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IFMSA Policy Document Asylum Seekers & Refugees' Health

Proposed by Team of Officials

Adopted by the IFMSA General Assembly March Meeting 2019, in Portorož, Slovenia.

Policy Statement

Introduction:

Against a background of predicaments in a setting infused with large flows of refugees, taking a stance on the global refugee crisis is as important and relevant to the medical profession as it is to the role of a physician to alleviate suffering and promote health. Asylum seekers and refugees face a unique set of health challenges stemming from their journeys and the specific challenges that accompany them. Responding to what the United Nations calls 'the worst migration crisis since World War II' will require a collective effort from the global community.

IFMSA position:

The International Federation of Medical Students' Associations (IFMSA) believes that taking a stance and responding to the refugee crisis by advocating for the right to seek asylum from persecution as mentioned in Article 14 of the Universal Declaration of Human Rights is vital. The IFMSA supports UN agencies', CSO and government initiatives targeted at increasing the protection of asylum seekers & refugees (AS&R) and improving their access to safe, non-discriminatory & quality healthcare; mainly initiatives led by the guiding principles of the Global Compact on Refugees. IFMSA affirms its stance in advocating for the pivotal role of the international community in both responsibility sharing during refugee crises and the importance of the humanitarian characteristic of international cooperation to alleviate the aforementioned crisis. Lastly, IFMSA demands accountability for all perpetrators violating international refugee and international human rights law.

Call to Action:

IFMSA calls on Governments to:

- Respect and implement International Human Rights and Humanitarian Law, Article 14 of the UDHR and the 1951 Refugee Convention by protecting the rights of the asylum seekers and refugees, without discrimination based on race, religion, sex, age, sexual orientation or mental or physical disability.
- Provide an increased availability of resettlement shelters and ensure safe, accessible and legal routes so that people in need of protection can reach the country without endangering their lives.
- Ensure national legislation protocols that protect AS&R from exploitation, arbitrary detention and prevents expulsion to any country where their lives are potentially threatened.
- Contribute funding resources and humanitarian assistance to countries with a high refugee population.
- Identify the needs of refugee women and children, and take measures to ensure that under-aged persons are provided channels of reunification with their parents or guardians in a safe country and ensure their access to health care facilities.
- Comply with all agreements made in the Global Compact on Refugees and utilize the Comprehensive Refugee Response Framework as a lead point for further advances.
- Ensure qualitative and disaggregated data collection on refugees, Internally Displaced Persons (IDPs) and stateless persons, and collaborate with other countries to provide informative and efficient research about refugees' social determinants of health and utilize the results to bridge the gap between research and policy advancements.



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- Provide adequate health care for AS&R, including, but not limited to affordable and equitable access to medicines, medical supplies, vaccines, diagnostics, preventive services and sexual and reproductive health care.

IFMSA calls on International Organizations and Non-Governmental Organizations (NGOs) to:

- Advocate for and collaborate with governments on forming legislative frameworks that guarantee the rights of AS&R.
- Involve AS&R in the decision making processes that influence them, giving them the opportunity to voice their views, such as national legislative frameworks that will impact them.
- Unite with governments in providing quality, non-discriminatory health care services to AS&R.
- Collaborate with youth organizations to build the capacity within civil societies to raise awareness on the rights of AS&R and to advocate for peacebuilding.
- Collect disaggregated data on the number and status of AS&R in host countries around the world to conduct research on the causes and possible solutions of displacement to support bridging the gap between research & policy making.
- Collaborate trans-sectorally to achieve an internationally recognized refugee status for climate refugees who face displacement due to decimated ecosystems

IFMSA calls on Medical Institutions to:

- Equip healthcare professionals with skills and tools on intercultural competence in order to take into account the specific determinants of health in addition to the health needs of AS&R.
- Raise awareness among the wider society to advocate for AS&R right to health, in collaboration with NGOs and youth led organizations.
- Commit to providing dignified, non-discriminatory and culturally sensitive healthcare to all AS&R.
- Refrain from using the immigration status of a person to influence their access to health.
- Abstain from participating in punitive actions involving AS&R nor administer non-medical or ethically unjustified diagnostic measure or treatment, such as sedatives to proceed with refoulement of the patient from the country.
- Strengthen and retain trained healthcare workers in developing countries, especially the hosting countries for AS&R.

IFMSA calls on Medical Schools to:

- Equip medical students with skills and tools on intercultural competence in order to take into account the specific determinants of health in addition to the health needs of AS&R.
- Educate their students on the importance of raising awareness among the wider society to advocate for AS&R right to health, and to eliminate the stigma associated with their status.
- Train their medical students to commit to providing dignified, non-discriminatory and culturally sensitive healthcare services to all AS&R.

IFMSA calls on its National Member Organizations (NMOs) to:

- Take active roles in their countries, advocating and raising awareness for the rights of AS&R, as well as introducing and supporting projects and activities that encourage social cohesion and integration of the refugees with the hosting community.
- Advocate for a sustainable expansion of accessible services in the health systems of hosting countries and engage different stakeholders (e.g., governments, NGOs) to implement a plan of action to ensure the wellbeing of AS&R.
- Promote research on the physical, psycho-social and public health aspects of AS&R health.
- Advocate for migrants' health to be part of the medical curricula.



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Position Paper

Background information:

According to the United Nations High Commissioner for Refugees (UNHCR), there were 68,5 million forcibly displaced people worldwide, of which 40 million internally displaced people, 25.4 million refugees and 3.1 million asylum-seekers, in June 2018. 85 percent of these people are being hosted in developing countries [1]. Since 2010, the number of refugees has almost doubled, and the number of asylum-seekers has tripled [2]. In 2018 alone, more than 600,000 people applied for asylum [3]. The Universal Declaration on Human Rights (UDHR), ratified in 1948, highlights in Article 14 the right to seek asylum from persecution in other countries. Although not legally binding, the declaration sets a framework that needs support from signatory states. In addition, states that have signed the 1951 Refugee Convention have the responsibility to protect refugees according to international refugee law [4]. In addition to Article 14, other sections within the UDHR also come into play when looking at the journey, vulnerabilities, and living conditions that AS&R often experience after leaving their country. Of particular importance for us as future health professionals comes Article 3, which establishes that everyone has the 'right to life, liberty, and security, of person', as well as Article 25, which provides everyone with the 'right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing, medical care and necessary social services' [5].

Discussion:

This document adheres to the definitions of refugee, asylum seeker, IDP and stateless person from the UNHCR Global Report 2005 [6].

Legislative Stance

Like all people, AS & R are protected by international human rights law, the foundation of which was laid in the 1948 Universal Declaration of Human Rights, affirming that "all human beings are born free and equal in dignity and rights" [5]. However, refugees and asylum-seekers are entitled to two sets of rights: those which states are obliged to respect, protect and fulfil under international human rights law, as well as the specific rights of refugees [8]. These specific rights have been laid out very clearly by the International Refugee Law.

The *1951 Refugee Convention and the 1967 Protocol relating to the Status of Refugees* establishes a legal framework around the right to seek asylum, article 14 of the Universal Declaration of Human Rights [8,9]. Both treaties are acceded by most member states and central to the international protection of refugees; they define the term "refugee", establish the principle of "non-refoulement" as refugees' right to be protected from forced return to a territory where their lives or freedom would be threatened, and sets states' responsibilities towards the refugee population [10,11].

In order to respond to regional specificities and needs, states in different parts of the world have developed and implemented their own regional laws and standards in addition to the international refugee protection regime from the 1951 Convention and 1967 Protocol. Examples of these are the *1969 OAC Convention governing the Specific Aspects of Refugee Problems in Africa* [12]; the *1984 Cartagena Declaration for Latin America* [13]; the *1994 Arab Convention on Regulating Status of Refugees in the Arab Countries* [14]; the *2001 Bangkok Principles on the status and treatment of refugees* [15]; the *2012 Ashgabat Declaration* [16]; and the creation of a common European asylum system based on legislative instruments adding content to refugee law in areas not addressed by the 1951 Convention. [8, 17, 18].

Apart from specific international refugee law, there are several international human rights law instruments, such as the Convention against Torture [19], the Convention on the Rights of the Child



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[25] and Convention on the Elimination of All Forms of Discrimination against Women [26], that provide significant protections to asylum-seekers and refugees [8].

Current Situation of Asylum Seekers and Refugees

Half of the world's refugees remain in "protracted situations" which are identified as unstable and insecure locations especially urban areas with dense population, as well as refugee camps. For example, 314,000 persons remain displaced from Darfur in Eastern Chad, and more than a million Somalis live as displaced persons in Kenya, Ethiopia, Djibouti and Yemen. Dadaab, a vast refugee camp in Kenya, houses families that have been sequestered in this remote and insecure location for more than three generations [20].

Public Health challenges of refugees and asylum seekers

Many refugees and asylum seekers lack access to health promotion, prevention and care and financial protection to afford those services. The circumstances and challenges affecting the health of refugees and asylum seekers are often specific to each phase of the migration cycle. Access to adequate health care is often diminished or absent in the country of origin, on the journey to safety, as well as in the hosting country of destination. The country of origin may have a less developed health service or disrupted health systems due to the protracted crises, which may contribute to health conditions experienced even before or since the onset of the travel. Refugees and asylum seekers are less likely to benefit from the host country health system, resulting in worse health outcomes. Refugees and migrants face several barriers accessing health services, which differs from country to country: culminating as linguistic and cultural barriers, high costs, discrimination, administrative hurdles, social isolation, inability to affiliate with local health financing schemes, adverse living conditions (such as camps), lack of information about health entitlements and lack of recognition of professional qualifications. Other factors contributing to worse health outcomes of refugees and asylum seekers are the increased risk of communicable diseases (communicable diseases that are endemic in their country of origin and vaccine-preventable and food and waterborne diseases to which they can be exposed to during their travels); the interruption of access to immunization and continuity of care; an increased risk of noncommunicable diseases due to interruption in care and medication for chronic conditions; and poorly hygienic or safe food and nutritional problems [21].

Communicable diseases and vaccination among refugees and asylum seekers

Refugees and asylum seekers are exposed to recognized risk factors for communicable diseases. Most of them come from countries endemic for poverty-related diseases [22]; the crises in their country of origin has often lead to the disruption of national health-care services (NHS), resulting in fall of vaccination coverage [23]; and they can be exposed to malnutrition and infectious agents in unsanitary, promiscuous and overcrowded contexts during their displacement [24]. Apart from this, refugees and asylum seekers face several challenges in receiving a full vaccination schedule through follow-up vaccinations: many vaccines must be given in consecutive doses, at regular pre-scheduled time intervals, while refugees are often on the move and not at the same place for a longer period of time; screening services for vaccine preventable diseases (VPDs) and vaccination are not always provided to migrants or are not easily accessible and centered on their needs [24-28]. Information on the immunization status of migrants and refugees is often lacking [24,29]; refugees and migrants sometimes refuse vaccination and registration by medical authorities for the fear of legal consequences, such as deportation or detention. Additionally the coordination among public health authorities of neighboring countries is often lacking, resulting in either duplications or lack of vaccine administration [24, 29, 30].

Mental Health

Armed conflict and natural disasters pose significant challenges for the long-term mental health and psychosocial well-being of affected populations. Regions that have long been plagued by war and conflict, suffer from mass loss of lives, displacement, and cross-generational changes to traditional, familial and societal structures. The results can be devastating to the emotional well-being of affected populations with notable increases in the prevalence of common mental disorders (CMDs) such as anxiety and depression [31]. Experiences that are mostly responsible for negative mental health outcomes are social isolation, barriers to access, discrimination, deplorable living conditions in refugee



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camps and irregular utilization of health care. In addition a history of torture, trauma or post-migration detention increases the mental health morbidity and mortality for this vulnerable population as well [21]. According to a WHO report on Mental Health, 10% of persons experiencing traumatic events in situations of armed conflict will develop serious mental health problems; psychological and psychosocial determinants cause another 10% to suffer a reduction in functioning in their daily lives.[32] Health systems directed at helping asylum seekers foster integration and improve access to healthcare and social services are crucial [33].

Women & Children

Fifty percent of the world's refugees are women and girls, yet they are massively underrepresented as a target population in humanitarian action initiatives [34, 35]. Women and girls are at an increased risk of gender based violence (GBV), but it has been seen that they are more often excluded from life-saving services and decision-making processes due to discriminatory social norms and have a limited mobility to get help due to physical insecurity [36]. It has been evident that many of them have been subjected to (Sexual) Gender-based violence (SGBV), including rape, domestic violence, sexual violence, abuse, exploitation and early and forced marriage [36, 37]. At least one in five refugee or displaced women have experienced sexual violence [36]. Although refugee men and boys can also be a victim of SGBV, these incidents are often under-reported as a result of social stigmas and cultural norms that make reporting particularly difficult for male survivors, since they are often not perceived as being susceptible to sexual violence, abuse or exploitation [37, 38, 39]. Sixty percent of preventable maternal deaths take place in settings of conflict, displacement and natural disasters. Also refugee women face poorer pregnancy and birth outcomes and face higher complications rates from unsafe abortion [36]. SRHR issues arise from gender based sexual violence, the lack of reproductive health care and no access to family planning services [40]. Access to sexual and reproductive healthcare can be limited due to legally restricted access based on immigration status or insufficient capacity in camps to provide adequate information and services [41]. Children are over-represented among the world's refugees: they constitute to 51 percent of the world's refugees in 2015, compared to one third of the global population [42]. Refugee children, particularly those who travel alone or are separated from their families (unaccompanied and separated children: UASC), are at an increased risk of abuse, neglect, violence, exploitation, trafficking or military recruitment [42,43]. However, the impact of conflict and violence extends far beyond physical dangers, leaving long-standing psychological and social effects on children's wellbeing. The process of displacement and resettlement alone can negatively impact the mental health of refugee children, resulting in decreased psychosocial adaptation, higher rates of anxiety and fewer effective coping strategies to manage stressful situations [43].

Reality on the ground: access to healthcare in different regions

Africa: By the end of 2016, an estimated 14.9 million forcibly displaced people originated from this region, of which 6.4 million were refugees, asylum seekers and stateless persons and 7.4 million were internally displaced. More than half of all refugees and internally displaced people were from the Democratic Republic of the Congo, Nigeria and South Sudan. Specifically related to health, several declarations and frameworks for action have been agreed upon and endorsed by African governments and states that clearly mention the need to promote human rights, reduce marginalization and give special attention to migrants, mobile populations, refugees and internally displaced persons in national and regional policies. However these rights are not sustained and access to health represents a significant challenge for this group, compounded by language barriers, denial of access on the basis of lacking documentation, and negative attitudes among healthcare providers [44].

Americas: A total of 808,000 people migrating across the international borders of Americas in 2015 were identified as refugees, as ascribed by the definition of a refugee by the International Organization for Migration. When it comes to health, the situation varies significantly between countries. Some countries have free access to health services in the formal public system, for everyone in precarious economic conditions, including migrants and refugees, other systems have health services offered only to asylum seekers with legal residence status in the public system. In another subset of countries, only emergency and limited private health services run by charities are available to these groups. In general,



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Asylum seekers and Refugees often have limited access to appropriate health services and financial protection when it comes to health [47].

Asia-Pacific: Access to healthcare for the AS&R population in South-East Asia is a complex circumstance and is underpinned by several social, economic and cultural environment factors in a challenging legislative status that does not promote their social inclusion. Key challenges include, but are not limited to, language and cultural barriers, lack of health literacy, lack of awareness about personal health and inability to afford healthcare. Lack of legal support has been a barrier to access healthcare in tens of countries including Malaysia and Myanmar [7].

Eastern Mediterranean Region: In the Eastern Mediterranean Region, countries like Lebanon and Jordan have been highly affected by the Syrian Crisis resulting in them hosting the first and second highest share of refugees compared to their population in the world.

This has led to significant burden on the health care systems of the countries of this region. Although countries in the region collaborate heavily with external donors and NGOs like the World Health Organization (WHO), United Nations' International Children's Emergency Fund (UNICEF), UNHCR and the International Medical Corps (IMC), providing quality care to all refugees and asylum seekers while mitigating the effects this crisis has had on vulnerable citizens of the host countries, host communities and institutions has proven challenging for all stakeholders involved [45].

Europe: During recent years, Europe has experienced a significant influx of refugees and asylum seekers trying to reach its shores. Based on the latest report from UNHCR, an estimated number of 5.2 million refugees (including people in refugee-like situations) and 1.4 million asylum seekers are currently residing in Europe. Refugees are formally owed protection, including access to health services, by their first country of registration for asylum. In practice, however, according to the European Union Agency for Fundamental Rights, their fundamental rights still remain under threat. Access to health care varies across the European Region and within national boundaries. It mostly depends on the legal status of the individual. Legal entitlement, however, does not guarantee access, and even where entitlements are established for certain groups and regulations permit access, further barriers may exist in terms of the organization of health care, unawareness of entitlements by health care providers and beneficiaries, limitations of health staff expertise, linguistic and cultural barriers, and the wider governance of migration [46].

Challenges

Detention Centers

Numerous refugees are held in detention facilities upon arrival to various host countries and face deportation. In many cases, living conditions in detention centres are poor and do not provide adequate health care, particularly in regards to mental health [48]. There is clear evidence of correlation between the length of detention period and mental health burden among refugees and asylum seekers [49,50]. A study suggests that of 131 detainees sampled in Australian detention centres, over 80% were classified as having depression [51].

Global Compact on Refugees

With the adoption of the New York Declaration for Refugees and Migrants in September 2016 [54], all 193 Member States of the United Nations agreed on the international responsibility of providing protection to those who have been forced to flee their countries as well as support the countries that have offered shelter to them and that these responsibilities must be borne more equally and predictably by member states [52-54]. This declaration included two key steps towards a more sustainable system for providing refugee protection and responding to the needs of host countries and communities: the adaptation of the comprehensive refugee response framework (CRRF), which sets out a wide range of measures to be taken by the international community in response to all aspects of displacements in a large-scale refugee situation, from admission and reception to meeting ongoing needs and searching for solutions; and to continue to improve international responses by working towards the adoption of a



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'Global Compact on Refugees' (GCR) in 2018, of which the first proposal was released on 20 July 2018. The GCR aims to strengthen the international response to large movements of refugees and protracted refugee situations and has four key objectives: to ease the pressures on countries that host large numbers of refugees; to enhance refugee self-reliance; to expand access to third-country solutions (i.e. resettlement and complementary pathways for admission); and to support conditions in countries of origin to enable refugees to return in safety and dignity [53, 54]. The programme of action of the GCR is divided into two sections, the 'arrangements for burden- and responsibility-sharing' and the 'areas in need of support', of which the latter proposes to deploy and increase resources and expertise to support and strengthen existing national systems of hosting countries in a manner that would facilitate access by refugees in a range of sectors, including health [53,55]. It states that "(...) *States and relevant stakeholders will contribute resources and expertise to expand and enhance the quality of national health systems to facilitate access by refugees and host communities, including women and girls; children, adolescents and youth; older persons; those with chronic illnesses, including tuberculosis and HIV; survivors of trafficking in persons, torture, trauma or violence, including sexual and gender-based violence; and persons with disabilities*"[64]. These resources and expertise to build and equip health facilities or strengthen services, could include capacity development and training opportunities for refugees and members of host communities who are or could be engaged as health care workers. The GCR encourages disease prevention, immunization services, and health promotion activities, as well as pledges by States and stakeholders to facilitate affordable and equitable access to medicines, medical supplies, vaccines, diagnostics, and preventive commodities for refugees [55].

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