hope
European Hospital and Healthcare Federation

Migrants and refugees

Good practices in hospitals and healthcare services

HOPE SURVEY

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INTRODUCTION

The increasing mobility and diversity of the population strongly affect healthcare services and hospitals: people on the move face greater health risks, suffer from conditions not commonly found in Europe and have different expectations about health services.

Access to adequate health care is further complicated by language barriers and migrants often being socially disadvantaged. Although health services are used to accommodating cultural diversity, European hospitals are facing new challenges.

HOPE and its members have been discussing this topic for many years. In the recent context of intensified migratory pressure on some EU countries, it seemed essential to collaborate and share good practices as well as knowledge on the specific health needs of migrants. The HOPE Board of Governors has recently urged members to review and list good practices. The present document is the result of this work.

HOPE involvement in European projects

The first European project that HOPE joined was called Migrant-Friendly Hospitals (MFH), co-financed by the EU. It started in 2002 and brought together hospitals from 12 EU-Member States, a scientific institution as co-ordinator, various experts, international organisations and networks.

These partners agreed to put migrant-friendly, culturally competent health care and health promotion higher on the European health policy agenda and to support other hospitals by compiling practical knowledge and instruments. One major strategy for determining if an organisation could become migrant-friendly and culturally competent was to implement and assess three selected sub-projects from diverse hospital settings in Europe. For this, local implementation was financed by hospital funds and backed by a European benchmarking process. The two and a half-year project concluded with a conference entitled “Hospitals in a Culturally Diverse Europe” in Amsterdam from 9 to 11 December 2004, where the experiences and outcomes were presented. These feature in a document known as the “Amsterdam Declaration”[1].

With a similar rationale, the Nowhereland project ran for three years (from 2008 to 2010) and its main goal was to improve the level of health protection for people across Europe, mainly by collecting, evaluating and sharing models of good practice. This was achieved by: mapping the legal and financial frameworks on national level in the European Union under which health care services/providers act, gaining an overview about needs and strategies of undocumented migrants in getting access to healthcare services, compiling experiences from NGOs and other advocacy groups; entering existing practices of health services in the EU on regional and local level into a database and identifying transferable models of good practice.

[1] www.mfh-eu.net/public/european_recommendations.htm

HOPE still follows the Task Force "Migrant Friendly and Culturally Competent Health Care" within the WHO network on Health Promoting Hospitals. It deals with promoting health and health literacy of migrants and improving hospital services for these patient groups, supporting organisations in becoming migrant-friendly and culturally competent health care organisations, as recommended in the 2004 Amsterdam Declaration.

Recent projects: the European Union and the WHO

Through the 3rd Health Programme (2014-2020), the European Union has made available funds to finance activities in the field in the Member States most impacted by arrivals. Some examples of healthcare services delivery to migrants as part of a European project can be presented.

The CARE (Common Approach for REfugees and other migrants' health) project[2] lasted for one year from 1st April 2016.

It addressed hotspots for migrants' health and other migrant facilities, encouraging countries to invest in preparing their own communities and healthcare systems[3]. In these two areas, the CARE project has achieved significant results, essentially based on the production and adoption of common tools for migrants' health assistance, monitoring of communicable diseases, training of health and non-health operators and, finally, awareness raising for migrants and the general public. In the participating countries (Italy, Greece, Malta, Croatia, Slovenia), these tools have been used by the CARE partners to implement action based on a common strategy, but clearly adjusted to different local contexts. Many of these tools may be adapted to other contexts across Europe.

SH-CAPAC[4] – Supporting Health Coordination, Assessments, Planning, Access to health care and Capacity building – supports European countries under particular migratory pressure in ensuring effective healthcare for refugees, asylum seekers and other migrants. This one-year project launched on 1st January 2016 was aimed at strengthening the public health response of local health systems, improving access to health care, and developing health workers' competencies for the delivery of migrant/refugee sensitive health services. The project contributed to meeting the objectives and priorities of the Annual Work Programme 2015 and developed coordination activities with national health authorities as well as with national and international stakeholders including the EU[5].

The European network to reduce vulnerabilities in health was created by *Médecins du Monde*[6] in January 2015 and brings together NGOs and academic partners from 17 EU Member States and 2 EFTA/EEA countries. Its main goal is to contribute to decreased EU-wide health inequalities and to more responsive health systems that are better equipped to deal with vulnerability factors. The network's founding members seek to gain greater capacity and skills through mutual learning about how to improve health service delivery, patient empowerment, common data collection and advocacy. As a

[2] Project website: http://careformigrants.eu/
[3] Read more at https://webgate.ec.europa.eu/chafea_pdb/health/projects/717317/summary
[4] Project website: http://www.sh-capac.org/
[5] See https://webgate.ec.europa.eu/chafea_pdb/health/projects/717275
[6] See https://mdmeuroblog.wordpress.com/

result, people facing multiple vulnerabilities will get access to higher quality care in the health programmes run by network members as well as a better understanding of mainstream healthcare systems. The network will set out a joint data collection process to serve as a new resource for health authorities at all levels. The process will be analysed and validated by a leading epidemiologist.

The project 8 NGOs for migrants'/refugees' health needs in 11 countries (BE, BG, DE, EL, ES, FR, HR, IT, NO, SE, SI) is a collaboration[7] supporting the health authorities of 11 EU countries in providing adequate and accessible health services to newly arrived migrants with a specific focus on children, unaccompanied minors and pregnant women. As part of the project, general health assessments were conducted in arrival and transit locations using the standardized personal health record developed by IOM and DG SANTE. Wherever possible, access to national health systems was supported through social and health mediation activities and information on migrants' rights to access care. Core indicators on migrants' health and main vulnerability factors were routinely collected and used both to improve field teams' responses and to inform health authorities. As a result, geographically changing needs were continuously assessed with a view to reducing cross-border health threats, improving local coordination between all operators and strengthening the capabilities of applicants and their teams to respond to urgent migrants' health needs.

The EUR-HUMAN project[8] - EUropean Refugees-HUman Movement and Advisory Network - aims to enhance the capacity of European Member States which accept migrants and refugees, to address their health needs, safeguard these populations from risks, and minimize cross-border health risks. The initiative focuses on addressing both the early arrival period and longer-term settlement of refugees. Past and current experience in Europe and elsewhere has been systematically reviewed to identify effective interventions for vulnerable groups and tools for assessing the initial healthcare needs of the arriving refugees including mental, psychosocial and physical health. Clinical protocols, guidelines, health education, health promotion materials and a training programme were developed for staff working at healthcare centres dealing with refugees and migrants. All these measures had to be evaluated and a final report for implementation in European settings produced to guide best practice in this important humanitarian effort.

The International Organization for Migration developed the EQUI HEALTH project aimed at improving the access and quality of health services, health promotion and prevention for migrants, Roma and other vulnerable minority groups, including irregular migrants. The 3-year action is prioritized by the European Union within the second EC Public Health Programme. The project is divided into three distinct but interrelated sub-actions: Southern EU Borders, Roma Health, and Migrant Health (which includes the EU and the EEA). In line with the aims of the Europe 2020 Strategy for fighting exclusion, this sub-action aims to foster a harmonized EU approach to access to and provision of healthcare for such populations, and to establish a mechanism for collaboration at regional and national level[9].

In line with Decision N° 1082/2013/EU of the European Parliament and of the Council on serious cross-border threats to health, and repealing Decision No 2119/98/EC, the RE-HEALTH project will contribute

[7] See: https://webgate.ec.europa.eu/chafea_pdb/health/projects/717307
[8] Know more at: https://webgate.ec.europa.eu/chafea_pdb/health/projects/717319
[9] IOM – Equi Health http://equi-health.eea.iom.int/

to improved capacity of EU Member States under particular migratory pressure to address the health-related issues of arriving migrants, while responding to cross-border health events and strengthening epidemiological surveillance, monitoring, and early warning, including preparedness, response planning, and coordination of national policies.[10]

The World Health Organisation (WHO)/Europe is working to strengthen the capacity of countries' public health services to deal with large influxes of migrants. The Public Health Aspects of Migration in Europe (PHAME) project conducts assessment missions in the Member States that are receiving or may receive large undocumented populations, to coordinate the health response to migration by identifying best practices and potential gaps in the public health sector before establishing contingency plans. The PHAME project aims to support the work of policy-makers, health planners, local health professionals and others who are responsible for providing quality health care to migrants. Its final objective is to develop expertise and capacity, as well as to identify and fill potential gaps in health-service delivery, including those for the prevention, diagnosis, monitoring and management of disease.[11]

[10] RE-HEALTH – International Organization for Migrants http://re-health.eea.iom.int/
[11] WHO Europe – The Public Health Aspects of Migration in Europe (PHAME) http://www.euro.who.int/en/health-topics/health-determinants/migration-and-health/policy

Austria

Projects addressing migrants' health needs in Austria mainly focus on the importance of easing access to healthcare services by reducing communication barriers for non-German-speakers. Migrants who do not understand the local language well enough are faced with higher barriers in accessing healthcare and social services than Austrians. For instance, there is evidence that migrants do not make sufficient use of preventive services. This increases the need for meeting migrants where they are staying and for projects that are adapted to these settings. These measures shall also be supported by migrants' communities in order to achieve an optimum level of acceptance.

The project "MiMi – Mit MigrantInnen für MigrantInnen" has three aims: facilitate access to healthcare, promote health and support health literacy for migrants in their respective native languages. Furthermore, it addresses the even more vulnerable group of migrant children and the sensitive issue of mental health, which adds value to the initiative.

The project is part of an international health programme, which is also implemented in two Austrian states (Vienna and Upper Austria). It has been developed by the Ethno-Medizinisches Zentrum e.V. (EMZ) in Germany and started as a pilot project in 2003. In Germany, the programme has been successfully implemented in about 60 municipalities.

In 2012, the MiMi project was launched in Vienna and later in 2014 it was also implemented in Upper Austria by Volkshilfe[12], a non-profit, non-party and trans-confessional organisation providing social services. EMZ provides expertise for the implementation in Austria.

In Austria, MiMi receives financial support by the Federal Ministry of Europe, Integration and Foreign Affairs (BMEIA) - also in charge of the evaluation of the project - and by the social health insurance agencies of Vienna and Upper Austria.

The programme provides language and culture sensitive health promotion services for migrants. These include special free education for socially engaged bilingual migrants to become "health guides" in the migrants' community.

The volunteer "health guides" disseminate information in their native languages at workshops organised for adults, children and young people. The themes include the Austrian healthcare system, nutrition and physical exercise, healthy ageing and nursing of the elderly, children's health, mental health, migration and health. The "health guides" have at their disposal quality-assured written information in various languages, including comprehensive contact details and addresses.

Two additional initiatives address communication issues for non-German-speaking patients in Austria, and provide interpreting and transcultural services.

[12] http://www.volkshilfe-wien.at/mimi_gesundheitslotsInnen

The first was originally implemented in 2011 by the Federal Ministry of Health and the Austrian Platform on Patient Safety. Non-German-speaking patients joined a working group, which was followed by the development of a concept on video interpreting services by the University of Vienna, the Ministry of Health and the Centre of translation sciences.

In 2013, a pilot project started that was organised by the Federal Ministry of Health and Platform on Patient Safety (Plattform Patientensicherheit)[13], involving 12 hospitals and 10 medical centres. Interpreting services were provided in Turkish, Bosnian, Serbian, Croatian and sign language. The project aimed at facilitating communication between foreign language speakers, as well as deaf patients and health professionals. The accompanying assessment activities focussed on the added value of video interpreting services for the health professionals involved, for patient safety, for liability issues and, in the long run, for cost containment in healthcare.

In 2014, after the test phase and evaluation, the SAVD Videodolmetschen GmbH[14] was established to continue the project and extend it to other public facilities, to the social sector and to private enterprises, with a view to optimizing the cost and benefit ratio. In 2015, SAVD won the public tender on video interpreting services for all public enterprises in Austria. In 2016, activities were extended to interpreting services during nights, weekends and holidays, with 7/24 coverage today.

Currently, SAVD is also operating in Germany and is making efforts to extend its activities to other European countries. Additionally, activities have been extended widely, but still include highly specialised services for the healthcare sector.

The second initiative aims to facilitate communication between migrants and health professionals. It is a postgraduate course on “Transcultural Medicine and Diversity Care”, organised by the Medical University of Vienna.

In order to support health literacy and self-responsibility of vulnerable groups, especially migrants, it is important to support the transcultural competences of health professionals. This includes understanding the diverse living environments and contexts of patients and adapting professional approaches accordingly.

This interdisciplinary course provides practical background information on how the socio-cultural environment may influence behaviour regarding health, illness and the body. It also looks at the psychosocial problems caused by migration, specific health issues and expectations of migrants regarding treatments.

The postgraduate course takes 5 semesters and is open to active working health professionals with practical experience.

[13] More information available at https://www.plattformpatientensicherheit.at/de/themen_004.htm
[14] More information available at http://www.videodolmetschen.com/ueber-uns/

Belgium

The big surge of refugee arrivals in Belgium, and the large number of minors (children and youngsters) among them, has pushed the Flemish Government to take action.

Most of the children arriving have experienced various traumatic incidents and need psychological and/or psychiatric treatment although this care is often inaccessible to refugee children and their families.

A recent UNICEF report[15] emphasizes the traumatic facet of the journey faced by migrants: "Often traumatized by the conflicts and violence they are fleeing, they face further dangers along the way, including the risk of drowning on sea crossings, malnourishment and dehydration, trafficking, kidnapping, rape and even murder…".

In spring 2016, the Flemish Government decided to provide for that year a temporary modest budget for some of the Community Mental Health Centres (CMHC) in Flanders: 1 Full-Time Equivalent (FTE)/province, 6 in total for Flanders and Brussels, to deliver ambulatory mental health care (for instance trauma treatment) to refugee children (and their families). Priority was to be given to unaccompanied minors that had been granted asylum and transferred to educational youth homes. Some youth institutions received supplementary capacity to create a home for this target group. The CAHMS -Children and Adolescent Mental Health Services- teams in the CMHCs deliver mental health treatment and care, both by individual consultations and by outreach measures and supervision for the youth professionals in homes, schools, educational consultancy centres, etc.

Zorgnet-Icuro is an umbrella organisation covering hospital care, care for the elderly and mental health. It works with the Flemish government in its efforts for improve mental health care. Zorgnet-Icuro supports the CMCHs that are involved in getting started with the initiative, and supervises activities. It also acts as a connector/mediator with the Flemish Government and data collector.

Currently, in addition to the Flemish Government and Zorgnet-Icuro, there are nine CMHCs in five provinces/counties and Brussels, an expertise centre specialized in refugee and migrant target group (Solentra) and several youth homes involved.

The implementation of the project was praised by the community and authorities, which may mean additional funding in the years to come.

The first feedback data collected shows that the initiative has been very effective in promoting this target group in mental health professionals' work. Given the project limited capacity, most CMHCs decided to involve several team members for a fraction of their working time rather than bringing in a professional to implement the project. This resulted in knowledge being spread more widely and

[15] UNICEF, 2016, Uprooted: the growing crisis for refugee and migrant children, available at: https://www.unicef.bg/assets/PDFs/2016/Uprooted.pdf

increased opportunities of mutual support. Some CMHCs even involved colleagues from other CMHCs in the province in order to reach a broader area.

Similarly, the project also reached beyond the narrow target group. Family members of the original target group as well as other children (and adults) on the run suffering from trauma or other mental health disorders were treated and listened to as part of the initiative.

Nonetheless, the first year of project implementation also provided possibility to draw conclusions on the constraints, namely the small budget allocated, the availability of resources to pay for interpreters, the restriction of only working with recognized refugees. The latter restriction does not apply when CMHCs operate in federal reception centres for asylum seekers.

The costs of the initiative can be estimated, with a different amount at each different stage reached:

1. Continuation of the project as first implemented in 2016;
2. Extension of the scope and inclusion of all CGGs;
3. Extension of the scope in each CGG to include services to adults, interpreters and additional operating cash.

The statistics of the Commissioner for Refugees show that in 2015 strikingly more unaccompanied minors applied for asylum. About 3,919 individual asylum applications were submitted. An age investigation by the Guardianship Service revealed that almost a quarter of the applications was submitted by adults at the time of the application for asylum. The exact number of underage applicants in 2015 is not known, because not all age investigations had been completed.

- Specific counselling or therapy: 3000 of the 4000 asylum applications were from unaccompanied minors. Half of these, that is 1,500, concerned the Flanders region. Overall, 60% of the asylum applications were successful, that is 900 approvals. Moreover about 40 to 50% of the minors whose application was successful might need trauma counselling. Indeed, if we assume that the prevalence is much higher in these children than in the general population, it seems realistic to estimate that 40 to 50% of the children require specific counselling or therapy. This would concern about 450 unaccompanied minor migrants in Flanders.
- Interpreters: currently the service is usually offered by the care centre, but there is a need to tackle the lack of interpreting services for specific languages.

As part of the project, every Full-Time Equivalent (FTE) performs 40 to 50 treatments a year. At least 10 FTEs were necessary for treating the unaccompanied children who arrived in 2015 only. Each project has also a remit to liaise, consult, support and train educational (non-psychiatric) professionals who are working with the children daily. As part of the project, these contracts count for half of a treatment performance period. This means at least 5 additional FTE are necessary for the entire team (+ 1 for Brussels). Therefore, in total, 15 FTE for the unaccompanied minors are required for Flanders and Brussels.

Extension to minors with trauma who are here with their parents, and for adults, provides a further argument based on the first hypotheses. Extension to adults, who most likely undergo similar trauma: + 15 FTE. "Unaccompanied" minors may need slightly less extra capacity (hypothesis): + 10 FTE.

Therefore, the estimated costs are:

1. For the continuation of the project as first implemented in 2016, about 450.000 EUR/year (personnel only in average 75.000 EUR/year);
2. For the extension of the scope and inclusion of all CGG, about 20*75000 = 1.5m EUR/year;
3. For the extension of the scope in each CGG to include services to adults, interpreters and additional operating cash, about 1.5m EUR/year*2= 3m EUR/year.

Cyprus

Cyprus is committed to protecting the right of refugees to receive the same level and quality of health care, with likewise respect and dignity, without any discrimination, regardless of citizenship, visa status or ability to pay. In addition, it has to be ensured that their individual needs, including cultural, linguistic, and health-related, are addressed. It is emphasized that the rights of patients must be respected and lower standards of care are unacceptable. In particular, the right to privacy and confidentiality must be protected.

Refugees need to receive health care as they often experience trauma in their country of origin and are susceptible to a range of diseases and conditions, including psychological disorders such as post-traumatic stress disorder, anxiety, depression, and the physical effects of persecution and torture. They may also suffer the effects of poor dental hygiene, poor nutrition and diet, and infectious diseases such as tuberculosis, which may be more common in their countries of origin.

The involvement of the Cyprus Ministry of Health, Medical and Public Health Services[16], starts with the Search and Rescue Team members, who are part of the compulsory crew of all search and rescue vessels, by air and sea. Given the geographical location of the island, refugees are coming to Cyprus's Exclusive Economic Zone (EEZ) on small fishing boats broadcasting an SOS signal for help.

The Search and Rescue Team members are continuously trained in order to maintain their efficiency of performance on board in providing the first health care assessment of refugees and the necessary treatment, in a culturally appropriate manner, with respect and dignity.

All refugees are gathered at an entrance point, at which all involved governmental services and humanitarian organisations will implement the action plan for the welfare of refugees.

The initial health screening for any obvious health problems is undertaken by a doctor or a nurse at the entrance point. After that a more thorough examination and assessment is carried out in the dispensary room which is set up for that purpose. All refugees with health problems undergo a comprehensive and timely health assessment in a culturally appropriate manner by suitably trained healthcare

[16] www.moh.gov.cy

professionals, who are part of a primary healthcare team. The healthcare team is composed of medical doctors, nurses, health visitors, paramedics or ambulance drivers. Apart from the healthcare team, one or two representatives from the Ministry of Health are on the scene, for detailed monitoring of all actions and reporting of any significant health findings. All such findings are referred to the doctor or person in charge and when indicated, in an emergency situation, the patient will be transferred immediately by Ambulance to the Accident and Emergency Department of the nearest hospital.

A few hours after their arrival in Cyprus, all refugees, except unaccompanied children, are transferred to the "Welcoming and Hospitality Centre for international protection applicants", to establish their temporary stay in the country, in the most appropriate and dignified way.

Unaccompanied children are never placed in detention, and are moved to a separate living area.

In the "Welcoming and Hospitality Centre", a healthcare team is rapidly developed and is composed of doctors, nurses and health visitors. This team is responsible within 24-48hrs for:

- Providing the necessary health care for sick people.
- Examining all refugees and taking blood samples for any contiguous diseases (HIV/AIDS, HEP B+C, Syphilis).
- Performing Mantoux (Tubercullin) to test all refugees for Tuberculosis.
- Performing all indicated Vaccinations (Polio, Tetraxim, HepB, etc.).

The one or two representatives of the Ministry of Health who accompany the refugees to the "Welcoming and Hospitality Centre" ensure that all the instructions and procedures for the health and wellbeing of refugees are implemented.

During the following days and as long as needed, the centre is covered on a 24-hour basis by a nurse, providing the necessary primary health care. When needed, the nurse contacts the "on call" doctor to provide more advanced health care.

Prolonged, indeterminate restriction of refugees contributes adversely to health. The longer a person is in constraint, the higher the risk of mental illness. All effort is made to enable refugees to return to their community as soon as possible.

Back in the community, the refugees have to be fully informed about the healthcare system of the country and how to access the full range of healthcare and medical options available.

Individuals who are released into the community must have timely access to their medical records from their stay in the "Welcoming and Hospitality Centre". Those who are deported should receive a copy of their medical record to take back with them.

The practice can be considered as a good example of responding to refugees' health needs. The teams engaged in the activities consist of officers from various Ministries and Organisations who have well defined roles. These persons are available 24/24 when the need arises. The response is quick and efficient. In addition, these teams carry out exercises at random times in order to maintain their responsiveness. However, these services are only possible as long as the numbers of migrants are relatively small.

Denmark

In Denmark, the Asylum Seeker Task Force provides hospitals with co-ordinated knowledge about legal issues regarding treatment and payment of asylum seekers in hospitals. This includes guidelines for hospital staff.

The programme started to respond to increasing questions about asylum seekers' rights to health care in hospitals.

The task force is placed under the administration of the Central Denmark Region[17] with the participation of two legal advisors and one head of office. It is a service provided at administration level, which has been created without increasing the budget.

Estonia

In the last years, Estonia has not been confronted with substantial migrant flows compared to other European countries. In 2015, only 226 people applied to Estonia, while in 2014 and 2013 the numbers were even lower, respectively 147 and 97. In 2015, 78 people were accepted as refugees. Most of the applications came from Ukraine and Russia, as well as from Georgia, Syria and Afghanistan. When refugees arrive in Estonia they are hosted in a special home and their state of health is examined by general practitioners or by specialist doctors if needed. All the refugees get the same healthcare services and health insurance under the same principles as other Estonian citizens. The Estonian healthcare system is indeed based on solidarity: some people are insured as they pay social taxes, other people are insured by the state or made equal to insured people by law (e.g. pregnant women, elderly, students, etc.).

The "Estonian Refugee Council"[18] is a non-profit organisation, giving assistance with cultural, social and labour market integration of refugees. The organisation is also involved in raising public awareness on refugee issues in Estonia and represents refugees' interests.

The Estonian Refugee Council launched a project to find volunteers to support refugees. Volunteers are asked to offer help and advice to refugees in areas such as: central and local government, local culture, employment, kindergartens, schools and education etc.. The volunteer support project started in September 2016 and the first round of training for volunteers took place in January 2016. The development of volunteer support project has received a budget of €22,434.

[17] www.rm.dk
[18] http://www.pagulasabi.ee/en

Finland

Health checks of asylum seekers in reception centres.

In Finland, reception centres are responsible for asylum seekers' social and health services. Therefore, all asylum seekers undergo basic health examination and screening for infectious diseases at reception centres.

Asylum seekers have the right to receive social welfare services that a relevant professional deems to be necessary (advice, guidance, dealing with social problems).

Adult asylum seekers are entitled to urgent healthcare services and also health care services that a relevant professional deems to be necessary. Minor asylum seekers are entitled to the same healthcare services as local people. Specifically, children under 7 years receive health and development screening at child health clinics, and all children are vaccinated. Additionally, vulnerable people (elderly, pregnant women, patients with disability, long-term illnesses or traumatised people) receive all necessary health services.

The process that asylum seekers undergo in the country starts with the registration centre. Later, they are transferred to the reception centre, where they receive a health check within two weeks. Nonetheless, emergency healthcare services are available during daily office hours (e.g. in case of fever, infection, pain, etc.). Health checks are performed by nurses who can always consult a doctor via telemedicine. The health check for an adult includes an individual interview, thorax x-ray, laboratory examinations (within three months) and vaccinations.

Additionally, general health information is provided to migrants in their own languages as a group, a family or an individual. The information consists of: what the health service is, how the health system functions, the right to complain, written consent to document the information in patient records, transfer of the information and summary of the hospital stay.

All reception centres in Finland operate under the guidance of the Immigration services and organise the necessary reception services.

France

Calais, in France, has seen large numbers of migrants and refugees coming from Eritrea, Syria, Pakistan, and Afghanistan waiting for an opportunity to cross the English Channel. They lived in shacks or tents, in little security and bad sanitary conditions. In October 2015, more than 6,000 migrants lived in the camp, and according to the last census, in May 2016, this number dropped to 3,913 migrants.

Triggered by a national plan on healthcare access, the "PASS" system was created in 2006 at the Centre Hospitalier de Calais. PASS stands for "Permanence d'Accès aux Soins de Santé" or "Permanency of Access to HealthCare". The initiative involves medical centres allowing people living in precarious conditions to be taken care of, with guaranteed free medical assistance. In Calais, the PASS office was taking care of around 100 to 120 migrants per day. Those who could not be taken care of in the centre (between 15 and 20) were referred to the hospital PASS. Therefore, around 80% of the migrants and refugees were treated in the Jules Ferry centre PASS office, while 20% were transferred to the hospital for more specific treatments.

The PASS system developed according to the timeline below:

- In March 2015, the IDE - nurses' consultations - were created in the Jules Ferry centre.
- In October 2015, the hospital PASS office was extended to medical consultations, psychologists, physiotherapists, and medicine prescriptions.
- In March 2016, the Calais PASS office was moved to a clinic next to the Jules Ferry centre.
- Eventually, on 13 April 2016, a "medical and post-discharge care" service of 16 beds was created next to the Jules Ferry camp to take care of migrant patients not anymore in need of hospital care.

The initiative involved several organisations within the Centre Hospitalier de Calais, namely the medical supervisor of the PASS and his team, the Director of Care, the Regional Care Agency (ARS - Agence régionale de Santé) with its General Representative and Coastline Territorial Representative.

The activities required investment in terms of training and education. Specifically, cross-cultural communication, hygiene and foreign languages (especially English and Arab) were essential. Thanks to previous experiences with migrants at the Calais Hospital and the PASS system, the programme offered its staff a course in cross-cultural communication.

Moreover, since 2006, the Calais hospital already had an interpreter working full-time in the PASS office of the hospital. With the creation of the second PASS office in the Jules Ferry camp, a second interpreter was hired. Moreover, the office also has two doctors mastering English, Arab and Central Asian languages.

The practice can be considered as a good example of assistance provided to migrants because of:

- The strong rallying of all the required resources (finance, human) in order to open within 48 hours a branch of the PASS at the Jules Ferry refugee camp while respecting the same operating conditions as the PASS hospital.
- Translation of all forensic documents in order to collect patient's consent and identity. The translation process was internally driven, with the maximum involvement of the hospital staff. Sometimes, the migrants themselves translated very specific subjects. In rare cases, an official translator was requested.
- Extended coordination with other people working in the camp and involved with the migrants and refugees (mostly associations). Every month, a medical meeting was held in order to draw

conclusions, plan and coordinate actions. This unity is also geographical as the different buildings are all gathered in the same place.

- Adaptation of the medical regulation to the specific situation of the migrants and refugees (cultural differences, language barriers, continuous care and specific cases like abortion). There is a strong necessity to be non-judgemental and pragmatic.

The PASS system costs in total €800 000, as €300 000 has been added to the original € 500 000. The medical and post-discharge care service and its 16 beds cost €635 000.

Germany

According to the German Asylum Seekers Assistance Law, undocumented migrants in Germany are – like asylum seekers – entitled to health care in cases of acute illness and pain, and maternity care. However, access to medical care for undocumented migrants is severely limited by the administrative procedures for obtaining subsidised care and the German Residence Act, which requires all public bodies, except educational institutions, to notify the immigration or competent police authorities if they obtain information about someone without a valid residence permit. This requirement does not apply to healthcare providers or their administrative staff, due to extended medical confidentiality.

Medibüro Kiel[19] works in a network of 32 Medibüros (Medical offices) and Medinetze (Medical networks) which provide access to health care to undocumented migrants across Germany. Several of the offices, which are largely independent of each other in their operations at local and regional level, cooperate with their local and regional authorities to both meet the immediate medical needs of undocumented migrants, and work towards a more sustainable solution that integrates the provision of health care for undocumented migrants into the public health service.

Recognising the need for undocumented migrants to access health services at the local level, several cities in Germany are taking measures to provide care, in cooperation with civil society, by setting up drop-in centres and providing specific services, such as vaccinations for children and care for pregnant women.

The initiative is also particularly useful in light of the fear often experienced by undocumented migrants of being denounced when seeking access to healthcare.

[19] More information available at http://www.medibuero-kiel.de/english/

Malta

The Migrant Health Liaison Office[20] was set up within the Department of Primary Health in August 2008 in response to the large influx of irregular migrants. This initiative aims to make quality healthcare provision to migrants more accessible. It provides the necessary information/education to migrants about health issues. It does this by overcoming language, cultural and health practice barriers.

On a day-to-day basis, the office, mainly engaged in the provision of primary health care, liaises with other government entities and other stakeholders working in the field of migration. Since its set-up, the activities of the office have been run regularly and are still ongoing.

The main activities of the Migrant Health office include provision of:

- health education sessions to migrants in open centres;
- a Health Orientation Programme for relocated migrants on arrival to Malta from another Member State;
- a training programme to cultural mediators in health care;
- support for trained cultural mediators working in Primary Health Care;
- outreach services on a one-to-one basis for migrants suffering from chronic conditions: diabetics, persons who do not know how to access a certain service, persons who need urgent appointments, etc.;
- translated health literature for migrants.

The complexity of cases at times requires detailed interdisciplinary work and communication between nursing, medical, social work, public health, psychiatry and other stakeholders. While a resolution to individual cases and service problems is possible, this process can be time consuming and equally complex. It can require education and training for health and social care professionals, teachers, immigration police, and university students on cultural issues in health care, female genital mutilation, human trafficking, etc.

The office was also involved in various training programmes as part of EU projects. Currently the unit is leading an EU-funded CARE Project as part of the Third Health Programme. The CARE Project will be providing training for health and non-health stakeholders who work with migrants.

Over the past years the office has worked amid large and medium influx of irregular migrants arriving in Malta. To date the demographic picture is still changing and therefore the office allows for flexibility and works by prioritization of arising issues.

An in-service study focused on the needs to address 'Language Barriers at Mater Dei Hospital' which served as the tool to create a working group to implement a cultural mediation service at the hospital.

[20] More information available at https://health.gov.mt/en/phc/mhlo/Pages/activities.aspx

Another in-service study, 'OYO: One Year On' has looked at the service of cultural mediators at a local health centre one year following the introduction of the service. This study revealed that cultural mediators facilitate clinical encounters and reduce frustrations of health professionals when confronted by migrants and their health issues.

The training programme: 'Cultural Mediators in Health Care' which was developed by the Migrant Health Liaison Office has been evaluated according to the evaluation sheets handed to the candidates and internship students who participated in the training sessions. To date 13 groups (100 migrants) have received the training.

In July 2016, the Migrant Health Liaison Office was invited by IOM Slovenia as a trainer for a one-week "Introductory Course for Cultural Mediators" in Ljubljana. Slovenia has experienced migratory pressures in the last six months and is currently trying to set up a cultural mediation service similar to the one in Malta. The training was organised by IOM Slovenia and funded by the Council of Europe Development Bank and the Migrant and Refugee Fund.

The total estimated annual cost of the service is rather low (€40,675), as it entails the costs for the payment of a full-time liaison officer in the grade of a charge nurse (~ €23,021), the payment for the services of two cultural mediators working in total 48.5 hours per week (€17,654).

Spain

In Spain different entities deal with migrant health care. From non-governmental organisations to Regional Health Services or Immigrant Temporary Holding Centres, good practices have been identified at different levels and could be extended to the rest of the country.

In Ceuta, good practices by associations have been identified with a focus on pregnant women and midwives. One example is an initiative to introduce pictograms for pregnant women as a communication tool to overcome the language barrier, an initiative by the 'Hospital de la Cruz Roja, Ceuta Asociación Andaluza de matronas'.

Pictograms were developed by midwives in order to allow pregnant women admitted to obstetric wards to communicate with healthcare professionals. The initiative was launched in 2006 after it was observed that many pregnant immigrants who had been admitted to Ceuta hospital didn't speak Spanish, thus causing communication problems with hospital staff (30% of childbirths in the Ceuta hospital are from women coming from Morocco). These women, who only speak local dialects, are often unable to communicate with healthcare professionals due to the lack of translators for their languages. Most of the time these patients have not had any contact with healthcare services before delivery as they cross the border just before. The lack of previous laboratory tests, ultrasound or any kind of pregnancy clinical record or follow-up data prevents the obstetricians and midwives from adopting adequate measures during deliveries. The aim of the initiative was to increase access to

adequate quality healthcare services and to promote equitable access to health promotion and care for migrants.

The initiative was launched by two midwives from the Ceuta hospital[21], another from Algeciras hospital (Andalucía) and a graphic designer. It was implemented after several months of design and interpretation of the symbols and translations. It was implemented in the Hospital of Ceuta and then in Melilla, in the hospitals and primary health centres of Andalusia and in many hospitals in Spain, Africa, Latin America, China, Europe. Its use is intuitive so no training was needed. Its utility and efficiency were observed from the beginning of the implementation as it has allowed aspects of clinical records to be compiled which would otherwise have not been possible. This tool has been translated into several languages.

It is a very useful support tool for healthcare professionals to provide adequate care to refugees and immigrants (women and their families) despite the language issue. Furthermore, the picture system allows the illiteracy issue to be overcome and lets patients indicate how they feel at any time. This project received an award at regional level in the category "Innovation in relation to citizenship". The next stage of the project should be the production of an in-depth study to verify the effectiveness of the pictogram. Actual costs have not been determined but as the pictograms are already designed, the cost will depend on the material to be used and limited to a brief training course for midwives.

In Galicia, the Regional Health Service (Servizo Galego de Saude) is behind a screening protocol for Chagas disease in pregnant women.

As a consequence of population migration flows in Europe, there are people infected with the Chagas disease in areas that are not endemic, and that is the case of Spain. The most important route of vertical transmission of this disease in Spain is through pregnancy because there is not vector-borne (like bugs for example).

The vertical transmission rate stands at 4-7% on average reaching 12.5% depending on the country of origin. In Galicia, there are estimated to be around 800 people infected with this disease, according to data by the Ministry of Health. Thus, a protocol for the detection of antibodies anti-T. cruzi is highly recommended in pregnant women at risk (mostly migrant women from endemic zones like Latin America) and their relatives living in this region.

This initiative was led and developed by health professionals from the Health Service of Galicia (paediatricians, gynaecologists, pharmacists, midwives and technical personal of the General Directorate of Health Assistance and General Directorate of innovation and management of the service Galician Service of Health) and implemented from January 2013 in the Autonomous Community of Galicia[22].

No special training is required and the protocol is reviewed annually by a working group consisting of gynaecologists, midwives, internal medicine specialists, microbiology specialists, haematology and nurses. This initiative complies with the criteria of adequacy, relevance, evaluation, and is based on the

[21] http://www.areasanitariaceuta.es/atencion-especializada/hospital-universitario-de-ceuta/
[22] http://www.sergas.es/gal/Publicaciones/Docs/AtEspecializada/PDF-2215-ga.pdf

latest scientific knowledge. This protocol was considered a good practice by the Ministry of Health and was published on its website in order to extend it to other regions.

In Melilla, the Immigrant Temporary Holding Centre (CETI in Spanish), which depends on the Ministry of Employment and Social Security, inaugurated in February 2016 a solidarity dental clinic ("A smile for the CETI"). This initiative ensures the provision of free preventive and therapeutic dental services to irregular immigrants received in this Centre[23]. While solidarity dental clinics are already working in other parts of Spain, it is the first one in the world to be set in an Immigrant Temporary Holding Centre, thanks to the altruist collaboration of various agencies which made donations (Colegio de Dentistas de Melilla, la Fundación de Odontología Social Luis Séiquer, la Fundación Obra Social La Caixa y el Consejo General de Odontólogos de España). No training is needed as the service providers are professionals whose commitment and ethics are valued by the General Council of dentists of Spain which awarded the project twice in 2013 and 2015

Sweden

In Sweden, the county councils/regions are responsible for health and medical care. Therefore, they are beneficiaries of special state grants to finance health and medical care and dental care for asylum seekers and newcomers.

The good practices identified so far in the provision of health care to migrants in different regions have been listed on the Swedish Association of Local Authorities and Regions (SALAR) website. The repository collects examples of activities aimed at improving integration and reception of asylum seekers and new comers. A specific section is devoted to good examples in health care. Most measures relate to primary care and health examinations, but there are also examples from hospital care and dental care. SALAR also facilitates experience sharing about efforts to improve mental health services for asylum seekers and newcomers.

These good examples of new methods for health examinations, originally reported on the SALAR website in Swedish, include:

- Centralized asylum and refugee health care[24]

Some county councils/regions have centralized the health examinations and are not conducting them at all in health centres. Instead, a special organisation has been set up for medical screening of asylum seekers and newcomers – partly to increase coverage and improve the implementation of these examinations, partly because the staff has gained special expertise in this field.

[23] http://www.cooecs.es/la-unidad-de-atencion-dental-solidaria-del-centro-de-estancia-temporal-de-inmigrantes-de-melilla-inicia-su-actividad/

[24] Example from Region Gavleborg.

- Mobile teams[25]

Many county councils/regions have created mobile teams of health professionals who visit asylum accommodation centres, and thereby offer and carry out health checks where the asylum seekers and newcomers live. They also provide information on the Swedish healthcare system, as well as guide those persons who need further contacts with the healthcare system.

- Health communicators to promote good health among newly arrived[26]

Several county councils, regions and municipalities have employed special health communication specialists. The purpose is to promote good health among the newly arrived and asylum seekers through information, knowledge sharing and dialogue in the mother tongue. The health communication specialists speak Swedish and languages that are common among the newly arrived. They have a health-related education and cultural competencies that facilitate the process of information dissemination and dialogue on health. The communicators' mission also usually includes knowledge sharing about the specificities of the Swedish healthcare system.

The purpose of health examinations is to detect illnesses and to offer and plan care and infectious disease control for the benefit of both the individual and the society. These examinations also give an opportunity to provide information about the Swedish healthcare system. The examinations are important both to determine the need for care in general, and from an infection control point of view. However, it is problematic to offer all asylum seekers a health examination. In 2014, almost half (44%) of all asylum seekers had a medical check-up. For this reason, it is important to find measures to increase the proportion being examined.

Switzerland

Whereas asylum seekers are systematically screened for tuberculosis (TB) upon entry to Switzerland, hard-to-reach groups such as homeless and undocumented immigrants are not so, despite having high risk of infection. Geneva's health and social authorities have designed a collaborative project to screen for active TB in shelters for homeless and undocumented migrants with specific measures to improve transition to hospital.

The Federal Office of Public Health has developed a diagnostic tool to diagnose TB[27]. Moreover, healthcare practitioners are supported by an interactive tool which aims to facilitate TB diagnosis. The tool provides a clearer understanding of the TB and aims to help patients and healthcare practitioners communicate better.

[25] Examples from Västmanland, Västernorrland and Sörmland.
[26] Example from Skåne, Stockholm and Östergötland
[27] More information available at: http://www.tb-screen.ch/app/report/formularen.php and http://www.tbinfo.ch/fr/prestations/tb-screen.html

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