian workers and for the needs of women and children. As a lead of the Gender Based Violence Sub Working Group, UNFPA Country Office Serbia also aims to consider all types of sexual and gender-based violence in its coordination, planning and advocacy activities.

PRACTICES. Together with the Danish Refugee Council and the NGO Atina, UNFPA Country Office Serbia is working on empowering refugee and migrant women and girls. The Danish Refugee Council team has been organizing workshops covering sexual and reproductive health needs and the challenges and obstacles that every woman needs to be aware of in order to ensure that she is taking care of her well-being. As part of the project implemented jointly with Atina, empowerment workshops have been organized covering different areas of life. Throughout the work, it was noted that women are often unaware that the violence they are suffering is undeserved or unacceptable and do not know who to turn to if they wish to respond to it; they also can hesitate to respond because of cultural norms or pressures they experience from the community. In this regard, the Atina empowerment workshops provide a unique opportunity for women to learn how to recognize violence and the ways in which they can stand up against it. Among the topics covered through these workshops were gender roles, stereotypes, forms of violence, human trafficking, honour killings and the importance of education. The significance of such activities became apparent immediately in the first cases of women from the refugee populations reporting violence they had witnessed.

PRACTICES. UNFPA Country Office Serbia is also preparing to introduce a life skills education programme among young boys and men within migrant, refugee and asylum seeker populations. First implemented in Greece, this programme aims to address the risks and challenges of young refugee and migrant boys and men, including sexual

exploitation, violence and tension. It recognizes that efforts need to be placed in building trust and willingness for those boys and men to ask for assistance, and in shaping the modality to address their needs. The life skills programme will work directly with refugee, migrant and asylum seeker boys and men to tackle each sphere of adolescent life, familiarizing them with Western values and norms to better adapt to their new lives. The programme ultimately aims to support long-term development in the lives of young boys and girls, and men and women, that will help them to become more independent and able to adapt to the new challenges and experiences they face.

(Source: United Nations Population Fund)

SPAIN

CONTEXT. In 2017, there were 5 947 106 international migrants in Spain, constituting 12.8% of the total population. The number of migrants has increased at an annual rate of 0.5% since 2015. Of these migrants, 28 205 were refugees and asylum seekers (0.5%). There has been a significant increase in refugees and asylum seekers particularly, with an annual rate of increase of 23.9% since 2015. Between 2010 and 2015, the number of refugees and asylum seekers increased 30.4% per year. For the period 2010–2015, Spain also had the ninth highest level of net emigration among countries globally, at approximately 114 000 emigrants per year. In comparison, for the period 2000–2010, Spain had the second highest level of net immigration globally, at 510 000 immigrants per year (1).

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. The Association Salud y Familia (Health and Family) is implementing several programmes to improve access to health services for irregular migrants in the Barcelona region. The association combines policy advocacy with coordination with service providers and the Government to guarantee access to a health card for irregular migrants. In collaboration with the public hospitals of Cataluña, they also implement the programme Mothers Between Two Cultures, aimed at designing and piloting intercultural education activities targeting migrant mothers with different cultural backgrounds and children of 3 years or younger. The objective is to improve coverage and reduce unmet needs in the area of maternal and child health prevention and promotion through strengthening knowledge, capacity and social support networks. The Association also offers a programme called Assistance for At-risk Maternity, which provides partial assistance for pregnant women to receive prenatal care and psychosocial support.

Addressing the health of migrant workers, occupational health safety measures, including improving working conditions; addressing health workforce shortages

PRACTICES. The Spanish Ministry of National Social Security and the Ministry of Labour and Immigration divide workers into six groups or social security regimes according to the type of work they perform; this grouping governs the amount of taxes paid by the employer and employee, injury and illness leaves, subsidies, disability compensations, pensions, working hours, vacation time and hiring and firing practices. The special household service regime covers workers who receive a wage to perform exclusively domestic services in various arrangements. A crucial element of domestic services is the nature of the contracts, which can often be verbal, making it difficult for workers to register complaints and regulate adherence to sick leave and occupational safety measures. A study carried out as part of a bigger project (Project Immigration, Work and Health) found that documentation status was relevant in terms of empowerment and bargaining but did not appear to influence work tasks or exposure to hazards directly. The authors suggested that household service workers should be covered by the general regime as that would at least establish better conditions for documented workers (10).

(Source: Human Rights Council, WHO Regional Office for Europe)

SWEDEN

CONTEXT. In 2017, there were 1 747 710 international migrants in Sweden, constituting 17.6% of the total population. The number of migrants has increased at an annual rate of 4.3% since 2015. Of these migrants, 317 477 were refugees and asylum seekers (18.2%). The number of refugees and asylum seekers has decreased annually by 1.4% since 2015. Between 2010 and 2015, however, the number increased by 27.5% per year (1).

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. The Swedish Government has initiated significant reforms that advance the right to access to health care for all migrants regardless of their immigration status. From July 2013, the new reforms granted access to ordinary health care to children below the age of 18 in an irregular situation, and granted access to emergency health care (including dental, maternity, sexual and reproductive care, and contraceptive counselling) to all migrants in irregular situations. The law also stipulates that county councils are able to offer irregular migrants the same level of care available to residents.

Promoting continuity and quality of care for refugees and migrants

PRACTICES. In Sweden, health screening must be offered to all applicants for international protection by the county councils/regions in which they reside. Screening is offered to identify any health problems relating to the individual but also as a measure for infectious disease control; it is voluntary and an interpreter can be engaged if necessary. The health screening aims to deliver a medical assessment of what kind of health care service should be offered to the person in question. The screening must include questions about the person's immunization status, his or her exposure to infections, as well as other information that may be needed to discover any infectious diseases. The questions must be based on the epidemiological situation of the places where the person in question has stayed before arriving in Sweden. The health screening must also include a health dialogue (hälsosamtal) concerning the person's past and present physical and mental health. A part of this dialogue must tackle the person's psychosocial situation and any traumatic experiences. A physical examination and tests must be carried out as part of the health screening. They should be based on the findings from the questions asked earlier and the health dialogue.

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

PRACTICES. A national and international telepsychiatry service between Sweden and Denmark was implemented to enhance access for refugee groups to more appropriate mental health care in terms of the bilingual proficiency and cultural competence of the health professionals (11). The free service was offered to 45 refugees and 12 asylum seekers, with a total of nine languages being spoken over the 34 months of the project. Each patient had an average of 5.2 telepsychiatry sessions with referrals either for diagnostic assessment and subsequent treatment or for treatment via the telepsychiatry service. Clinicians not only spoke the same language as their patient but also had a comprehensive knowledge of the health care system in both the host country and the patient's original country. A questionnaire was administered to patients in the final session. The questions explored their attitudes towards aspects of telepsychiatry, including technology, confidentiality, preference and information. Two open-ended questions investigated participants' views on the benefits and disadvantages of this type of service. Patients reported a high level of satisfaction with the service, stating that they would be happy to use telepsychiatry again and to recommend it to their peers. Patients preferred telepsychiatry sessions with a clinician who spoke their native language than a normal interpreter-assisted consultation as the latter also increased their concerns regarding confidentiality. This project is an example of providing early access to culturally appropriate mental health care to prevent and reduce the risk of poor health outcomes related to noncommunicable disease.

(Source: International Labour Organization)

SWITZERLAND

CONTEXT. In 2017, there were 2 506 394 international migrants in Switzerland, constituting 29.6% of the total population. This number has increased at an annual rate of 1.8% since 2015. Of these, 110 044 were refugees and asylum seekers (4.4%). Current asylum seekers mostly come from Afghanistan, Eritrea, Somalia and the Syrian Arab Republic. Since 2015, there has been an annual rate of increase of 1.9% in the number of refugees and asylum seekers. Between 2010 and 2015, the number of refugees and asylum seekers increased 15.5% per year (1).

Addressing the social determinants of health and health inequality for refugees and migrants

PRACTICES. The Confederation and the cantons consider the successful integration of foreigners as co-determining for social cohesion and the future of Switzerland as a business location. The State Secretariat for Migration, with the involvement of the cantons, develops the strategic guidelines for the promotion of integration, while the cantons are responsible for the development and implementation of integration measures on the ground. The goals of the promotion of integration are (i) to strengthen social cohesion on the basis of the values of the Federal Constitution, (ii) to promote the mutual respect and tolerance of domestic and foreign residents, and (iii) to ensure the equal participation of foreigners in the economic, social and cultural life of Switzerland.

There are two approaches: a regular structural approach and a specific integration approach. The regular structure approach includes integration promotion on site, primarily in the existing integration-relevant regulatory structures (e.g. schools, vocational training, labour market, health care system) and is financed from the ordinary budgets of the competent authorities. Specific integration promotion is complementary to the regulatory structures. First, it looks for existing gaps (e.g. low-threshold language promotion, professional integration of refugees). Second, it supports the regulatory structures in the implementation of the integration contract (e.g. vocational counselling for late followers). The State Secretariat for Migration and the cantons promote specific integration measures with the cantonal integration programmes 2014–2017.

Lessons learned and recommended future priority actions. It takes long-lasting and continuous effort to have an impact in the lives of beneficiaries. As integration measures are also led at the cantonal level, 26 different practices, policies and rhythms of implementation can be identified. An assessment of this approach and its impact is not available. Policies need to be assessed to check their efficiency and impact and to systematically collect data; this requires a coordinated approach between federal offices.

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. Under the National Programme Migration and Health 2014–2017 run by the Federal Office of Public Health and in collaboration with cantonal authorities and institutions, many good practices have been set up in recent years that contribute to supporting migrant health, promoting equity in health care and encouraging non-discrimination practices. The programme specifically focuses on ensuring equal access to health care regardless of migration status, promoting health literacy among migrants, empowering patients and encouraging active patient participation, facilitating integration, training health professionals on managing diversity, conducting research on vulnerable groups within migrant populations, and improving communication between health professionals and patients experiencing language barriers. One of the initiatives under the programme is the Swiss Hospitals for Equity Network, whose mission is to promote high-quality care for all patients irrespective of nationality, ethnicity, language, culture or socioeconomic circumstances. The programme has also set up an online platform to support health professionals' intercultural competences, and a telephone interpretation service is available in 50 languages.

Creating health monitoring and health information systems for refugees and migrants

PRACTICES. The Federal Office of Public Health initiated a survey in summer 2017 to analyse the current existing gaps in the care of traumatized refugees and migrants, and to formulate management recommendations. Further surveys and actions are planned for forthcoming years, as mental health is a serious topic of concern in regard to that population group.

(Source: Federal Office of Public Health)

TAJIKISTAN

CONTEXT. In 2017, there were 273 259 international migrants in Tajikistan, constituting 3.1% of the total population. This number has decreased at an annual rate of 0.3% since 2015; however, Tajikistan still continues to experience intensive cross-border labour migration, predominately to and from the Russian Federation. This pattern of migration is marked by conditions such as unstable access to health care, exposing Tajik migrant workers to increased health risks and negative health outcomes. Of all migrants, only 2894 were refugees and asylum seekers (1.1%). There has, however, been an increase in refugees and asylum seekers particularly, with an annual rate of increase of 10.1% since 2015 (1).

Addressing the health of migrant workers, occupational health and safety measures, including improving working conditions; addressing workforce strategies

PRACTICES. The Ministry of Health and Social Protection (Ministry of Health) of Tajikistan, together with the International Organization for Migration, has engaged the Ministry of Labour, Migration and Employment (Ministry of Labour) to foster policy development, and the planning and implementation of activities aimed at improving the health of migrants and guaranteeing their right to health. Special attention has been given to strengthening the capacities of government entities also outside the health sector, including Ministry staff, to address migrants' health needs. Activities include integrating Ministry of Labour representatives into the development of migrant health-related policy, conducting national and regional trainings on HIV and tuberculosis prevention and providing technical support for implementation by the Ministry of Labour of a project on HIV prevention among migrants and their families. As a result of these activities, there is now a joint work plan on tuberculosis prevention among migrants for 2017–2020 signed between the Ministry of Labour and the Ministry of Health. The Ministry of Labour is also leading activities in engaging the Tajik diaspora for tuberculosis prevention among migrants in the Russian Federation and now plays a key role in promoting the implementation of the Minimum Care Package for Cross Border Tuberculosis Control and Care among Migrants. In 2017, the Ministry of Labour conducted high-level meetings with representatives of the Ministry of Health, Ministry of Foreign Affairs, NGOs and the Tajik diaspora with the subsequent development of the 2018 work plans on tuberculosis and HIV prevention among migrants through the Tajik Diaspora Network. The interagency partnership in Tajikistan on tuberculosis and HIV among migrants is an example of an effective multisectoral and interorganizational approach for collaborative action on migrant health. It demonstrates the importance of enhancing capacity across sectors to better integrate health into national policies and programmes.

Lessons learned and recommended future priority actions. Throughout the whole process, the MLME has demonstrated high commitment to a multisectoral approach for addressing the health needs of migrants. Nevertheless, recurrent staff turnover in the Ministry indicates a need for permanent training and technical support on the topic of migration and health. The Ministry of Health and Social Protection needs to consider the capacity of the MLME, particularly its representation in the Russian Federation, to reach migrants in the host country. The MLME has a strong cooperation with the Tajik diaspora in the Russian Federation that needs to be utilized for health promotion, particularly in cross-border control and care of tuberculosis and HIV among migrant workers and their families.

(Source: International Organization for Migration)

TURKEY

CONTEXT. In 2017, there were 4 881 966 international migrants in Turkey, constituting 6% of the total population. This number has increased at an annual rate of 8.3% since 2015. Of these migrants, 3 115 317 were refugees and asylum seekers (63.8%). The majority are from the Syrian Arab Republic and under temporary protection. There has been a significant overall increase in refugees and asylum seekers, at an annual rate of 6.2%, since 2015. Between 2010 and 2015, the number of refugees and asylum seekers increased 112.3% per year. For the period 2010–2015, Turkey also had the third highest level of net immigration among countries globally, at approximately 325 000 immigrants per year (1).

Enabling participation and social inclusion of migrants

PRACTICES. There are currently more than three million refugees living in Turkey, the majority of which are refugees from the Syrian Arab Republic. With the aim of both integrating Syrian health professionals and ensuring that the health care needs of Syrian refugees are met, the Turkish Government has now allowed Syrian health professionals to work in the health system in Turkey. The Public Health Directorate General of Turkey associated with the Ministry of Health, together with the WHO Country Office Turkey, has developed adaptation training for Syrian doctors, nurses, midwives and patient guides/bilingual medical translators living in Turkey. Supported by the European Civil Protection and Humanitarian Operations, the training provides classroom and practical coursework to certify and authorize Syrian health professionals to practise in refugee health centres and deliver primary services to refugees free of charge. They also work under the mentorship of Turkish health professionals for several weeks to familiarize themselves with the health system. The goal is to give the professionals the knowledge and experience needed to best apply their skills in the Turkish setting.

Lessons learned and recommended future priority actions. Training is not only a way to address some of the key barriers to health care among refugees from the Syrian Arab Republic in Turkey and ensure the provision of culturally and linguistically appropriate services but it is also a good example of collaboration between national and international partners to strengthen health system capacity. With establishment of this capacity within the primary health system, health service provided to the host community is also improved with the release of pressures on emergency, secondary and tertiary care.

Creating health monitoring and health information systems for refugees and migrants

PRACTICES. Information about the health status and risks to health of the population is one of the cornerstones of prevention, particularly for evidence-based planning and evaluation of health policies and preventive activities. Use of compliant and mainstreamed health information systems for both migrant populations and host communities allows disaggregating and analysing data for development of evidence-informed policies in this regard. Some population-level information, such as morbidity and mortality, can be obtained from registries, while some can be obtained from STEPS, the WHO STEPwise approach to surveillance of risk factors for noncommunicable diseases (12). This survey focuses on obtaining core data on the risk factors established as determinants of the major disease burden. The WHO STEPS survey for Syrian Arab Republic refugees living in Turkey was a cross-sectional study based on the refugee population in 10 provinces and conducted in December 2015. The STEPS questionnaire assesses five major risk factors: daily cigarette smoking, consuming fewer than five portions per day of fruit and/or vegetables, failing to meet physical activity recommendations, overweight or obesity, and high blood pressure. Only 0.3% of the Syrian Arab Republic refugees aged 18–69 years was at low risk of noncommunicable diseases, compared with 41.1% at moderate risk (with one or two risk factors) and 58.7% at high risk (three to five risk factors). Having three to five risk factors was more common among men (61.3%) than women (56.1%); 45.7% of men and 46.1% of women in the 18–44 year age group were at high risk. A strikingly high percentage of men (81.7%) and women (87.1%) aged 45–69 years had high combined risk (more than three risk factors).

Lessons learned and recommended future priority actions. When a health system responds to the needs of refugees, comprehensive consideration must also be given the burden from noncommunicable diseases and their risk factors to yield improved health outputs. WHO surveys can be an important tool to understand the risk factors surrounding vulnerable groups, and tailored interventions must be implemented to adequately increase health literacy and awareness on healthy lifestyles. Also, use of mainstreamed health information systems and inclusion

of explicit components on migration and health to these systems would strengthen the evidence base in development and implementation of health interventions.

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. In the face of the migration crisis, short- and long-term plans have been made for the organization of reproductive health services, including storage of materials. Training programmes have also been implemented. All reproductive and maternal health services are provided free of charge and without sex-based discrimination. Furthermore, migrant maternal deaths are monitored and included in the national maternal mortality data system.

The preventive health service offered to all children living in Turkey is also given to refugee children. In this context, heel blood is taken from newborns right after birth and hearing scans are carried out in infants and newborns. All infants in the country, including refugee infants, are given vitamin D from birth and iron support from 4 months of age, and all infants and children are followed according to the national monitoring schedule. All refugee children in the childhood age group can benefit complementarily from all preventive health services through both family health centres and community health centres. In addition, all stillbirths and infant deaths are registered within the Infant Mortality Monitoring System: causes of death are determined by examining them in provincial inspection boards, problems and issues are determined and efforts are made to resolve problems so that a death does not happen again for the same reasons. This system also includes refugees. Implemented health programmes are provided in order to reduce risk factors such as traumatization faced by war victims.

Lessons learned and recommended future priority actions. It takes a certain amount of time to realize the plans outlined above and countries should be prepared for this. Maternal mortality among migrants was initially examined with a different data system but when the migration trend continued, these data were added to the national data system and started to be monitored. It is recommended that mobility of refugees within the country should be minimized, special reimbursement programme should be established within the universities for follow-up after screening programmes specific for infants and children, and a registration system similar to the MERNIS (the Central Civil Registration System) should be established to cover the health needs of refugees and migrants.

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

PRACTICES. Refugees and migrants from countries where diseases are endemic are considered as risk groups in terms of malaria and cutaneous leishmaniasis. In the framework of the Malaria Elimination Programme, active case-finding activities are carried out in areas where these groups reside, with welfare centres to ensure appropriate treatment and early detection of disease. Treatment and follow-up checks of those detected with malaria are conducted. Screening studies are also carried out in these groups and treatment and follow-up of those with detected infection is instituted in order to control disease and prevent spread. Medicines for malaria, leishmaniasis and visceral leishmaniasis in these groups are given free of charge by the Turkish General Directorate of Public Health. Vector control studies are being carried out continually using the integrated vector struggle approach in the regions where refugees and migrants live. Arabic brochures have been printed and distributed in order to increase information and awareness among migrants and refugees, especially those from the Syrian Arab Republic. The use of same advanced and integrated health information system allows local and national health authorities to be immediately notified if a communicable disease is detected.

Lessons learned and recommended future priority actions. Sensitive health promotion efforts in cultural and linguistic terms may reduce the challenges caused by lack of language skills at the initial phase. However, even after employment of translators, patients may feel discomfort when accessing health services or reflecting their emotions and negative experiences through a second person. Within this limitation, employment of native health personnel or provision of intercultural competence training to translators are interventions proving useful in the context of Turkey.

(Source: General Directorate of Public Health)

UNITED KINGDOM

CONTEXT. In 2017, there were 8 841 717 international migrants in the United Kingdom, constituting 13.4% of the total population. This number has increased at an annual rate of 2.5% since 2015. Of these, 151 621 were refugees and asylum seekers (1.7%). The number of refugees and asylum seekers has reduced since 2015, with an annual rate of decrease of 1.8%. Between 2010 and 2015, the number decreased by 8.3% each year (1).

Enabling participation and social inclusion of migrants

PRACTICES. The Migrant and Refugee Communities Forum is a bilingual mentoring support scheme in the United Kingdom, developed in 2007 in order to take advantage of the skills of unemployed refugee doctors who wanted to support non-English-speaking migrants and refugees experiencing mental illness. The Forum uses a cultural brokerage model from the United States. Mentees not only reported feeling better but started attending college, volunteering and securing paid work (13). The Forum has opened the mentoring role to all individuals who want to support migrants and refugees. Training and structured support is provided for mentoring vulnerable migrants and refugees weekly for at least six months to help them to break out of isolation and build confidence for a new start (14).

Addressing the social determinants of health and health inequality for refugees and migrants

The Barka Project in London is part of a larger effort also occurring in Belgium, Germany, Ireland, the Netherlands and Poland and involving both governments and NGOs. The intention is to improve access to occupational skills training, rehabilitation and housing for migrants suffering from homelessness and substance misuse. The project connects the migrant with both home and host country services depending on needs and helps to overcome cultural and language barriers in accessing health care in the host country. In 2014, 145 people were given occupational skills training, rehabilitation or help in finding homes in London (15).

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

Primary care teams in northern England with a high proportion of asylum seekers have adjusted service provision to improve access and quality of care in several areas. Linguistic needs include documentation of the language and literacy level of all patients, provision of interpreters and communication in the preferred language, longer appointment times to allow for interpretation and explanation, and simplified labelling of prescriptions for easier understanding. Mobility of asylum seekers creates needs for enhanced access to medical records for different agencies and provision of copies of written material for patients when referred to secondary care. Specific health service needs include testing for HIV and sexually transmitted infections for high-risk groups, catch-up immunization for patients younger than 1 year of age, and screening for issues such as homelessness and a history of torture. Staff expertise is improved through the provision of interpreters, enhanced cultural competency training and intersectoral working. To consolidate and sustain good practice, performance indicators that recognized these services were developed at the Whitehouse Centre in Huddersfield, United Kingdom (16).

(Source: Human Rights Council, WHO Regional Office for Europe)

REGIONAL INITIATIVES

In responding to the health needs of migrants, refugees and asylum seekers, the WHO European Region has taken a number of policy initiatives in the context of the recently adopted United Nations 2030 Agenda and the Sustainable Development Goals (17), as well as the WHO European health policy framework Health 2020 (18), which was endorsed at the Sixty-second session of the Regional Committee for Europe in September 2012.

The Migration and Health programme

The Migration and Health programme, formerly known as Public Health Aspects of Migrants in Europe (PHAME), was established in 2011 to support Member States to strengthen the health sector's capacity to provide evidence-informed responses to the public health challenges of refugee and migrant health. The programme operates under the umbrella of Health 2020. The programme provides support to Member States under four pillars: technical assistance; health information, research and training; partnership building; and advocacy and communication. The programme promotes a collaborative intercountry approach to migrant health by facilitating cross-country policy dialogue and encouraging homogeneous health interventions along the migration routes to promote the health of migrants and refugees and protect the public health of the host community.

Using an innovative toolkit developed by the programme (4), several joint public health and health system assessment missions have been conducted in Albania, Bulgaria, Cyprus, Greece, Hungary, Italy, Malta, Portugal, Serbia, Spain and the former Yugoslav Republic of Macedonia to analyse and upgrade response of the countries to large-scale migration.

The WHO Regional Office for Europe established a field presence in Gaziantep (Turkey) in October 2013 to increase capacity to respond to the public health needs of Syrian refugees. Here WHO continues to assess the needs of these refugees; provides capacity-building support to Syrian medical professionals, who are then permitted to treat Syrian Arab Republic refugees in Turkey; provides technical and financial assistance for outbreak response and setting up early warning systems and immunization campaigns; supplying medical equipment and drugs; and supports dissemination of information material to refugees.

The Migration and Health programme has worked in collaboration with WHO Regional Office for Europe's Division of Health Systems and Public Health and the Division of Communicable Diseases and Health Security, and in coordination with the Hellenic Ministry of Health, to conduct rapid assessment visits to Athens, Chios Idomeni and Lesvos, collecting data and reviewing public health needs. Areas of collaboration included strengthening coordination to respond to the health needs of refugees and migrants, increasing immunization services, optimizing a national health plan and increasing health promotion.

The Knowledge Hub on Health and Migration

The Knowledge Hub on Health and Migration is a joint effort between the WHO Regional Office for Europe, the Ministry of Health of Italy, the Regional Health Council of Sicily and the European Commission. The partnership is committed to building expertise and competency on the public health aspects of migration and making knowledge and information in this area widely available.

As part of the work of the Knowledge Hub, a summer school on refugees and migrant health was held in Sicily, Italy in 2017. It is the intention that the summer school will be repeated in subsequent years.

Migration and Health Knowledge Management

The WHO Regional Office for Europe, in collaboration with the European Commission Directorate-General for Health and Food Safety, has established the Migration and Health Knowledge Management project to fill knowledge gaps in the area of migration and health in the Region. The project focuses on expanding knowledge and understanding of migration and health, fostering knowledge sharing and supporting the development and uptake of evidence-informed guidance to ensure actions meet the health needs of refugees, migrants and asylum seekers.

The project aims to develop a knowledge management system to raise awareness, foster knowledge sharing and increase the uptake of good practices and evidence-informed approaches to migrant health. The project develops technical guidance recommendations across six priority issues in migrant health: child health, elderly health, health

promotion, mental health, mother and newborn health and noncommunicable diseases. For each priority issue, knowledge and good practices will be shared in various formats for immediate use and application. Interactive webinars on various topics on refugee and migrant health are being conducted to complement the technical guidance component and bring unique, thought-provoking perspectives on refugee and migrant health challenges.

The Strategy and Action Plan for Refugee and Migrant Health

At the High-level Meeting on Refugee and Migrant Health, held in Rome, Italy, on 23–24 November 2015, Member States of the WHO European Region agreed on the need for a common framework for collaborative action on refugee and migrant health, acting in a spirit of solidarity and mutual assistance to promote a common response, thereby avoiding uncoordinated single-country solutions.

In the context of the Sustainable Development Goals and Health 2020, the Strategy and Action Plan for Refugee and Migrant Health in the WHO European Region was developed (19) and endorsed by the WHO European Regional Committee in 2016. The Strategy and Action Plan provides a coherent and consolidated national and international response to protecting lives and providing for the health needs of refugee and migrant populations in the countries of transit and destination, and to respond to the health needs associated with the migration process.

Although most Member States of the European Region have the capability to respond to the public health challenges associated with migration, they still require better preparedness, greater capacity for rapid humanitarian response and increased technical assistance. The current situation is an opportunity not only to deal with short-term needs but also to strengthen public health and health systems in longer-term actions.

There are nine priority areas included in the Strategy and Action Plan:

- strategic area 1: establishing a framework for collaborative action
- strategic area 2: advocating for the right to health of refugees, asylum seekers and migrants
- strategic area 3: addressing the social determinants of health
- strategic area 4: achieving public health preparedness and ensuring an effective response
- strategic area 5: strengthening health systems and their resilience
- strategic area 6: preventing communicable diseases
- strategic area 7: preventing and reducing the risks posed by noncommunicable diseases
- strategic area 8: ensuring ethical and effective health screening and assessment
- strategic area 9: improving health information and communication.

(Source: WHO Regional Office for Europe)

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