

IFMSA Policy Proposal

Forced Displacement and Health

Proposed by Team of Officials

Adopted at the 71st IFMSA General Assembly March Meeting 2022

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Policy Statement

Introduction:

Forced displacement results in a unique set of health needs as people go through different displacement routes, inside and across borders, getting exposed to a variety of social, economic, legal, and environmental challenges. Addressing these needs and promoting the health of the forcibly displaced require a collective effort from the global community and an intersectoral approach. It's, hence, imperative for us, as medical students and health workers, to have a concrete stance and vision in contributing to the fulfilment of the right of refugees and forcibly displaced people, especially their right to health.

IFMSA position:

The International Federation of Medical Students' Associations (IFMSA) reaffirms the right to seek asylum from persecution as mentioned in Article 14 of the Universal Declaration of Human Rights. Furthermore, the IFMSA reaffirms the entitlement of refugees and forcibly displaced people to all human rights as enshrined in the principles of universality and inalienability, and without any form of discrimination. The IFMSA supports initiatives targeted at increasing the protection of refugees and forcibly displaced people and improving their access to safe, non-discriminatory and 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 alleviating the needs of refugees and forcibly displaced people and ensuring their protection. Lastly, IFMSA demands accountability for all perpetrators violating international refugee and international human rights law.

Call to Action:

Therefore, IFMSA calls on:

Governments to:

- Respect, implement and act in accordance with international law and human rights agreements, including, but not limited to the United Nations Declaration on Human Rights, Convention Relating to the Status of Refugees and the New York Declaration for Refugees and Migrants.
- Increase the access and availability of safe, humane resettlement shelters, as well as safe, legal migration routes for those seeking protection.
- Implement national legislation protocols that protect asylum seekers and refugees from exploitation, arbitrary detention, refoulement and expulsion to any country where their lives are potentially threatened.
- Provide humanitarian assistance, including funding, resources, technical information, and services, to countries with substantial population displacement as well as host countries.
- Protect and provide appropriate additional support to asylum seekers and refugees women, children, LGBTQIA+ and other marginalised populations, in the community, as well as in camps, shelters, detention and other holding facilities.
- Protect underaged asylum seekers and refugees, ensuring they are not separated from parents or guardians, and, if separated, have safe and orderly channels of reunification with them.
- Comply with all agreements made in the Global Compact on Refugees and utilise the Comprehensive Refugee Response Framework as a lead point for further advances.
- Work collaboratively and cooperatively with stakeholders and governments, in accordance with the Global Compact of Refugees, to protect asylum seekers and refugees and achieve long-term, sustainable and humane solutions.
- Undertake and implement qualitative, quantitative and disaggregated data collection on asylum seekers and refugees, Internally Displaced Persons (IDPs) and stateless persons, with the aim of informing policy-making, the provision of tailored and sensitive services and the strengthening of social and economic living conditions

- Ensure the health system is able to provide adequate health care for refugees and forcibly displaced populations, including, but not limited to affordable and equitable access to medicines, medical supplies, vaccines, diagnostics, preventive services and sexual and reproductive health care.

International organisations and non-governmental organisations (NGOs) to:

- Advocate for and collaborate with governments on forming legislative frameworks that guarantee the rights of asylum seekers and refugees, especially the provision of quality, non-discriminatory health care services.
- Involve asylum seekers and refugees in the decision making processes that affect their lives and rights, giving them the opportunity to voice their views, such as in national legislative frameworks that will impact them.
- Collaborate with youth organisations to build the capacity within civil societies to raise awareness of the rights of asylum seekers and refugees and to advocate for peacebuilding.
- Collect disaggregated data on the number and status of asylum seekers and refugees in host countries around the world to inform decision making.

Health Sector, Medical Institutions and Medical Schools to:

- Equip healthcare professionals with skills and tools on intercultural competence, in order to take into account the specific determinants and sociocultural parameters when addressing the health needs of asylum seekers and refugees.
- Raise awareness among the wider society to advocate for asylum seekers and refugees right to health, in collaboration with NGOs and youth-led organisations.
- Train their healthcare workers and medical students to commit to providing dignified, non-discriminatory and culturally sensitive healthcare services to all asylum seekers and refugees, and ensure universal access to health, regardless of immigration status.
- Respect the rights of asylum seekers and refugee patients and function in absolute accordance with the principles of medical ethics, thus abstaining from punitive actions, breaching the patient's autonomy, or administering non-medical or unjustified diagnostic measures and treatments.
- Recognize the medical qualifications and training of asylum seekers and refugees as international medical graduates, utilising their expertise and facilitating their integration into the medical system.

IFMSA National Member Organisations (NMOs) and medical students to:

- Take active roles in their countries, advocating and raising awareness about the rights of asylum seekers and refugees, both internally for their members, and externally for their communities.
- Introduce and support 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 host countries and engage different stakeholders (e.g., governments, NGOs) to implement a plan of action to ensure the wellbeing of asylum seekers and refugees.
- Build and develop partnerships with other governmental and non-governmental organisations, to boost the impact of the NMOs advocacy efforts and to encourage and facilitate the engagement of the NMOs members with the asylum seekers and refugees communities (i.e through internship opportunities, community dialogues and workshops).
- Promote and get involved in university-level research on the physical, psycho-social and public health aspects of asylum seekers and refugees' health.

Position Paper

Background information:

Forced displacement remains a major humanitarian challenge in the modern-day world, with more than 84 million people forcibly displaced worldwide as of mid-2021; almost double the level registered a decade ago, by the end of 2011, at 42.5 million [1][2]. Of these, 48 million are internally displaced people, 26.4 million are refugees and 4.1 million are asylum seekers [2].

The Universal Declaration on Human Rights (UDHR) proclaimed, in Article 14, the right to seek asylum from persecution in other countries. It also affirmed equal and inalienable rights of all humans, including those on the move, such as the right to "life, liberty, and the security of person", the right to recognition before the law, the right to work, the right to education as well as the right to "a standard of living adequate for health and well-being" [3]. In addition, the 1951 Convention Relating to the Status of Refugees and its 1967 Protocol defined the term 'refugee' and further outlined and underpinned their rights, while setting forth the legal obligations of States to protect them [4].

Discussion:

1. Definitions:

Forced displacement (or displacement) is the forced removal, individually or collectively, of persons from their home, country or community [5].

A **refugee** is "any person who, owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group, or political opinion, is outside the country of their nationality, and is unable or, owing to such fear, is unwilling to avail themselves of the protection of that country" [4]. As per the definition, refugees have two defining characteristics: (1) **involuntary movement** (2) **outside the country or territory of origin**.

An **asylum seeker** is any "individual who is seeking international protection" and "whose claim has not yet been finally decided on by the country in which the claim is submitted". [6].

According to the Handbook on Procedures and Criteria for Determining Refugee Status: "A person is a refugee within the meaning of the 1951 Convention as soon as they fulfil the criteria contained in the definition. This would necessarily occur prior to the time at which their refugee status is formally determined. Recognition of their refugee status does not therefore make them a refugee but declares them to be one. They do not become a refugee because of recognition, but are recognized because they are a refugee" [7]. Accordingly, the term "refugee" also encompasses all those seeking asylum, regardless of the status of their claim. For the purpose of this paper, the usage of the term "refugees" entails both "refugees" and "asylum seekers".

Internally displaced persons (IDPs) are "persons or groups of persons who have been **forced or obliged** to flee or to leave their homes or places of habitual residence, in particular as a result of or in order to avoid the effects of armed conflict, situations of generalised violence, violations of human rights or natural or human-made disasters, and who **have not crossed an internationally recognized state border**" [8]. As per the definition, IDPs have two defining characteristics: (1) **involuntary movement** which takes place (2) **within national borders**. The term IDP is a descriptive status that does not grant a special legal status nor can be refused [9].

2. Current Situation of Displaced Persons

2.1. Demographics

There were more than 82.4 million forcibly displaced people around the world at the conclusion of 2020;

26.4 million refugees, 48 million internally displaced persons, 4.1 million asylum seekers, and 1 million children who were born as a refugee between 2018-2020. The total number of displaced persons has doubled over the past decade, resulting in more than 1% of the global population being displaced. Over two-thirds of displaced persons are from Syria, Afghanistan, Venezuela, Myanmar and South Sudan. Developing countries host 87% of refugees, the top three host countries include Turkey (3.7 million), Colombia (1.7 million) and Pakistan (1.4 million). Additionally, 73% of hosts are also neighbouring countries [10].

Over the past decade, there have been historically high levels of forcibly displaced people due to a surge in violence since 2010. The displacement situations are becoming increasingly more protracted; close to 16 million people have been in exile for longer than 5 years. Half of the world's refugees remain in “protracted situations”, which are defined as unstable and insecure locations, especially urban areas with dense populations, as well as refugee camps [11].

The worldwide distribution of asylum applications demonstrates that the United States receive the highest number of applicants. However, a significant number of people have submitted asylum applications to countries in South America (as a result of the Venezuela crisis), and some European countries (including Germany and Spain) [12].

2.2. Access to healthcare in different regions

In Africa:

Sub-Saharan Africa is a host for around 36 million people of concern to the UNHCR; 38% of the total world population [13]. This can be, in part, attributed to the ongoing crises in South Sudan, the Central African Republic, and Nigeria, as well as new conflicts in Burundi and Yemen.

In regards to health, several declarations and frameworks for action have been agreed upon and endorsed by African governments and states. These clearly mention the need to promote human rights, reduce marginalisation and give special attention to populations on the move and forcibly displaced persons in national and regional policies [14]. However, these rights are not sustained and access to health represents a significant challenge for this group. This is further compounded by language barriers, denial of access due to lacking documentation, and negative attitudes among healthcare providers [14].

In the Americas:

The region hosts about 18.4 million people of concern to the UNHCR; 20% of the total world population [13]. Nevertheless, several countries in the region have shown political commitment to addressing the protracted refugee situation [15].

In regards to healthcare, some countries have free access to health services in the formal public system, and for everyone in precarious economic conditions, including migrants and refugees. However, 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, refugees often have limited access to appropriate health services and financial protection when it comes to health [16].

In the Asia-Pacific:

The region hosts approximately 9.8 million people of concern to the UNHCR; 11% of the total world population [13]. Following the coup in Myanmar, around 406,000 people were displaced internally and another 32,000 fled the country [17].

Most of the countries in the region have not signed the 1951 Refugee Convention nor its 1967 Protocol [18]. Additionally, most of the countries do not have administrative or legal frameworks regarding refugee protection. Consequently, asylum seekers and refugees are treated as illegal migrants and face difficult

living conditions as a result. Access to healthcare, financial, education or other types of social support for refugees is difficult in this region [18].

Many also face detention resulting in many refugees experiencing ill-treatment and violence. In detention centres, physical and mental health suffers considerably. Additionally, there is minimal or no legal access or advice provided in these facilities. Consequently, many refugees in detention centres are at serious risk of refoulement [18].

In the Eastern Mediterranean Region:

The region hosts approximately 15.8 million people of concern to the UNHCR' 17% of the total world population [13]. More than 40% of the Syrian population are displaced inside the country and in neighbouring states, making it one of the largest refugee producers. Iraq also faces extensive internal displacement, where 3 million people have fled their homes since 2014 and in Yemen, more than 2.3 million individuals have been internally displaced since 2015. More than half of the world's refugees live in Pakistan, Iran, Lebanon and Jordan. In these countries, the majority live in the local population, with only a small percentage residing in camps [19].

Countries in the region collaborate heavily with external donors and NGOs, such as the World Health Organization (WHO), United Nations' International Children's Emergency Fund (UNICEF), UNHCR and the International Medical Corps (IMC). However, providing quality care to all refugees and asylum seekers, while mitigating the effects of these crises on vulnerable citizens within the host countries, has proven challenging for all stakeholders involved [20].

In this region, countries are insufficiently prepared to provide adequate protection to asylum seekers and refugees. Their laws and policies are inadequate, ineffective or non-existent. Consequently, the necessary and basic needs and services that they require are difficult to meet. Many of the asylum seekers and refugees in the Eastern and Mediterranean region have a lack of rights, protection, services and livelihood necessities. Due to the extensive number of displaced people, the UNHCR is unable to provide protection for the entire group[21].

In Europe:

The region hosts about 12 million people of concern to the UNHCR; 13% of the total world population [13]. One-third of these live in turkey. This country is one of the largest refugee-hosting nations with 3.7 million refugees. The greatest amount of internally displaced people are in Ukraine, with 734,000 internally displaced people along with another 1.6 million conflict-affected persons [22].

In the region, refugees are formally provided with protection in the country where they first register for asylum; this protection includes access to health services. However, according to the European Union Agency for Fundamental Rights, in many member states, the rights of asylum seekers and refugees in Europe is under threat. Many of their fundamental rights are being routinely denied, especially at the stage at which their asylum status is being determined [23].

3. Legislative Stance

Like all humans, asylum seekers and refugees are protected by international human rights law, guided by the foundation of the Universal Declaration of Human Rights (1948). Article 14 of this declaration states that "everyone has the right to seek and to enjoy in other countries asylum from persecution" [3]. Additionally, the United Nations Convention Relating to the Status of Refugees (1951) and Protocol (1967), offers key protections based on non-refoulement, non-discrimination and non-penalisation. Both treaties are acceded by most member states and are central to the international protection of refugees; they define the term "refugee", establish the principle of "non-refoulement", and set state responsibilities towards the refugee population [4]. 142 countries have adopted both the Convention and the Protocol.

However, there are 43 UN members that have not adopted international laws, some of which host large refugee populations [24].

Along with international refugee law, there are several international human rights law instruments that protect displaced persons [24]:

- Convention against Torture and Other Cruel, Inhuman, or Degrading Treatment or Punishment (CAT)
- Convention on the Rights of the Child (CRC)
- International Covenant on Civil and Political Rights (ICCPR)
- International Covenant on Economic, Social and Cultural Rights (ICESCR)

These treaties provide that no one shall be subjected to torture, cruel or inhuman or degrading treatment and refoulement (Article 7 ICCPR, Article 3 CAT and Article 37 CRC). Arbitrary detention is prohibited under Article 9 of the ICCPR to ensure the liberty and security of persons; however, Article 10 provides that if they are deprived of their liberty, they need to be treated with dignity and humanity. Also, children should only be detained as a last resort under Article 37 of the CRC. The CRC also promotes a range of rights for refugee children, including everything from not being separated from their families to protection from abuse [25].

The New York Declaration for Refugees and Migrants (2016) is another important protection tool for displaced persons. It seeks to fully protect the human rights of asylum seekers and refugees and makes strong commitments to prepare and address challenges in this space [26]. Some of these commitments include ensuring all asylum seekers and refugees children receive education within a few months of arrival, preventing and responding to sexual and gender-based violence, improving the delivery of humanitarian assistance to the most affected countries and more. It also called upon the development of the Global Compact on Refugees and the Global Compact for Safe, Orderly and Regular Migration. This declaration was unanimously adopted by all 193 UN Member States [27].

Global Compact on Refugees

The Global Compact on Refugees (GCR) ensures that all 193 Member States agree on their international responsibility of providing protection to those who have been forced to flee their countries, as well as supporting the countries that have offered shelter to them. It ensures that these responsibilities are borne more equally and predictably by member states [28][30].

The compact looks to create a more sustainable system for providing refugee protection and responding to the needs of host countries and communities. It aims to strengthen the international response to large movements of refugees and protracted refugee situations. It has four main objectives [30]:

- Ease pressure on host countries;
- Enhance refugee self-reliance;
- Expand access to third-country solutions;
- Support conditions in countries of origin for return in safety and dignity.

The GCR also looks to adapt the Comprehensive Refugee Response Framework (CRRF). This framework 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. It includes everything from admission and reception, to meeting ongoing needs and searching for solutions. Progress has been made on the adaptation of the CRRF. It has received improved support from large stakeholders, including \$2bn from the World Bank and more than \$1bn from development donors to particular countries with refugee displacement. New initiatives have also been established to safeguard refugee livelihoods, education and justice. There are expanding pools of resettlement countries, growth in private and community sponsorship schemes and increased focus on improving conditions in the country of origin to allow safe

and dignified return [31].

The GCR program also has two other sections for scenarios outside of large-scale refugee situations; the 'arrangements for burden- and responsibility-sharing and the 'areas in need of support. The latter proposes to deploy and increase resources and expertise to support and strengthen existing national systems in host countries that would facilitate the access by refugees in a range of sectors, including health [29][31]. This would involve capacity development and training opportunities for refugees and members of host communities who are or could be engaged as health care workers. Additionally, the GCR encourages disease prevention, immunisation 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 [31]. The GCR also has a strong focus on collaboration and responsibility-sharing. They look for States to attend the Global Refugee Forum to promote sustained engagement and make pledges on areas including financial, material and technical assistance, resettlement and complementary pathways for admission into third countries and other actions to support the global compact [29].

4. Gender and Sexuality Dimension

Women are considered to be at a greater risk of harm than men during and after times of massive disaster, as a result of social and political inequalities [32]. For women and girls, displacement generates settings conducive to sexual and gender-based violence (SGBV), such as verbal threats and intimidation, physical and sexual assault, and early and forced marriage. Intimate partner abuse is on the rise in refugee populations, adding to the complexities and difficulties of the refugee experience [33].

The UNHCR has a strong focus on gender equality for displaced persons from all ages and backgrounds, this includes empowering women and girls' participation in leadership, education and building the necessary skills to become economically self-reliant. The UNHCR also collaborates with men and boys as both practitioners and survivors of sexual and gender-based violence [34]. During times of conflict, men are exposed to potentially traumatic experiences such as physical battle, attack, combat, injury, and seeing violent injury and death in higher numbers and with greater intensity [35]. Additionally, the loss of the 'provider and protector' position, the "shame" of relying on relief agencies after a disaster and the limited self-determination that comes with the refugee experience, all separate men from their traditional masculine identities, responsibilities and relationships, having negative consequences [35].

Another stage is to recognize homophobia and transphobia as kinds of SGBV that cannot be fully handled by focusing solely on sexual violence, and this necessitates a shift away from a gender binary model of thing [36]. The number of LGBTQIA+ identifying refugees and asylum seekers has increased in recent decades, with the majority qualifying as refugees as "members of a particular social group" under the 1951 Refugee Convention [36]. LGBTQIA+ identifying persons can face discrimination, violence and persecution, sometimes daily. However, even though they can seek asylum elsewhere, they are still at significant risk of facing stigma and abuse in the country they fled to [37]. Only 37 UN Member States provide asylum for people facing persecution due to sexual orientation, gender identity, gender expression and/or sex characteristics. Many other countries do not have operational or legal frameworks to handle LGBTQIA+ identifying refugee cases, often leading to discrimination against this group [38].

5. Children and Young People:

Children account for 42 per cent of all forcibly displaced people worldwide, compared to almost 30 per cent of the global population [39]. Furthermore, it is estimated that an average of up to 340,000 children per year were born in refugee settings in the years 2018-2020 [39]. Many child refugees may end up spending their entire childhood, and even lives, in displacement, with their futures uncertain.

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 [40]. Furthermore, displacement may weaken the family and social support networks, disrupt education and impact the health and well-being of children [40]. The processes of displacement and resettlement, being slow and complicated, 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 [40].

The aforementioned increased risk for refugee children also extends to refugee youth. While the refugee population is relatively young, youth are often overlooked as a group with specific needs. This is reflected in the lack of research and disaggregated data on youth refugees[41][42]. However, there has been increasing recognition of the importance of addressing the specific needs of displaced youth and of their role in supporting their own communities. The Global Refugee Youth Consultations (GRYC) was organised in several countries between 2015 and 2016, coming as a breakthrough initiative to listen to and amplify the voices of young refugees. The consultations process resulted in identifying 10 challenges facing refugee youth [41]:

1. Difficulty in accessing **quality learning**, formal education, and skill-building opportunities
2. Limited youth **employment** and livelihood opportunities
3. Difficulties obtaining **legal recognition** and personal documents
4. Lack of safety, security, and freedom of **movement**
5. Poor access to **youth-sensitive healthcare** including psychosocial support
6. **Gender inequality**, discrimination, exploitation, and violence—including for LGBTQIA+youth
7. Specific protection and practical challenges for **unaccompanied youth**
8. **Lack of information** about asylum, refugee rights and available services
9. **Discrimination**, xenophobia, and “culture clash”
10. **Lack of opportunities to participate**, be engaged, or access decision-makers

Furthermore, while uncovering challenges, the consultations also resulted in the formulation of 7 core actions for humanitarian actors to undertake in working with and for young refugees. These core actions are[41]:

1. **Empowering** refugee youth through meaningful engagement
2. **Recognising**, utilising, and developing refugee youth capacities and skills
3. **Ensuring** refugee youth-focused protection
4. **Supporting** the physical and emotional wellbeing of refugee youth
5. **Facilitating** refugee youth networking and information sharing
6. **Reinforcing** refugee youth in their role as connectors and peacebuilders
7. **Generating** data and evidence on Refugee Youth to promote accountability to youth

Both refugee children and youth are at heightened risk to be affected by displacement due to their age-specific and development needs. On the other hand, refugee children and youth also show resilience and determination [42]. Hence, it's crucial that refugee-related policies and programs are developed to serve the “best interests” of children and youth, being sensitive to their specific needs and inclusive to their potential as positive agents of change.

6. Public Health Challenges for Migrants

6.1. Social Determinants of Health

Social determinants of health (SDoH) have been defined by Healthy People 2020 as being part of five classifications [43]:

- Social and communal surroundings

- Education
- Economic security
- Health and health services
- Built environment and neighbourhood

These factors are thus inherently structural in nature and are directly related to poorer health outcomes; individuals with restricted access to health care services, poor education, or low-quality housing experience more severe health disparities [44]. Previously, studies done on migrants' health were disconnected from the context of SDoH, but recent evidence showed the close linkage between both entities [45]. The deficiency in addressing such linkage when tackling migration issues has led to several missing opportunities in the field.

Migrants and refugees who struggle with poor health due to social determinants and circumstances generally comprise large families living in densely populated areas, low paid workers with high degrees of financial and food insecurity, high levels of stress and limited language proficiency of the host country [46]. For example, according to WHO, many migrants, specifically those who are low-skilled or semiskilled, occupy jobs that do not abide by occupational health and safety regulations, making them more dangerous and demanding. However, despite working for longer hours than workers from the host country, migrants are less likely to complain and thus have worse health-related outcomes [47]. Additionally, several studies, reports and research surveys were carried out in different countries like Italy [48], Jordan [49] and Lebanon [50] on the living conditions within refugee camps and settlements. The studies generally reported these settlements' conditions to be very poor, often overcrowded and with a deficiency in basic supplies including water, electricity, and shelter. Some of these studies also reported an increase in prevalence in adverse health outcomes in the population [48], in addition to a direct relationship between poor living conditions and poorer health outcomes [50]. Such evidence thus warranted the calls for having national policies to address and tackle the SDoH of migrants [51].

6.2. Access to Healthcare and Health Information

According to WHO, many refugees and migrants lack access to health promotion, prevention and care, and financial protection, all of which constitute important healthcare services [47]. Refugees' access to healthcare was shown to differ between different countries depending on several factors, including the laws and policies that govern such access [52]. Such barriers for example included the absence of adequate and institutionalised procedures regarding the provision of care for unaccompanied minors, as highlighted by a European report, which frequently led to breaks in the continuity of care [53]. Other organisational barriers were also highlighted across several countries [54]. Even when accessibility is made legal, inequalities experienced by migrants in accessing such services persist, as reported by several studies [55][56].

Language barriers and the lack of knowledge on existing care options and healthcare procedures were among the factors that exaggerated migrants' health vulnerabilities [57]. Cultural and communication issues regarding health issues were important predictors of poorer health outcomes among refugees across different countries [58]. Such issues make it difficult to provide access to information that is culturally and linguistically suitable, making these populations have a lower chance of improving their health and wellbeing [59]. Health literacy among refugee populations was thus given a priority in several studies [59][60], especially between migrants and healthcare professionals and workers. Under-addressing such an issue was linked to poor health care provision for migrants according to one study [61].

Healthcare access by undocumented migrants was a particularly challenging and restricted process [62]. Policies regarding migrant access to different services usually occur in silos, with the healthcare sector

usually being excluded or marginalised [63]. Insurance plan schemes, if present, also rely on citizenship or legal immigration status, leaving undocumented migrants largely excluded [64], creating financial barriers as only a few can afford to pay [65]. Even when such services were available, evidence showed that healthcare services were underused by undocumented migrants, with different studies attributing this fact to the tendency of migrants to be unaware of their entitlement or to the inadequacy of the care provided [53][66].

6.3. Communicable diseases and vaccination among refugees and asylum seekers

Communicable Diseases

Asylum seekers and refugees are exposed to recognised risk factors for communicable diseases. Generally, they have disrupted or poor-quality health services in their country of origin, and there is a higher risk of infectious disease associated with migration [67][68]. This is because through going on long dangerous migration journeys, many experience overcrowding and poor sanitation access which increases the risk of communicable, food-borne and water-borne diseases [67]. This has resulted in there being triple the burden of infectious diseases amongst forcibly displaced compared to the general population [69]. This led to a number of communicable diseases being relatively prevalent in the asylum seekers and refugees population. The most common diseases include latent and active TB, and hepatitis [68].

However, asylum seekers and refugees are not a 'source' of communicable diseases in their host country. There is no systematic link between migration and the importation of such diseases. This is evident by the fact that migration patterns are independent of the epidemiological spread of communicable diseases in the European region for example. Additionally, the risk of exotic communicable diseases being imported, such as the Middle East respiratory syndrome or Ebola, is extremely low. These are more likely to be imported via travellers, healthcare workers or tourists rather than asylum seekers and refugees [67].

Vaccination

Asylum seekers and refugees are considered an at-risk population for inadequate immunisation due to both pre- and post-arrival factors. Pre-arrival factors include there being differences in the vaccination schedule between the origin and host country, disruption in immunisation and healthcare services, forced migration causing poor access to healthcare and potential issues associated with vaccine quality (such as the maintenance of the cold chain) [70]. Post-arrival factors include challenges in the delivery and the completion of catch-up vaccination programs in the host country. This is due to catch-up schedules being complex in nature, lack of previous immunisation records, trouble navigating and/or accessing health systems and challenges associated with language services including immunisation information [70][71].

COVID-19

Asylum seekers and refugees are a particularly vulnerable population for COVID-19 due to multiple factors. This includes challenges associated with maintaining safety measures in overcrowded facilities, camps and detention centres, lack of access to countries for resettlement or asylum due to border closures and a potential lack of income support for those that lost their job [72]. Additionally, many asylum seekers and refugees are not considered the dominant race in their host country through ethnicity, language, race or cultural factors. Consequently, they can experience poorer access to quality healthcare, have healthcare-seeking behaviour be sub-optimal, and have distrust for governments due to fear of being deported or detained if they seek healthcare. As a result, asylum seekers and refugees experience a higher burden of COVID-19 and are disproportionately represented in cases, hospitalisations and deaths from infectious diseases [73].

In regards to vaccination, asylum seekers and refugees have begun receiving vaccinations in 101 of 162

countries that are monitored by the UN High Commissioner for Refugees (UNHCR) [74]. In high-income countries, 57.30% of the population have been vaccinated compared to only 2.14% in low-income countries as of August 2021 [75]. As 86% of asylum seekers and refugees reside in developing countries, there is a significant impact on this population caused by the lack of COVID-19 vaccine supply and its financial implications in these countries [76]. Furthermore, migrants are not explicitly included in 72% of National Deployment and Vaccination Plans for COVID-19 [77]. Additionally, there can be many barriers for asylum seekers and refugees to access vaccination services, this includes stigma, exclusion and mistrust, fears associated with safety and deportation and detention, and lack of financial means and information [78].

7. Mental Health and Psychological Support:

The various reasons that force people to flee their homes, such as conflict and disasters, pose a significant burden to the mental health and the psychosocial well-being of affected populations. These experiences crucially impact refugees and asylum seekers, leading to the development of disorders such as anxiety, depression, and post-traumatic stress disorder [79]. The disasters and humanitarian emergencies that usually constitute the causal factors of forced displacement are defined by a breakdown in social structures, erosion of value systems, rise in violence, weak governmental institutions, and limited access to health services and humanitarian support, and thus foster an environment where human rights may be disregarded and violated, traumatising the affected individuals [80]. Additionally, the settings that displaced populations face post-migration are often characterised with insecurity, limited access to education, occupation and services, social isolation, and institutional or behavioural discrimination [81]. These settings have severe consequences on their mental health's morbidity and mortality, especially if other complicating factors, such as torture, trauma, or detention, are present [81]. It is thus essential for policy to highlight and for action to focus on the mental health needs of refugees and asylum seekers, as their status renders them particularly vulnerable [82].

Mental health and psychosocial support (MHPSS) is a composite term defining a set of supportive interventions aiming to promote and protect psychological and social welfare, by tackling the mental health needs of a certain population [80]. Based on the IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings, the necessary interventions are implemented through four phases, including [80]:

- Ensuring the availability of basic services and security
- Providing support for the community and family
- Administering focused non-specialized support
- Delivering specialised services

The core component of mental health and psychosocial support mechanisms should be a person-centred model of care that provides continuous and holistic assistance to refugees and asylum seekers [83].

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