World Health Organization

REGIONAL OFFICE FOR **Europe**

COMPENDIUM

of health system responses
to large-scale migration in
the WHO European Region

COMPENDIUM
of health system responses
to large-scale migration in
the WHO European Region

Abstract

The scale of international migration in the WHO European Region has increased substantially in the last decade. The dynamics of large-scale migration pose specific challenges and opportunities to health systems, and responses will differ from country to country. Strengthening health system responses is one of the priority areas in the 2016 *Strategy and action plan for refugee and migrant health in the WHO European Region*. Its agreed actions include the identification and mapping of practices for developing and delivering health services that respond to the needs of refugees, asylum seekers and migrants. This compendium aims to collect and present some of these practices in the form of case studies. Selected in 2016, the case studies reflect experience from different levels of administration in a variety of European countries, and during the different phases of the migration journey.

Keywords

Contents

Acknowledgements

About the compendium

Recent years have demonstrated the speed at which migration flows can evolve, and the impact they can have in terms of both the numbers of people affected and the rapidity with which people can move from one part of the world to another. These events highlight the ways in which sociopolitical circumstances or natural disasters in countries of origin can override the demographic plans of transit and host countries.

Large migration inflows pose specific challenges to health systems. They require an understanding of context and a nuanced and informed approach to refugee and migrant health – an approach that will, by the very nature of migration, differ from country to country.

In 2016, at the 66th session of the WHO Regional Committee for Europe, European Member States adopted the *Strategy and action plan for refugee and migrant health in the WHO European Region*[1], which includes renewed commitments for WHO and Member States to work on migration and health. Strengthening health systems and their resilience is one of the priority areas identified in this document. It states that refugees and migrants should be provided with all necessary health support in the initial stages of the migration process; assisted in overcoming the difficulties of arriving in a new environment and using a new health service; and, subsequently, offered all essential, necessary and appropriate health services, according to available resources.

To meet these objectives, one of the actions agreed was the identification and mapping of good practices in developing and delivering health services that respond to the needs of refugees, asylum seekers and migrants.

In view of the increased scale of migration in the past decade, countries possess more and more experience related to improving the responsiveness of health systems to adequately address the health needs of these mobile groups. This compendium aims to collect some of these experiences in the form of case studies. The case studies were selected in 2016 to reflect experience from different levels of administration in a variety of European countries, and during the different phases of the migration journey. Each case study specifies the precise population group of focus (refugees, asylum seekers and/or migrants).

Health system responses to large-scale migration in the Region are diverse and context-specific. As such, this compendium does not aim to provide a comprehensive and detailed picture of all responses, but rather to illustrate such diversity through a limited selection of case studies covering the different functions of the health system.

---

1   Strategy and action plan for refugee and migrant health in the WHO European Region. Copenhagen: WHO Regional Office for Europe; 2016 (http://www.euro.who.int/__data/assets/pdf_file/0004/314725/66wd08e_MigrantHealthStrategyActionPlan_160424.pdf, accessed 26 November 2018).

1 Intercultural mediation in Belgian hospitals:

structural integration of mediation practices between health professionals and patients from ethnic minority groups

Author information

Liv Stubbe Ostergaard, Research Associate, Danish Research Centre for Migration, Ethnicity and Health, Department of Public Health, University of Copenhagen, Denmark

Allan Krasnik, Professor, Danish Research Centre for Migration, Ethnicity and Health, Department of Public Health, University of Copenhagen, Denmark

Key messages

- Following the arrival of a large number of migrants from Morocco and Turkey to Belgium in the 1970s–1980s, the Intercultural Mediation (ICM) programme was established in hospitals, primary care centres and asylum centres, The Federal Public Service (FPS) Health, Food Chain Safety and Environment provided funding.

- The objectives of the ICM programme are to overcome linguistic and cultural barriers and improve communication between health professionals and migrant patients from ethnic minority groups, thus improving the accessibility and quality of care, enhancing the responsiveness of the health system and reducing inequities in health-care delivery.

- Intercultural mediators usually share a similar cultural background with the patients, which allows them to work from a relationship of trust. They come from different professional backgrounds, such as nursing, social work, philology, psychology or medicine.

- A three-year training curriculum was initially developed for mediators. However, training programmes are now only organized in an ad hoc basis due to low participation.

- The Intercultural Mediation and Policy Support Unit of the FPS Health, Food Chain Safety and Environment conducts regular monitoring and evaluation of the ICM programme to improve the service. Ongoing challenges relate mainly to the working relationship between mediators and health professionals, the lack of comprehensive training programmes and funding, and the needs and difficulties experienced by the mediators themselves. Yearly assessments are conducted to decide upon the continuation of funding.

- In addition, since 2009, the Video Remote Intercultural Mediation project offers services in 20 languages with the aim of extending mediation services to a larger number of hospitals and primary care centres.

- Today, about 100 mediators are employed onsite in 52 general hospitals and 12 psychiatric hospitals in Belgium. In addition, about 70 hospitals, 20 primary care centres and 10–20 medical care centres of Fedasil, the Federal Agency for the Reception of Asylum Seekers, make use of the video mediation services.

Intercultural mediation in Belgian hospitals: structural integration of mediation practices between health professionals and patients from ethnic minority groups

3

1. Introduction

Since 1999, the Federal Public Service (FPS) Public Health, Food Chain Safety and Environment in Belgium has funded the use of intercultural mediators in general and particularly in psychiatric hospitals. In addition to in-person mediation, video mediation in over 20 languages is also available in hospitals, primary care centres and asylum centres.

Intercultural mediators are employed to improve the quality of communication between health professionals and migrants from ethnic minority groups, as well as to increase the responsiveness of the hospital environment to their sociocultural and health-care needs and reduce health-care inequalities.

The mediators are full employees of the hospital and are thus also subject to the institution's rules and procedures. They are involved in interpreting and facilitating communication during encounters between patients and health professionals (including cultural brokerage, helping patients take up their role in the health-care process), and conducting advocacy activities at the individual and group level *(1)*.

The Belgian Intercultural Mediation (ICM) programme is structurally integrated in the regular system of hospital funding financed by the Federal Government and the national health insurance system. Several well established assessments and evaluations of the programme have been conducted.

This case description is primarily based on an overview article with material from two evaluations of the ICM programme, conducted in 1997 and 2000 *(1)*, as well as a 2016 guide for setting up ICM programmes produced by the Intercultural Mediation and Policy Support Unit in Belgium *(2)*. In addition, it draws from an interview with Hans Verrept, Head of the Intercultural Mediation and Policy Support Unit at the FPS Health, Food Chain Safety and Environment.

2. Context

The initiation of the ICM programme is the result of demographic and political developments in Belgium in the 1970s and 1980s, when labour migrants came to the country from Morocco and Turkey. Many of the newcomers did not speak any of the three national languages in Belgium (French, Flemish and German), and hospitals and other health facilities experienced linguistic and cultural challenges in treating these patients. Such barriers impact negatively on accessibility and quality of health care, and could affect the rights of the patient as well as their treatment.

To address this, the Government created the Royal Commissariat for Migration Policy to commission experts to prepare policy recommendations for the different fields relevant to migration. The Centre for Ethnic Minorities and Health, which consists of a group of medical doctors, medical sociologists and anthropologists, prepared the health-related recommendations. One of their recommendations was that intercultural mediators be trained and employed in the health-care system in order to overcome linguistic and cultural barriers and to improve the accessibility and quality of care delivered to migrants from ethnic minority groups.

This recommendation led to the initiation of the Intercultural Mediation in Health Care project in 1991, in which mediators were trained and employed in the health-care sector. The project covered a five-year period. Ministries of the Flemish Region and Brussels provided financing, and the Flemish Centre for Integration of Migrants and the nongovernmental organization Foyer coordinated its implementation.

Its three-year curriculum for training mediators included formal tuition, learning on the job, and intensive supervision and coaching. After completing their training, most mediators continued to work in different sectors of health care. The Government chose to use intercultural mediators (as opposed to interpreters) because they had larger roles to play: they were tasked with overcoming language barriers, but also sociocultural barriers and the consequences of interethnic tension, racism and discrimination *(2)*.

During the second half of the 1990s, the project was largely integrated within the regular structures of the health-care system – first in special clinics for mothers and babies and afterwards in hospitals. When a royal decree stipulated that a certain amount of money should be available for intercultural mediation in the regular hospital budget, the FPS Public Health, Food Chain Safety and Environment provided funding. In addition, the Video Remote Intercultural Mediation project was initiated in 2009 in order to reach more people and limit expenses related to transportation of mediators.

3. The issue: integrating intercultural mediation services in hospitals

a. What is it?
Belgium set up an ICM programme in Belgian hospitals administered by the Intercultural Mediation and Policy Support Unit under the FPS Public Health, Food Chain Safety and Environment, as well as a Video Remote Intercultural Mediation project funded by the national health insurance system. These two projects define intercultural mediation as all activities that aim to reduce the negative consequences of language barriers, sociocultural differences and tensions between ethnic groups in health-care settings *(2)*.

b. Who delivers the service?
The services are provided by mediators who usually share the cultural background of the patient, and work from a relationship of trust. The mediators come from different professional backgrounds such as nursing, social work, philology, psychology and, for some, medicine.

c. Services provided and target group
The mediators commonly accompany patients to consultations and take on the tasks of interpretation, cultural and social decoding, listening and advising, conflict resolution and advocacy for patient rights. Newcomers especially benefit from the services of a mediator, as they tend to lack connections in their new society *(3)*.

In Belgium, 50–60% of the interventions are for Moroccan and Turkish patients, as this large migrant group is comprised of many individuals who are ageing and speak little French, Flemish or German. Russian-speaking patients are also using the services; however, many Russian-speaking migrants have been sent back to their countries of

Intercultural mediation in Belgian hospitals: structural integration of mediation practices
between health professionals and patients from ethnic minority groups

5

origin. There has been a large increase in Arabic-speaking patients, and Dari- and Farsi-speaking patients also comprise a rather large group.

The roles performed by mediators are summarized in the ladder model in Fig. 1.

One aspect of mediators' role is to perform triadic interventions, in which the identification of cultural and social issues as well as interpreting and cultural brokering are important dimensions facilitating contact between patients and health professionals. Another is discussing with health professionals those cases where something is hampering smooth collaboration. Here, mediators provide information on how to make services more culturally acceptable.

"An important task of the mediators is to remove fears from the care providers who have little experience with ethnic minority patients, and who have all these imaginations of 'don'ts'. Here the mediators can explain which things are acceptable for Belgians that may not be acceptable for someone from their own group."

– Hans Verrept
Head of the Intercultural Mediation and Policy Support Unit
at the FPS Health, Food Chain Safety and Environment

In some cases, health professionals engage mediators when their patients do not speak French, Flemish or German, as they prefer mediators who are familiar with patient navigation and culturally competent care rather than just translation. Because the mediators work for the hospital, they are dedicated to facilitating care in this environment. Other health professionals only call upon the mediators only when interaction with a migrant patient is problematic.

The practice of intercultural mediation is becoming more and more common and integrated. A patient, nurse or social worker working at the hospital can also call upon mediators; however, most interventions involve medical doctors.

d. Training
The schools that initially offered the three-year training programme stopped doing so because the number of candidates was too low. Currently, no comprehensive training programme is available for the mediators. Foyer is still training mediators and organizes training sessions funded by the Flemish Government.

Within the context of the ICM programme, regular training courses are organized at the hospitals, in particular on interpretation and guidelines for the work of intercultural mediators in health care, as well as on relevant topics such as patients' rights, cultural brokerage, working in mental health care, dealing with conflicts, etc. However, this is carried out on an ad hoc basis.

Fig. 1.   The ladder model of intercultural mediation

VISIBILITY

Advocacy

Help provider/patient take up their roles

Culture brokerage

Resolve misunder-standings

Linguistic interpreting

FACILITATION
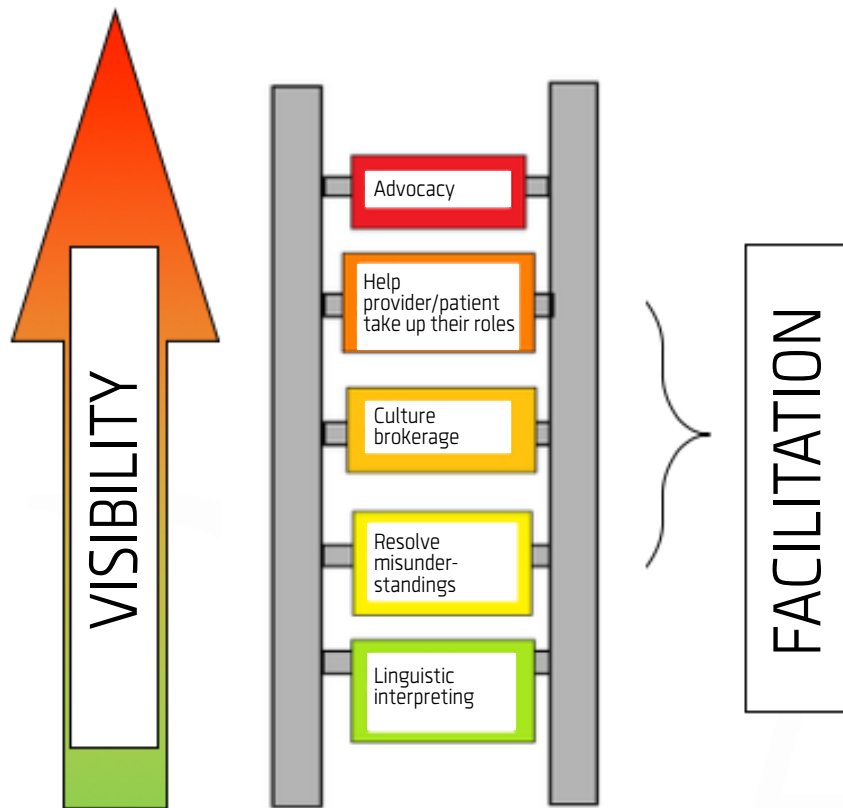
Source: reproduced by permission of the publisher from Verrept & Coune *(2)*.

Twice a year, mediators are invited to take part in obligatory supervision sessions during which trouble cases are discussed *(4)*. In some universities, health professionals receive some training in the use of mediators. The Intercultural Mediation and Policy Support Unit has previously held trainings for the health professionals, but very few showed up for the sessions.

e. Quality management

According to the royal decree, intercultural mediators must fulfil certain requirements to be eligible for funding. The candidates must have completed a university degree in the field of medicine, paramedicine, anthropology, translation or interpretation. In addition, they must have undergone training in the field of intercultural mediation or be able to prove relevant experience of at least two years in this field.

Intercultural mediation in Belgian hospitals: structural integration of mediation practices
between health professionals and patients from ethnic minority groups

7

Candidates with a secondary-school diploma can also apply by providing a training certificate and/or proof of experience in the field of intercultural mediation equivalent to a university degree. In some cases (for instance, if a candidate with relevant language skills does not fulfil required educational background), the hospital can make a specific request to the Intercultural Mediation and Policy Support Unit to waive the diploma requirement. The final stage of their recruitment process takes place at the same unit, which assesses the would-be mediator's interpretation skills *(5)*.

The Intercultural Mediation and Policy Support Unit assesses the ICM programmes at the hospitals on a yearly basis, and bases further funding on their efficiency and effectiveness. It makes use of specially designed questionnaires to register the activities of the mediators. In addition, mediators' activities are observed through participant observation, and meetings are held with both representatives of the hospitals and mediators. During these meetings, hospitals receive feedback based on the data collected by the Intercultural Mediation and Policy Support Unit. Representatives of the hospitals have the opportunity to provide essential additional information on the functioning of the mediation, and to suggest strategies for improvement *(1)*.

f. Organization and funding

The ICM programme at the hospitals is organized and funded by the state through the hospital budget. The Intercultural Mediation and Policy Support Unit manages the programme, administers the budget, and is in charge of the monitoring, evaluation and continued education of the mediators.

Hospitals can apply for funding and, if they fulfil certain criteria (for example, criteria related to the number of ethnic minority patients) and if there is money left in the budget, they can receive a separate budget for the employment of one or more mediators to work on premises. The hospitals employ the mediators but, as described above, mediators must fulfil certain requirements defined by the Intercultural Mediation and Policy Support Unit to be eligible for funding.

In addition, some mediators are employed by the Video Remote Intercultural Mediation project, which is co-funded by the FPS Health, Food Chain Safety and Environment and the National Institute for Health and Disability Insurance (INAMI-RIZIV). In this project, mediators intervene through videoconference equipment using Google Hangout and a special application developed for the ICM programme. The aim of this project is to make intercultural mediation available to a larger group of hospitals and primary care centres. The project will also be implemented in nonresidential care, which will lead to the employment of an as-yet unspecified number of supplementary mediators *(4)*.

Since 2007, Foyer's Intercultural Mediation in Health Care project has employed about 12 mediators who focus on work with Roma people *(5)*. Mediators also work in mother and baby clinics.

Hans Verrept explained that the annual budget for onsite mediators in the hospitals is about 2.5 million euros, and around 1 million euros for the video mediation.

4. Impact and lessons learned

Today, about 100 mediators are employed onsite in 52 of the 215 general hospitals and in 12 psychiatric hospitals in Belgium. Together, they carried out over 110 000 interventions in 20 languages in 2013 *(4)*. Furthermore, Hans Verrept noted that about 70 hospitals, 20 primary care centres and 10–20 medical care centres of Fedasil make use of the video mediation services. In 2015, 5000 video interventions were carried out.

In 1993–1995 and again in 1997–2000, the ICM programme was evaluated using mainly qualitative methods *(1)*. The first study primarily focused on the effects of intercultural mediation on the quality of care and the problems associated with the introduction of intercultural mediators in hospitals. The second study also placed an emphasis on the problems associated with the introduction of the programme in hospitals and the quality of the interventions of the mediators.

The following sections are based on insights from these evaluations as well as the interview with Hans Verrept. They describe some of the initial successes and challenges experienced in the ICM programme and how the challenges have since been addressed.

a. Effects on the quality of care
Both evaluations found that intercultural mediation, when adequately used, improves the quality of care for patients from ethnic minority groups. Some of the main insights from the evaluations pointed to the following.

i. Improved communication
Mediators facilitated the exchange of correct and detailed information between health professionals and patients. This was a result not only of the mediator's actual work, but also of patients' feeling less inhibited about telling their stories with the mediator present (and/or in the absence of an informal interpreter such as a child or spouse). In addition, data from the evaluations suggest that adaptations in communication strategies and style contribute to the effectiveness of interactions with patients from ethnic minority groups.

> *"In combination with an element of trust, we find that the patient gets better care and he/she feels at ease with discussing issues he/she wouldn't have been at ease with without the presence of the mediator."*
>
> **– Hans Verrept**

Intercultural mediation in Belgian hospitals: structural integration of mediation practices between health professionals and patients from ethnic minority groups

9

ii. Providing culturally sensitive care

In some hospitals, the mediators suggested ways to better adapt the hospital environment to the presence of a culturally diverse clientele (for example, several hospitals provide a room for Muslim patients to pray). Hospitals also adapted certain procedures to make them more acceptable to ethnic minority groups, and adapted diets to different eating habits. Mediators were able to resolve a number of conflicts between health professionals and patients from ethnic minorities, and sometimes successfully defended their clients against insensitive and racist practices.

iii. Effects on patient satisfaction

Especially at the hospitals, the presence and interventions of the mediators contributed tremendously to patient satisfaction. This also holds true for patients for whom the intercultural mediator did not provide interpretation services. They felt less isolated and lonely. Patients very often expressed their gratitude to the mediators. They also stressed this aspect during the interviews with the researchers, stating, for example, that "meeting someone of your own country at the hospital gives you a feeling as if your heart is opening up".

The feelings associated with the presence of someone of their own ethnic group seemed to be more important to patients than whether or not the mediators helped them to cross linguistic and cultural barriers. Many interpreted the fact that the hospital was funding an ICM programme as a sign that the hospital actually wanted to help them.

b. Problems associated with the introduction of intercultural mediation in hospitals

In the evaluations, a range of challenges regarding the introduction of the ICM programme in hospitals became apparent. These challenges and the approaches taken to overcome them are presented below and in the section on lessons learned.

i. Low number and type of interventions carried out by intercultural mediators

The evaluations showed that many health professionals did not rely on mediators when they encountered a linguistic or cultural barrier. The data suggests that the effectiveness of the ICM programme was seriously hampered by the relatively low number of interventions in which health professionals, patients and mediators met together.

ii. Insufficient preparedness of intercultural mediators

The quality of the interpretation done by the mediators was often poor. As in many other programmes, the mediators had been insufficiently prepared to perform their task well. In addition, most health professionals had received no training whatsoever on how to cooperate with mediators. Both factors meant that the interventions of the mediators and the communication process between health professionals and their patients lacked transparency.

iii. Insufficient awareness among health professionals of the tasks of intercultural mediators

Some health professionals asked mediators to perform tasks that they themselves should normally perform with the assistance of a mediator. This was the case for about 30% of the interventions. This may pose risks for the patient and the mediator. The integration of the mediators in teams of health professionals was a major problem faced by the ICM programme.

iv. Culturalization of problems of patients from ethnic minority groups

Many health professionals tended to attribute patients' health problems and problems experienced during the health-care delivery process too quickly and incorrectly to their culture. In the ICM programme, this phenomenon is referred to as culturalization. Once health professionals associate a problem with the culture of the patient, they have a tendency to shift the responsibility for finding a solution to the mediator. This proved to be very stressful for mediators, and often led to a dead end in the health-care delivery process. This phenomenon was most commonly observed in the treatment of patients with psychosocial problems and with noncompliant patients.

v. Inadequate ability to advocate for patient rights

Due to mediators' low status within the hospitals, it was very hard for them to defend patients' rights or intervene when their well-being or dignity was at stake.

vi. Isolation of the intercultural mediators

Some hospitals only have one or several mediators, which means that mediators can feel lonely, isolated and professionally challenged, as they are often exposed to complicated consultations that they may not feel confident in dealing with.

vii. Lack of an adequate training programme

Currently, no complete, adequate training programme for mediators exists, which means that people with very different backgrounds work in this role (for example, nurses, psychologists, doctors) and salary levels vary considerably. Mediators must fulfil certain criteria in order to be eligible for funding, but it would be ideal to have an adequate training programme recognized at national and regional levels that could also guarantee standardized salary levels.

c. Lessons learned

Based on the evaluations, the following improvements were made to the ICM programme.

- The challenges related to low numbers of interventions and lack of recognition of the mediators have to some extent been overcome by the fact that the mediators are employed by the hospital, which depends on funding from the Intercultural Mediation and Policy Support Unit. In order to receive funding, hospitals were required to undertake actions to adequately integrate mediators and to have a certain number of interventions. As a result of these actions, as well as more knowledge and recognition of the ICM programme in general, the services of the mediators are being used much more often today.

- To address feelings of isolation and professional challenges among some of the mediators, the Intercultural Mediation and Policy Support Unit conducts supervision sessions in which mediators can present difficult cases and receive feedback and advice for developing their skills. In some instances, a member accompanies the mediators in their work for half a day and gives them feedback. This also provides the Intercultural Mediation and Policy Support Unit with first-hand knowledge about the ICM programme and enables feedback to the political level.

Intercultural mediation in Belgian hospitals: structural integration of mediation practices between health professionals and patients from ethnic minority groups

11

- The Intercultural Mediation and Policy Support Unit is also working towards making it compulsory for the hospitals to provide mediators with psychosocial support to avoid secondary traumatization, depression and burn out.

- When hospitals are not adequately supporting mediators or are asking them to perform services outside their curriculum, the Intercultural Mediation and Policy Support Unit can intervene. Hospitals must comply in order not to lose their funding.

- Video mediation can also make the mediators less vulnerable to attempts from certain patients to make the mediators do things they should not be doing. The service is also used extensively in psychiatry, and in instances involving aggressive patients where the mediator feels safer working via video. However, when working onsite (for example, in psychiatry), mediators can have a debriefing with the psychiatrist at the end of the consultation – this is often not the case in video mediation.

- Continuous coaching and training of the mediators remains a challenge, and work is ongoing to develop their skills, standardize professional requirements and incorporate the mediators into a standardized care-delivery process. The Intercultural Mediation and Policy Support Unit is currently involved in the TIME project *(6)*, which is working to develop standardized models for the training and employment of intercultural mediators throughout the European Union. The Unit hopes to be able to implement lessons from this project. As part of the continuing professionalization of intercultural mediation, the *Guide for intercultural mediation in health care (2)* has been developed. A detailed description of the process of developing standards for intercultural mediation in health care is also under submission for a book on intercultural mediation.

> *"Some mediators suffered a lot from hearing what people from Syria had gone through and there was no adequate support … It is really tough working with people from your own background that have gone through horrible things that you might even have witnessed yourself."*
>
> **– Hans Verrept**

Hans Verrept noted that it is important to organize the ICM programme in such a way that the mediators can earn a living doing this work, and to establish mediation as a profession with accompanying rights. It is also important to have mediators who are specialized in health care, know the medical terminology, and are able to work with intimate themes such as sexual issues and urology. Furthermore, it is advisable to have mediators specialized in the field of mental health.

He also emphasized that health professionals also have a role to play in cultural mediation, and that learning how to work with intermediaries should be part of mainstream health education.

"Intercultural mediation works best with a culturally competent care provider."

– Hans Verrept

d. Outlook for the future

In recent years, there has been an increase in the use of video intercultural mediation for refugees, asylum seekers and migrants in Belgium. These services have been widely used by doctors at asylum centres, where they are available without an appointment. They are also used at hospitals, where they are funded by the FPS Health, Food Chain Safety and Environment. These services are available in over 20 languages.

Since 2017, video mediation has also been available for a large number of primary care centres. Hans Verrept stressed that the area of mental health will benefit from these services in the future as health providers work to address challenges and keep up with increasing demand among refugees.

In 2017, a consultation process was carried out to write a set of recommendations based on the experience of the ICM programme for policy-makers at all levels. Hans Verrept noted that ongoing efforts are being made to incorporate the ICM programme in the policy plans of the different ministries. Although this is a challenging process, progress is being made. For instance, standards on equity in health care have already been incorporated into the policy plan of the Ministry of Public Health.

Intercultural mediation in Belgian hospitals: structural integration of mediation practices between health professionals and patients from ethnic minority groups

13

References

1. Verrept H. Intercultural mediation: an answer to healthcare disparities? In: Crossing borders in community interpreting. Definitions and dilemmas. Amsterdam: Benjamin Translation Library; 2008:187–201.

2. Verrept H, Coune I. Guide for intercultural mediation in health care. Brussels: Federal Public Service Public Health, Food Chain Safety and Environment; 2016 (https://www.health.belgium.be/sites/default/files/uploads/fields/fpshealth_theme_file/en_2016_04_20_leidraad.pdf, accessed 12 October 2018).

3. Petrei F, Morariu L. Two successful examples of reasonable accommodation and intercultural mediation in the health-care sector. In: Institutional accommodation and the citizen: legal and political interaction in a pluralist society. Strasbourg: Council of Europe Publishing: 2009:241–262.

4. Research report on intercultural mediation for immigrants in Belgium – France – The Netherlands. Brussels: Intercultural Mediation and Policy Support Unit FPS Health, Safety of the Food Chain and Environment; 2015.

5. Implementation of the National Roma Integration Strategy and other national commitments in the field of health. Le Grand-Saconnex: International Organization for Migration; 2014 (https://publications.iom.int/books/implementation-national-roma-integration-strategy-and-other-national-commitments-field-health, accessed 12 October 2018).

6. TIME – Train Multicultural Mediators for a Multicultural Europe [website]. Pyrgos: Mediation–TIME; 2016 (http://www.mediation-time.eu/index.php?lang=en, accessed 12 October 2018).

2 Video remote interpretation in the Danish health-care sector:
easy access to interpretation via video

Author information

Liv Stubbe Ostergaard, Research Associate, Danish Research Centre for Migration, Ethnicity and Health, Department of Public Health, University of Copenhagen, Denmark

Allan Krasnik, Professor, Danish Research Centre for Migration, Ethnicity and Health, Department of Public Health, University of Copenhagen, Denmark

Key messages

- Video remote interpretation (VRI) technology enables interpretation services to be conducted remotely. The first project to implement VRI services in hospitals across Denmark took place in 2009–2012, financed by the Ministry of Health and Ministry of Finance, and managed by the organization MedCom. The aim of the project was to extend the availability of interpretation services in health-care settings for migrant patients while improving their quality and efficiency, and reducing time and resources.

- VRI is available virtually in any language, and can be used in consultations with speech- and hearing-impaired patients. VRI can also be used on mobile devices in offsite situations such as home visits.

- Interpreters are located at interpretation centres, and their services are booked at prearranged times. Interpretation takes place via a web camera and a microphone. Secure encrypted connections are provided through the Danish National Health Data Network to preserve confidentiality.

- Evaluations of the VRI project have pointed to a reduction in the use of family members as interpreters; an increase in the provision of professional and more objective interpretations; a reduction in time needed per intervention; and better working conditions for interpreters. The VRI project has also resulted in economic benefits, although these are less than expected. Challenges persist, however, including scepticism and fears among health professionals.

- Key factors for success included support from senior management and the allocation of dedicated resources to implement the project, including spreading its use and increasing understanding of its technological aspects in hospitals.

- The positive experience of the VRI project has led to its expansion across the hospital sector, general practices, the psychiatric sector and municipalities. Efforts are ongoing to centralize all interpretation agencies in Denmark, thus standardizing their services and allowing for greater specialization in specific sectors, such as health care.

1. Introduction

Video remote interpretation (VRI) is a technology that enables interpretation sessions to be conducted via a camera, screen and microphone. From 2009 to 2012, VRI was implemented as a project in hospitals across Denmark's five regions. Furthermore, pilot projects were carried out in several general practices in each region, in the psychiatric sector and in the municipal sector.

The project was launched to improve the quality of interpretation services by providing access to easy and simple interpretation via video when non-Danish-speaking patients are treated in hospitals and in the primary-care sector. In addition to improving quality, the project was meant to increase availability and efficiency, saving both time and resources. Studies and experiences from hospitals in California, United States of America, where VRI is widespread, served as inspiration. Experiences there show that, on average, 20 minutes are saved per consultation with the shift from in-person interpretation to VRI, and that resources are saved as well *(1)*.

VRI used in the health sector addresses some of the traditional issues linked to interpretation, such as the use of family members as interpreters, transport time and patients who fail to show up for their appointments. It is relatively easy to implement and to adapt to new settings, and deals with a central issue of migrant health – communication and access to correct information. VRI also illustrates how technology and digitalization can contribute to better quality and efficiency in health-care settings.

This case description is primarily based on evaluations of the project conducted between 2011 and 2017, combined with insights from the Danish migrant health clinics, which use VRI equipment extensively. The authors also conducted interviews with two individuals involved in the implementation of VRI in hospitals: Claus Terkelsen, Technical Consultant for the VRI Project in the Region of Southern Denmark, currently works on implementing the system in general practices in the Region; and Eva Lund, Regional Project Manager at the VRI Project in the Region of Southern Denmark, is responsible for implementation and education in the biggest hospital in the Region.

2. Context

All patients in contact with the health-care system in Denmark have the right to information. For non-Danish-speaking patients, it is necessary to ensure that they are able to communicate with staff and are sufficiently informed of diagnosis and treatment.

The proportion of the Danish population made up of immigrants of non-western origin and their descendants has increased steadily since 1980, and continues to grow. In 2016, immigrants and their descendants constituted 12.3% of the Danish population, representing a total of 703 873 people. The majority of these individuals came from non-western countries (7.9%) *(2)*.

Language barriers in health-care services for this group usually require an interpreter who is physically present at the consultation. Correct interpretation is a patient's right under Danish law[2] *(3)*. In 2014, 64 000 interpretation sessions were conducted at Danish hospitals with yearly expenses amounting to 44.5 million kroner (6 million euros) *(4)*. In total, interpretation in the Danish health-care sector amounted to 125 million kroner (16.8 million euros) in 2014 *(5)*.

---

2   The Health Act LBK No. 913 and Notice of Interpreters under The Health Act, Executive Order No. 1413.

However, several problems are associated with traditional interpretation services, including bottlenecks, inefficient workflows and the use of family members as interpreters. Traditionally, the interpreter shows up on the spot at a prearranged time. In cases where the department is behind schedule or the patient has not turned up, costs are incurred for a service that is not delivered. When the interpreter comes from the same environment as the patient, they may know each other. Sometimes family members, including children, are used to interpret between patient and staff. This is problematic, as family interpreters are not professionals and there is no assurance that they translate correctly. Additionally, as family members are not subject to confidentiality agreements like other interpreters in the health sector, the patient may hold back information on sensitive topics. Using family interpreters, especially children, also involves emotional and ethical problems.

To address these issues, VRI was tested as a pilot project in 2008 in two Danish hospitals experienced in the use of telemedicine. Good results led to VRI being implemented at several hospitals from 2009 to 2012.

3. The issue: implementing VRI in Danish hospitals

a. What is it?
VRI is a service for consultations with patients who do not speak and understand Danish sufficiently to communicate with staff. VRI creates a space in which the patient, doctor and interpreter can see and hear each other, but in which the interpreter is no longer physically present. VRI is available virtually in any language, and it is also possible to use VRI in consultations with speech- and hearing-impaired patients. Furthermore, the service is available for tablets and smartphones where there is internet access over Wi-Fi or mobile broadband. Thus, VRI can be used in offsite situations such as home visits.

b. How does it work?
With VRI, interpreters are located at interpretation centres much like call centres. Interpretation services are booked at prearranged times. The interpretation takes place via web camera so the remote interpreter, patient and staff can see and hear each other in a unified communications environment.

The equipment used for the translations can be video-conferencing equipment, which is smaller, or portable video devices for meeting activities between two and three participants. Examples of these are Tandberg/Cisco E205 or Polycom V700. The system is Skype-like, but with better quality of service, sound and picture. Other options are personal computers with a web camera and speaker phone, and computers with a web camera and video-conferencing equipment such as Skype for Business or Jabber. Video interpretation applications are also available for tablets or smartphones. Individual organizations can choose the equipment and information technology (IT) solution they prefer.

A central video hub (VDX) supports communication between interpreting agencies and doctor/patient locations. Secure connections are provided through the Danish National Health Data Network, an encrypted network used in the Danish health sector.

c. How is it organized and funded?

The Danish Ministry of Health funded the project. At the national level, the organization MedCom[3] was responsible for project management and implementation, including establishment of the technical hub and the necessary network connections over the National Health Data Network.

MedCom was the overall project manager. Overseeing the project was a steering committee with representatives from MedCom, the involved municipalities, the regions, interpreting service providers and providers of the central video hub. Furthermore, MedCom worked closely with Cisco, which provided the networking equipment.

MedCom operations were run by a senior project manager and three team leaders who were responsible for five subdivisions of the project: technical aspects, municipalities, practice, hospitals and providers of interpreting services. In addition to the five subdivisions, there were three groups working on the project: an implementation group, a video technology group and an interpreting service provider group. MedCom served as the link between the national and the regional levels. It was responsible for funds allocation for project managers and technical equipment in the regions. MedCom reported back quarterly to the Ministry of Health and the Ministry of Finance's Fund for Welfare Technologies.

Binding cooperation agreements were signed with all regions. Much of the VRI implementation strategy was delegated to the regions to ensure adoption that matched regional organization and structures. The regional IT departments were the primary regional partners in the project.

The project received 41 million kroner (5.5 million euros) from the Fund for Welfare Technologies (previously the ABT pool), which supports labour-saving technologies. This funding was meant to cover technical equipment; the establishment and operation of the central video hub; salaries for project staff at MedCom; cooperation agreements with the regions, pilot municipalities and general practices; compensation for project employees in the regions; and project evaluation.

4. Impact and lessons learned

VRI has been implemented across Denmark, and most extensively in the Region of Southern Denmark. There, the number of VRI sessions is catching up to the number of traditional interpretations. In 2011, VRI constituted over 30% of the total number of interpretations in the Region; for 2012, the figure was 57%. Today, 60% of the Region's 30 000 annual paid interpretations are done via video link with interpreters in remote office locations *(6)*. In Odense University Hospital (OUH), 82–85 % of all interpreter sessions are conducted using VRI *(5)*.

Several evaluation reports have been published. MedCom evaluated the implementation of VRI on a national level in 2013 *(7)*, and produced an evaluation of the implementation in general practices from 2011 *(8)*. Furthermore, the

---

3   MedCom is a publicly financed cross-sectoral organization that works towards implementing technical communication solutions in the Danish health-care sector. MedCom was founded in 1994 and is owned and funded by the Ministry of Health, Danish Regions and Local Government Denmark.

consultant group Rambøll conducted an analysis in 2014 of the potential for increased use of VRI in the health sector *(4)*. One hospital section that often uses VRI is the migrant health clinic at OUH, and insights from their use of the equipment were also included in an internal evaluation *(9)*. The following section builds on insights from these evaluations as well as interviews with the project manager and technical expert involved in the implementation of VRI in the hospitals.

a. Service user perspective
The evaluations show that VRI can improve quality and reduce costs. Both patients and staff provided good overall feedback on their experiences of using VRI, and further research demonstrates that VRI provides more effective interpretations and improves patient communications.

i. More objective interpretations and less use of family members as interpreters
One of the advantages of VRI is that it provides more objective and professional interpretation services. In a traditional interpretation situation, interpreter and patient may meet in the waiting room and form a prior opinion about the content of the consultation. Similar issues have been observed when a family member acts as interpreter. This can be a problem for the doctor or nurse. This is not the case with VRI, as interpreter and patient do not meet each other prior to the visit. The system also enables the use of an interpreter from another part of the country who does not know the patient or his/her family. Some clinics find that patients who have not been able to talk to doctors or social workers for years due to fear that interpreters may gossip or translate incorrectly now feel comfortable with a VRI session.

ii. Increased privacy and more focused conversations
VRI supports the patient's less visible need for a private sphere. Conversations are on average shortened by 15–20%, and there are clear indications that a video interpreter interferes less than an interpreter who is physically present. Likewise, the conversations between the doctor/nurse and the patient are generally of better quality and more focused when the interpreter is only present on video. A calmer environment is created, which provides better conditions for listening and comprehending – VRI creates less "noise" and enables a focus on what is important in a conversation: listening, asking and understanding.

This is particularly important for patients with post-traumatic stress disorder, who are easily distracted. With no extra people in the room, they feel more in charge of the situation. Furthermore, it is possible to turn off the camera when a patient is being examined, so the interpreter can interpret what is going on without being able to see the patient. However, it is important that the patient is informed prior to the conversation that VRI will be used to create trust and avoid confusion.

iii. Possibility of acute interpretations in various settings
From the health professional's point of view, VRI is also easy to deploy in different settings. Crucially, it has become easier to offer acute interpretations as the interpreter does not have to travel. In Denmark, where it can still be a challenge to get acute access to an interpreter who speaks one of the less common languages, VRI ensures better access to knowledgeable interpreters for these minorities. The use of tablets or smartphones enables interpretation in ambulances, during home visits, in prisons and in social services offices. This reduces the number of visits as well as misunderstandings, and avoids expensive unnecessary hospitalizations.

iv. Increased quality of interpreters

The migrant health clinic in OUH emphasizes the positive impact of the Region of Southern Denmark using a single interpretation agency to provide VRI. This means that most of the skilled interpreters work at this agency, and thus health professionals are more likely to work with a skilled interpreter. Furthermore, experiences show that VRI enables quicker professionalization of interpreters as they use more of their time interpreting than travelling.

v. Interpreters as part of the professional team

Feedback from interpreters regarding VRI shows that they feel more a part of the treatment team, as the patient does not meet them in advance and spend time with them before the consultation starts. Some interpreters also point out that when the interpretation services are centralized, they have a better chance of making a living, as they are being called more often.

vi. Scepticism from health-care professionals regarding technical aspects

The challenges associated with implementation of VRI typically relate to health professionals' scepticism of new equipment and technology. They fear that it will be time consuming and complicated to use. Thus, it is important that someone instruct users in advance and demonstrate that the equipment is user-friendly.

vii. Fear that video interpretation will complicate examinations

Some health professionals fear that the absence of an in-person interpreter will complicate examinations in which the patient must be instructed in, for example, the use of an inhalation mask or a physical exercise. However, experience shows that the interpreter can also help to instruct the patient via the screen.

Some also fear complications in cases where a patient must go to several examinations in different sections of a hospital. In traditional, in-person interpretation, the interpreter is often the one showing the patient where, for example, to go for X-rays. However, this is outside the scope of the interpreter's job. With the introduction of VRI, this assignment has been given to the onsite staff without problems.

b. Technological aspects

Despite scepticism from some health professionals, the evaluations show that sound and image work well and are easy to use when individual units have a stable network connection with sufficient bandwidth. For ad hoc sessions in rural locations, more advanced SD-WAN routers may be required, which can bond all available wireless connections into one virtual connection. The technology can also be used for other purposes such as meetings and conferences.

c. Organizational aspects

The degree of implementation of the VRI project varied across regions, potentially due in part to different levels of engagement from senior management. In the Region of Southern Denmark, one project manager was employed to deal exclusively with implementation and education of the users, whereas the project managers in the other regions had a much broader work portfolio. The combination of support from senior management, allocated resources and the deployment of a dedicated project manager solely focused on implementation is key to wider deployment in other regions.

Additionally, in the Region of South Denmark VRI was free of charge for the departments, whereas departments had to finance in-person interpretation themselves. This acted as another incentive to transition to VRI.

Placing the responsibility for implementation in the regions' IT departments had a number of advantages related to getting equipment and technical infrastructure in place. Extensive managerial support has been seen at the IT level. A disadvantage of this arrangement was that the IT departments did not have daily contact with the departments where VRI was taking place. This gap between the project management and the users led to some cases in which the equipment was installed in hospitals but not used. The project and further dissemination could have benefitted from closer contact.

d. Financial aspects

In spite of participants' positive experiences, the expected economic benefits of VRI have not been as great as expected. In 2015, the Region of Southern Denmark saved 4 million kroner (540 000 euros) by using VRI instead of hiring in-person interpreters for hospitals and the psychiatric sector. In addition, it saved an estimated 5 million kroner (670 000 euros) in salary for staff thanks to more effective and accelerated interpretation sessions *(10)*. Factors that are not included in this calculation are the costs of general upgrading of IT equipment on a national level, and the fact that the video equipment installed is also used for other purposes, such as meetings and conferences.

However, in the total project business case, there was an expectation that the project would save up to 10 million kroner (1.3 million euros) nine years after implementation. Evaluations show that during the first three years, the national economic benefits have not materialized. This is probably due to the fact that the expected time savings have not been as remarkable as anticipated, and procurement agreements did not lower costs to the extent expected.

e. Lessons learned

i. Governance and organization

The Danish trials show that it is important to ensure solid anchorage of and support for the project at all management levels. It is key that the project leaders driving local change processes are dedicated and very familiar with the use of VRI. The project managers from the Region of Southern Denmark highlight the importance of dedicated resources for the project as well as the provision of financial incentives to the departments using VRI. At OUH, all expenses related to VRI are billed via central budgets, while expenses for in-person interpretation are billed locally. This provides individual departments with a strong incentive to use VRI instead of in-person interpretation, and underlines the importance of the conversion to VRI *(4)*.

ii. Funding

The fact that the project has been publicly funded has been important, as the Danish health-care system is publicly financed. This funding model has given the state more control of the implementation process. It allowed the system to be implemented directly into the organization and to ensure its sustainability.

iii. Human resources

Continued upgrading and qualification of health-related interpreters are key, regardless of the form of interpretation. The Region of Southern Denmark uses one interpretation agency for VRI, which has allowed the agency to establish an interpretation centre with permanent jobs for the interpreters who are engaged frequently and are becoming more specialized. The possibility for home offices is currently being discussed.

iv. Technical dimension

Lessons from the project show that the availability of the right technical equipment is crucial. The psychiatric sector in the Region of Southern Denmark has been successful in its complete transition to the use of VRI in a short time by making sure that all equipment and technical infrastructure were accessible and straightforward to use *(4)*.

The project managers from the Region of Southern Denmark emphasize that well functioning infrastructure (for example, in relation to technical support) is important –staff must know who to contact in case of technical problems. Training in the use of the equipment is also important. When the equipment is installed in new departments, it is a good idea to have a project manager offer a short introduction regarding use of the equipment and to demonstrate how to conduct an interpretation session. The training should be adapted to the individual needs of departments, general practices and municipal sectors. In such training, it is also important to make the procedures for booking interpreters clear.

f. Outlook for the future

Since the initiation of the project in the hospital sector, the service has been implemented in general practices, the psychiatric sector and in municipalities. The experience with VRI has been largely positive. The use of mobile video equipment via, for example, a Jabber application for iPads, is also gaining ground, enabling interpretations in ambulances, emergency rooms and in operation rooms if they are contained in a sterile container. However, VRI does not in itself create more qualified interpreters. To achieve this, a national certification programme for interpreters must be developed and become a prerequisite for interpreters working in health care.

Currently, a new procurement process directed towards interpretation agencies is being initiated, joined by Danish Regions. The process places an emphasis on centralization of the interpretation agencies and standardized prices and terms. The centralization of the agencies will create a larger customer base for the agencies and increase the incentive to cover more languages and use interpreters with a specialty in health care – possibly with requirements of specific education or certifications. VRI constitutes a central part of this process, as well as in the upgrading of the interpreters *(5)*.

References

1. Video interpreters cut wait times in half. Customer case study. San Jose: Cisco Systems; 2006 (https://www.cisco.com/c/dam/en_us/solutions/industries/docs/healthcare/ACMC_CS_v3.pdf, accessed 10 October 2018).

2. Integration: Status og Udvikling 2016 [Integration: status and development 2016]. Copenhagen: Ministry of Immigration and Integration; 2016 (in Danish) (http://uim.dk/publikationer/integration-status-og-udvikling-2016, accessed 10 October 2018).

3. Lige Adgang til Sundhed [Equal access to health]. Copenhagen: The Danish Institute for Human Rights; 2014 (in Danish) (https://www.humanrights.dk/sites/humanrights.dk/files/media/dokumenter/udgivelser/lige_adgang_til_sundhed_pdfa.pdf, accessed 10 October 2018).

4. Analyse af øget brug af videotolkning og videomøder [Analysis of increased use of video interpretation and videoconferencing]. Copenhagen/Hellerup: Rambøll Management Consulting, Implement Consulting Group; 2014 (in Danish) (https://digst.dk/media/12603/bilagskompendie_final-oeget-brug-af-videotolkning-og-videomoeder.pdf, accessed 10 October 2018).

5. Tolkning – fællesudbud i de danske regioner [Intepretation: joint offer in Danish regions]. Odense: Health Innovation Centre of Southern Denmark; 2016 (in Danish) (http://www.syddansksundhedsinnovation.dk/projekter/tolkning-faellesudbud-i-de-danske-regioner/, accessed 10 October 2018).

6. Videotolkning – tolkning via skærmen [Videointerpretation – interpretation via screen]. Odense: Health Innovation Centre of Southern Denmark; 2016 (in Danish) (http://www.syddansksundhedsinnovation.dk/projekter/afsluttede-projekter/videotolkning-tolkning-via-skaermen/, accessed 10 October 2018).

7. Evaluering af Teletolkeprojektet – Implementering af et telemedicinsk redskab på danske hospitaler [Evaluation of the Teletolke project – implementation of a telemedicine tool in Danish hospitals]. Odense: MedCom; 2013 (in Danish).

8. Evaluering af ABT-projekt: Pilotafprøvning af videotolkning i almen praksis [Evaluation of the ABT project: pilot testing of video interpretation in general practice]. Odense: MedCom; 2011 (in Danish).

9. Sodemann M, Rønde Kristensen T, Nielsen D. Tak fordi I lavede en bedre version af mig [Thanks for making a better version of me]. Odense: Migrant Health Clinic; 2013 (in Danish).

10. Når Værdien er i Kroner [When the value is in kroner]. Copenhagen: Center for Offentlig Innovation; 2016 (in Danish) (https://www.coi.dk/media/6998/n_r_v_rdien_er_i_kroner_-_10_eksempler.pdf, accessed 10 October 2018).

3 Migrant health clinics:

hospital-based care coordination in Denmark for patients with ethnic backgrounds other than Danish

Author information

Liv Stubbe Ostergaard, Research Associate, Danish Research Centre for Migration, Ethnicity and Health, Department of Public Health, University of Copenhagen, Denmark

Allan Krasnik, Professor, Danish Research Centre for Migration, Ethnicity and Health, Department of Public Health, University of Copenhagen, Denmark

Key messages

- Denmark's first migrant health clinic opened in 2008 at the Department of Infectious Diseases at Odense University Hospital (OUH) in the Region of Southern Denmark. The clinic aims at providing better health care and coordination of care with the health system for migrant patients from ethnic minority groups who have complex and multifaceted health or compliance issues. It was established as a response to the increasing evidence of inequalities in both access to and quality of health services for this patient group.

- Patients are usually referred to the clinic by general practitioners (GPs) or other physicians. Health professionals at the clinic include nurses, social workers, medical doctors, dietitians, physiotherapists, psychologists and staff from nongovernmental organizations. Assessment and treatment of patients are conducted in collaboration with GPs, relevant hospital departments, municipal integration offices and social medicine institutions. Emphasis is placed on understanding and dealing with issues linked to socioeconomic conditions that might inhibit effective treatment; when necessary, home visits are conducted to gather additional information about the patient's family and living environment.

- Additional objectives of the clinic are to teach and educate health professionals on cultural competencies, and to share experiences and case studies to further spread knowledge about how to treat and interact with patients from diverse ethnic backgrounds.

- The clinic is organized as an outpatient care clinic linked to the Department of Infectious Diseases at OUH, and receives ad hoc funding from activities of both the Department and the Region.

- Evaluations of the clinic's work have shown an improvement in the health status of its patients; a decrease in the use of medications, in emergency room visits and in social benefits received; and better cultural understanding among health professionals. A lack of resources and the existence of multiple budget sources, however, pose challenges.

- Following the positive evaluations of the first migrant health clinic, two additional clinics were established in 2013 in Copenhagen and in the North Denmark Region.

1. Introduction

In 2008 in Denmark, a migrant health clinic was established to provide better treatment and care coordination for patients with ethnic backgrounds other than Danish – a group that is often stranded in the Danish health system because of social, linguistic and cultural barriers. The clinic is an outpatient clinic linked to the Department of Infectious Diseases at Odense University Hospital (OUH) in the Region of Southern Denmark.

The clinic seeks to provide this particularly vulnerable group of patients the same opportunity for assessment and treatment as others. It aims to document, mitigate and prevent health issues caused by language barriers, low or no schooling, stereotypes, assumptions, prejudices, lack of ethnic competencies among health professionals, and the organizational gaps of the general health services in relation to vulnerable patient groups *(1)*. The clinic represents a possible intersectoral model of how a specialized effort for a vulnerable patient group can be institutionalized in hospitals as part of the general health-care system.

This case description is primarily based on material from evaluations of the clinic; reports; and an interview with Morten Sodemann, Founder of the Migrant Health Clinic at OUH.

2. Context

In Denmark, a growing heterogeneous ethnic population has posed a range of new challenges to the established health system. Such challenges relate to reaching out to and treating a patient group with differing linguistic, social and cultural backgrounds; different disease patterns; atypical presentation of common diseases; and, often, unresolved health and socioeconomic issues *(2)*.

All residents of Denmark have access to the public health system, and most services are provided free of charge. National legislation ensures that diagnosis and treatment are provided within certain time limits. General practitioners (GPs) are patients' primary contact point with the health system. When necessary, GPs will refer patients to specialists, hospital care or health services provided by the municipalities *(3)*.

Evidence shows that a significant group of patients with ethnic backgrounds other than Danish do not have access to disease prevention, treatment and rehabilitation at the same level of ethnic Danish patients *(1,2)*. Danish doctors and nurses lack the basic clinical and ethnic qualifications and competencies that would enable them to offer these individuals quality of care that approximates that received by ethnic Danish patients. Consciously or unconsciously, discriminatory practices take place with regard to choice of examinations, treatments and re-examinations.

Equal and effective treatment as well as patient safety are inhibited due to problems related to language barriers, lack of information–sharing or miscommunication. Furthermore, the combination of health and social issues can blur the disease picture and inhibit correct assessment, diagnosis and treatment as well as the provision of social welfare assistance *(1,2,4)*. Thus, a vulnerable group of patients risks floundering in the system for years without getting the correct diagnosis and treatment.

The migrant health clinic at OUH was established in 2008 as a response to increasing documentation of inequalities in both access to and quality of health services for ethnic minority patients in the primary and secondary sector. Its aim is to provide care for refugee or immigrant patients whom the regular health system cannot adequately serve, and who are in need of care coordination involving both health professionals and social workers.

3. The issue: providing health and care coordination for ethnic minority patients through migrant health clinics

a. Short description
The migrant health clinic at OUH is a specialized unit linked to the Department of Infectious Diseases. It specializes in ethnic minority health and care coordination for refugee or immigrant patients for whom access barriers have proven difficult to overcome. According to Morten Sodemann, its purpose is twofold: to solve problems for individual patients and empower them to navigate in the health system; and to build the competencies needed by health professionals to treat and interact with ethnic minority patients.

b. Target group
The clinic diagnoses patients with refugee or immigrant backgrounds who have complex and multifaceted health and/or compliance issues that require treatment. Symptoms can be accompanied by post-traumatic symptomatology after exposure to trauma due to war or conflict. Most patients referred to the clinic have uncharacteristic somatic health issues that are often projections of complicated psychological or social problems. Sometimes they have lived in Denmark for many years but have become lost in the system. Thus, the clinic is not for all patients with refugee or immigrant backgrounds, but rather for those whom the primary sector or other hospital wards have not been able to diagnose or treat.

In addition to direct work with the patients, action at the clinic is directed towards teaching and educating health staff. Through teaching and advocacy, the clinic trains staff in cultural competencies and shares experiences and case studies. Furthermore, staff from the clinic may accompany patients for examinations in other hospitals wards, acting as a form of mediator.

c. Referral procedures
Patients can be referred by GPs and other physicians, including social medicine doctors and other hospital wards. The clinic prefers that a patient's GP send a reference, as evaluation and treatment at the clinic is done in collaboration with them. The reference should be justified, and not simply take the form of a copy of journal notes or of others' discharge summaries. The reference should as far as possible include the following information:

- why the patient's problem is complex and multifaceted;
- a summary of previous assessments;
- ongoing assessments and current references;
- current medications;
- social issues, including labour market status;
- country of origin;

- languages spoken and whether there is a need or desire for an interpreter; and
- a copy of all discharge summaries (including from GPs and specialists) and, for example, descriptions of imaging diagnostics (except discharge summaries from OUH).

d. Service providers

The work is conducted using a cross-sectoral approach involving the clinic's nurses and social workers, medical doctors and other professionals within and outside OUH. This may involve dietitians, physiotherapists, psychologists, district nurses and staff and volunteers from nongovernmental organizations.

The clinic increasingly conducts home visits to get a full picture of the life of patients and their family situations. Assessment and treatment are coordinated in collaboration with patients' GPs; other hospital departments or other relevant bodies, including the integration offices of the municipalities; and social medicine institutions.

Nurses at the clinic are generalists and address patients' physical problems as well as psychological and social issues. They show interest in, acknowledgement of, and empathy for the patient's narrative and life history. This may uncover the often multifaceted problems that affect patients. As part of the clinical process, it is essential to address emotions, living conditions and the life situation associated with being a refugee or an immigrant. This is often the key to patients' better understanding and self-care when dealing with complicated, multifaceted health problems *(5)*.

The clinic has deployed a municipal social worker with 15 years of experience in the area of migration and asylum to develop the longitudinal coordination element of its work. The need for a network analysis across sectors has been highlighted, as in some cases there are over 50 public and semiprofessional therapists/support people in the patients' network. The social worker is employed permanently as the care coordinator. The presence of a social worker in the team contributes significantly to establishing a safe and trusting relationship with each patient, because a single plan is created that addresses all of their issues simultaneously *(4)*.

e. Services provided

The overall services offered at the clinic are:

- systematic assessment and examination of complex and long-term health or compliance problems among refugee or immigrant patients with language and reading barriers;
- assistance to other doctors/departments to create more appropriate communication forms;
- investigation of what has gone wrong in previous assessments to identify possible improvements in the health system to ensure equal health care for all patients;
- care coordination, including addressing the patients' socioeconomic and juridical issues; and
- education, systematic skills development and research.

Patients are offered health and problem-solving services, through interdisciplinary conversations with the clinic staff. Initially, one to two conversations lasting up to two hours are conducted, and these are typically followed by 10 additional consultations lasting about half an hour each. Most conversations are conducted via interpreters. Treatment processes in the clinic typically range from six months to three years.

The patient-centred work at the clinic focuses on understanding the patients' issues, clarifying what has gone wrong in previous assessments, helping patients to navigate the health system, and coordinating and supporting treatment. Emphasis is placed on understanding and dealing with patients' socioeconomic issues and other issues that inhibit effective treatment – for example, issues related to residence permits are often a major stress factor for the patients.

Patients' issues are identified and addressed through a detailed and comprehensive dialogue that enquires into the patient's life history and the barriers that have prevented assessment and treatment. Mental and social problems are addressed and examined holistically, and an interdisciplinary team coordinates and facilitates access to treatment and rehabilitation.

All patients are assigned a contact doctor and a nurse, and, if needed, a social worker and/or a pharmacist. Helpers ensure that patients show up for examinations and tests, take the appropriate medicine and comply with the treatment. Patients with chronic diseases are taught to live with their conditions and to use appropriate health and social services. Furthermore, patients receive support in coping with everyday problems that may have contributed to their complex symptom picture or have hampered relevant examination and treatment.

"A central dimension of the work conducted in the clinic is to clean up and to remove the complex noise and mess that is blurring the disease picture."

– Morten Sodemann
Founder of the Migrant Health Clinic at OUH

The clinic also functions as a knowledge centre. Apart from patient-centred assignments, clinic staff educate medical students, nurses, psychologists and social workers. The clinic is also involved in skills development and training in general health care. Its expertise is available for GPs and other hospital wards as well as relevant professionals in the municipalities. Furthermore, the clinic provides information-sharing and undertakes educational tasks in professional forums and for ministries and organizations at national and regional levels.

f. Organization and funding
The clinic is organized as an outpatient care clinic linked to the Department of Infectious Diseases in OUH. It does not have its own budget, as it is an outpatient clinic linked to another department. Half of the employees at the Department are project employees, so the clinic's core staff is rather small in number. The clinic receives ad hoc funding from several sources. Basic funding is supplemented with activity-based funding from the Department as well as contributions from regional activities and research funds.

The annual expenses for salaries in 2012 amounted to 3.4 million kroner (500 000 euros); this covered one doctor full time, one doctor part time, three nurses full time, one research nurse part time, one secretary and one social worker full time *(2)*.

4. Impact and lessons learned

Since 2008, the clinic at OUH has treated approximately 1600 patients. All patient cases are evaluated and assessed. After each patient case is finalized, a conclusion incorporates lessons learned regarding previous treatments, prior misunderstandings between patient and health-care staff, and what was done at the clinic to correct them.

Two official evaluations of the clinic have been made. A 2013 internal evaluation and report are based on experiences and lessons learned at the clinic from 2008 to 2013 *(1)*. The report contains various patient stories and examples from the clinic based on experiences with 700 patients. In addition, a medical technology assessment of the clinic specifically focused on care coordination was conducted in 2014 *(2)*. Included in this evaluation is a register-based study of the use of health services for a patient group at the clinic before and after treatment. The following information about the clinic's achievements, challenges and lessons learned is based on these evaluations, as well as on the interview with Morten Sodemann.

a. Achievements
i. Improved health status
The evaluation from 2013 shows that 32% of the patients treated in the clinic had neglected social, economic and psychological problems which worsened their condition, and 25% had hitherto overlooked health problems.

Additionally, 18% of the patients had misinterpreted or wrongly assessed symptoms/diseases. According to the evaluation, two thirds of the patients saw their health status improve as a result of the clinic's efforts *(1)*.

ii. Change in use of health-care services
Results from the 2014 evaluation show a decrease in use of medication and social benefits received over time for the patient group at the clinic. They show a statistically significant decrease in emergency room visits among the patients of the clinic, while among the general population of migrants the opposite is seen, specifically in acute somatic admissions *(2)*.

iii. Increased cultural understanding
A majority of the municipal social workers and GPs with patients affiliated with the clinic found that they obtained a better overview of the patients' situation and issues, which helped them in their work *(2)*.

iv. Economic benefits for the municipalities
In the evaluation from 2014, the data set is too small and too uncertain to carry out economic calculations and come to definite conclusions about the economic effects of the clinic's work. Furthermore, in conducting economic calculations of efforts to rehabilitate ill migrants, factors such as the long-term benefits of increased tax revenues

and the reduced time and resources spent on patients who had often been in the municipal system for a long time, should be included to assess the full effect of treatment at the clinic.

The 2014 evaluation, however, does suggest that clinic's efforts may be associated with economic benefits for municipalities related to a decrease in reliance on social security benefits. Furthermore, the observed decrease in the use of medication and emergency room visits is likely to save resources in the health system *(2)*.

v. Dissemination of the work conducted in the clinic
Today, the clinic has a close relationship with many of the other hospital wards and conducts ongoing training of health-care staff to keep their competencies updated. The clinic has also developed a shared outpatient offer with the diabetes unit where they conduct co-consultations.

Politically, the clinic benefitted from a national campaign on equity in health that was launched just after its establishment. As a new initiative it received much political and media attention due to the fact that it addressed the issue in concrete, clinical way.

b. Challenges
i. Lack of resources
Morten Sodemann emphasized that insufficient resources have presented a big challenge. The team working at the Department is relatively small, and must provide services to patients while also disseminating their clinical experience. This involves teaching several times a day as well as answering questions from politicians and municipal councils. Resources are not necessarily allocated for these activities.

ii. Complicated funding structures
The fact that the clinic does not have its own budget and is funded by various sources, both directly from the Region and via the regular hospital budget, has proven challenging. Furthermore, some regional pools are earmarked for the clinic, which has created problems internally for the hospital administration.

iii. Challenges related to "inventing" a new patient group
The development of the clinic was initially met with scepticism. Particular resistance was encountered among civil servants who considered the clinic's establishment to be cumbersome and a waste of time. Much effort went to explaining the need for such a clinic and what it should be used for. The developers also spend a lot of time fighting for interpretation services to be recognized as a clinical tool.

c. Lessons learned
i. Persistence in the establishment phase
Morten Sodemann underlined the importance of persistence in the clinic's establishment phase, and of demonstrating its unique approach and methods to other hospital wards. This can be done by, for example, accompanying patients to other hospital wards and demonstrating how to interact with them, how to use video interpretation equipment, how to evaluate the consultations afterwards, etc.

ii. Use of case studies and patient evaluations to develop knowledge and spread the message

The clinic has made use of a collection of patient cases that demonstrate various aspects of their work and that are used in evaluations and for teaching purposes. The cases provide different role-specific views relevant for hospital managers, health-care providers and municipalities. The cases have served as good concrete learning tools, both internally and externally.

The cases have also been useful at the political level. Politicians from across the political spectrum have appreciated the concrete case descriptions. Regional politicians have been key in driving the processes and have praised the clinic's approach to serving vulnerable patients.

> *"Our clinic adopted a helicopter perspective to address recurring gaps in the health care system, and we showed that it was relatively easy to address them and do something about it."*
>
> **– Morten Sodemann**

iii. Importance of integration into the established health system

Questions have been raised regarding responsibility for the target group: should it reside with the municipality or the GP? Morten Sodemann explained that the patients received at the clinic are precisely those on whom other actors have given up. The clinic is well suited to treat these patients and its staff have the necessary skills. However, it is critical that the clinic is integrated in the established health system and that its staff can educate other health professionals.

iv. Making the basis of referral clear

It is important to make the referral procedures clear to GPs and to make sure the patient group referred to the clinic is compatible with the services offered there. Many patients with refugee or immigrant backgrounds are high functioning and do not need the services offered at the clinic. To avoid GPs automatically referring patients with refugee or immigrant backgrounds, it is important to engage them in a clear dialogue to make sure they are aware of the target group.

d. Outlook for the future

The high demand for the services offered at the clinic and the positive evaluations from patients and staff underline the need for clinics that can master the development of cultural competencies; document discriminatory practices and propose improvements to ensure more desirable continuity of care; and thus act as a clinical special department for particularly complicated or serious courses of disease for ethnic minority groups.

In 2012, the Danish Health Authority hosted a seminar on equity in health that led to the 2013 establishment of a second migrant health clinic at Hvidovre Hospital in Copenhagen. The process of establishing the second clinic,

which is included in the regular health-care budget, was rapid. In addition, another migrant health clinic will be established in the North Denmark Region.

In addition to the value of establishing migrant health clinics at all hospitals, Morten Sodemann emphasized the importance of training health professionals and enabling them to serve vulnerable patient groups. Ethnic sensitivity qualifications should be a part of all social and health science education, both core curricula and postgraduate training. Particularly, doctors' communication skills and use of interpreters and related technology should be strengthened. The ability to conduct cross-cultural conversations should be strengthened to prevent discrimination and misdiagnosis. Health professionals must learn to incorporate awareness of the fundamental conditions of living as a refugee or immigrant from ethnic minority groups in the assessment of patient needs and resources.

Morten Sodemann explained that the demand for patient navigation at the hospitals in general is growing. He sees a movement towards the clinic becoming part of a general patient support unit in which the clinic team has the competencies related to patients with refugee or immigrant backgrounds.

"The patients with complex illnesses, the old who cannot see or hear, the ones who lack relatives – the more demanding patient groups – they all need some kind of support in a modern, highly efficient health-care system."

– Morten Sodemann

References

1. Sodemann M, Rønde Kristensen T, Nielsen D. Tak fordi I lavede en bedre version af mig [Thanks for making a better version of me]. Odense: University of Southern Denmark; 2013 (in Danish) (https://viden.sl.dk/artikler/voksne/socialt-udsatte/tak-fordi-i-lavede-en-bedre-version-af-mig-erfaringer-fra-indvandrermedicinsk-klinik-2008-2013/, accessed 21 November 2018).

2. MTV rapport – Indvandrermedicinsk Klinik [Report – migrant health clinic]. Odense: Odense University Hospital; 2014.

3. Healthcare in Denmark – an overview. Copenhagen: Ministry of Health; 2016 (https://www.sum.dk/English/~/media/Filer%20-%20Publikationer_i_pdf/2016/Healthcare-in-dk-16-dec/Healthcare-english-V16-dec.ashx, accessed 21 November 2018).

4. Etniske minoriteter i det danske sundhedsvæsen – en antologi [Ethnic minorities in the Danish health service – an anthology]. Copenhagen: Danish Health Authority; 2010 (in Danish).

5. Nielsen D, Svabo A, Rønde Kristensen T, Sodemann M. Livshistorien er i centrum i Indvandrermedicinsk Klinik [Life history in focus at the migrant health clinic]. Sygeplejersken. 2011;7:50–3 (in Danish).

4

Germany:
financing health services provided to asylum seekers

Author information

Kayvan Bozorgmehr, Head of Research Group, Department of General Practice and Health Services Research, University Hospital Heidelberg, Germany

Judith Wenner, Research Fellow, Department of Epidemiology and International Public Health, School of Public Health, Bielefeld University, Germany

Stefan Noest, Professor, Department of General Practice and Health Services Research, University Hospital Heidelberg, Germany

Christian Stock, Senior Researcher, Institute for Medical Biometry and Informatics, University Hospital Heidelberg, Germany

Oliver Razum, Professor, Department of Epidemiology and International Public Health, School of Public Health, Bielefeld University, Germany

Key messages

- In the 1990s, the Asylum Seekers' Benefits Act established a financing system for asylum seekers in Germany parallel to the welfare and health-care system of the general population. This led to different approaches to the financing of health services for asylum seekers across federal states.

- The compulsory entry medical examination and individual-level care services for asylum seekers in reception centres are covered by relevant state authorities, although the content and organizational aspects of both the services and the examination vary in each state due to a lack of standardization. Some federal states, however, have started negotiating a unified statewide catalogue of services and fees for the entry medical examination.

- After asylum seekers' dispersal to districts, cities and communities, the local welfare agency is the purchaser of health services for individual-level care. The responsibility of financing individual-level health services is linked to residence status, duration of residence and employment status. Local public health offices fund population-level services related to hygiene and the prevention and control of notifiable infectious diseases.

- In many federal states, asylum seekers must apply personally at the local welfare agency for a health voucher to access a health-care provider. The voucher system has proven, however, to have negative effects both in terms of efficiency and equity. To overcome the voucher bureaucracy, some federal states have introduced electronic health cards for asylum seekers. This system has helped by increasing risk-pooling capacity and reducing the financial burden for many communities at the lowest levels of administration, but some economic implications are still controversially discussed.

- The highly decentralized nature of the German health-care system, combined with a lack of political leadership, has prevented the expansion of effective reforms across federal states. Moreover, health policy in this area is strongly influenced by questionable migration policy considerations aimed at deterring future asylum seekers. The existing evidence suggests that it would be effective to use the existing regular system of health-care financing and risk pooling, instead of fragmented parallel systems for minority groups based on their residence status.

1. Introduction

The task of a financing system is to raise adequate funds for health in a way that enables people to access needed services while ensuring their financial protection from impoverishment. To this end, an ideal financing system fulfils three functions: revenue collection; pooling of prepaid revenues and risks across societal sectors; and purchasing of interventions, services and providers based on predefined benefit coverage and entitlements *(1)*.

The introduction of Germany's Asylum Seekers' Benefits Act in the 1990s established a financing system for asylum-seekers separate from the welfare and health-care system of the general population *(2)*. Since then, several initiatives and approaches in financing health services for asylum seekers have emerged in the decentralized German health-care system.

This case study presents and discusses good practices in the financing of health services for asylum seekers in Germany from a health system perspective.

2. Context

a. Financing of health services in the routine health-care system
The German health-care system is a statutory social health insurance system with an opt-out option to private health insurance based on a threshold of individuals' gross annual income. Revenue collection is based on payroll contributions. Since 2009, contributions have been transferred to a central reallocation pool, and then redistributed to the health insurance funds according to a morbidity-based risk-adjustment scheme.

The number of statutory health insurance funds, covering approximately 90% of the population, fell from more than 1800 in the 1970s to 118 in 2016 *(3)* due to cost-containment policies and regulations fostering competition and fusions *(4)*. About 10% of the population is covered by 41 private health insurance companies *(4,5)*. Purchasing of services and reimbursement of providers is based on different funding schemes.

Service providers of the Association of Statutory Health Insurance Physicians are reimbursed for ambulatory care based on the Uniform Value Scale. Services for patients with private health insurance are charged according to the Catalogue of Tariffs for Physicians, an ordinance issued by the Federal Ministry of Health allowing physicians to charge more (by a factor of 1.7 or 2.3) *(4)*. Public health offices provide tax-funded services mainly in the area of prevention and control of infectious diseases.

b. Asylum regulations and financing of health services
Financing of health services is strongly linked to the asylum process (see also "Germany: optimizing service provision to asylum seekers" in this compendium). The compulsory entry medical examination and individual-level care services in reception centres are covered by relevant state authorities. After asylum seekers' dispersal to districts, cities and communities, the local welfare agency is the purchaser of health services for individual-level care. Local public health offices fund population-level services related to hygiene and the prevention and control of notifiable infectious diseases.

The responsibility of financing individual-level health services is linked to residence status, duration of residence and employment status (see Fig. 1). As soon as asylum seekers enter regular employment, they contribute to the statutory social health insurance system and are entitled to regular services (even before the 15-month period in which entitlements are restricted). Their health-care costs are then covered by the health insurance funds.

Fig. 1.   Asylum processes and health-care financing for asylum seekers depending on residence and employment in Germany
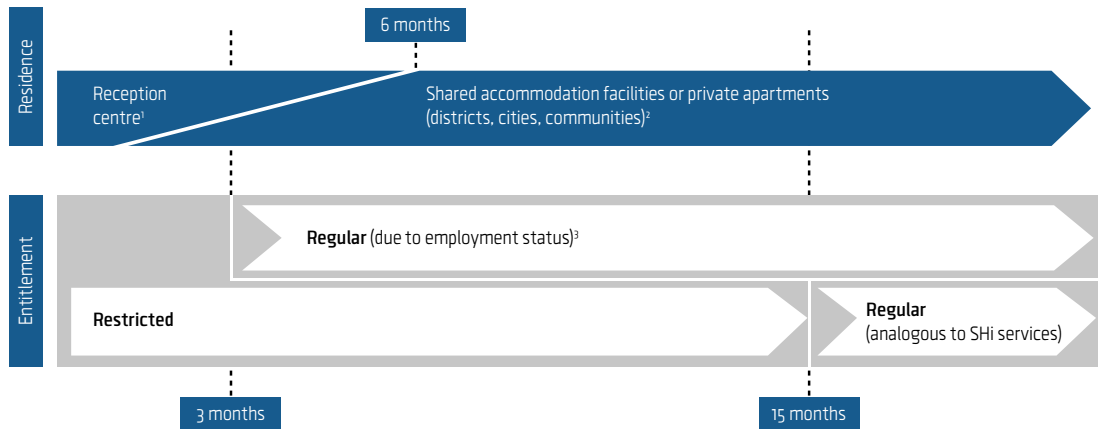
Healthcare costs covered by:
[1] state authorities (tax based)
[2] local welfare agencies (tax based)
[3] sickness fund / private health insurance (pre-paid payroll contributions)

There are, however, complete restrictions on access to the job market for the first 3 months (for asylum seekers from so-called safe countries of origin, the complete restriction on access to the labour market lasts throughout the whole asylum process until the case is closed) *(6)*. During the fourth and fifteenth months, employment is conditional on the lack of nationals to fill the vacant position (following the so-called subordinate principle). After 15 months, no conditionality on access to the labour market exists.

Due to restrictions in entitlements during the first 15 months, specialized care for asylum seekers needs approval by respective authorities. Additional barriers to access exist due to the voucher system, which has been the predominant means of granting physical access to health care since the 1990s *(7,8)*. In the voucher system, asylum seekers must apply personally at the local welfare agency for a health voucher before they can physically access a health-care provider (except in cases of emergency). The health voucher is used by the provider to receive reimbursement, and submitted either directly to the relevant authorities at the state/district level or through the system of the Association Statutory Health Insurance Physicians, which in turn reimburses the providers after charging the authorities for the services provided.

Due to the decentralized mandate for the provision of health care to asylum seekers, financing schemes are heterogeneous: some districts and authorities reimburse providers based on the Uniform Value Scale, while others use the Catalogue of Tariffs for Physicians.

Overall, the regulations affect the efficiency and equity of the financing system in the following ways.

- The voucher system comes with high administrative costs *(9)* and creates parallel structures to the regular financing system in each community.

- Revenues are collected at the lowest level of administration and risks are not pooled beyond the administrative boundaries of districts or, with few exceptions, federal states.

- Purchasing of services is not unified: the same service is produced based on different fees, creating potential for efficiency gains.

Achieving an equitable contribution of districts to the financial costs of health care for asylum seekers is particularly relevant, as asylum seekers have different health-care needs based on their individual constitution (age, sex, country of origin, pre- and perimigration health risks, and personal history) *(10,11)*. Although asylum seekers are dispersed across federal states based on quotas, proxies for health needs among asylum seekers (for example, younger or older age) are not equally distributed across the 412 districts in Germany (see Fig. 2).

Fig. 2. Relative rate of the proportion of accompanied asylum seekers <7 years (left) and asylum seekers >64 years (right) among all asylum seekers at district level relative to the national average (2013)
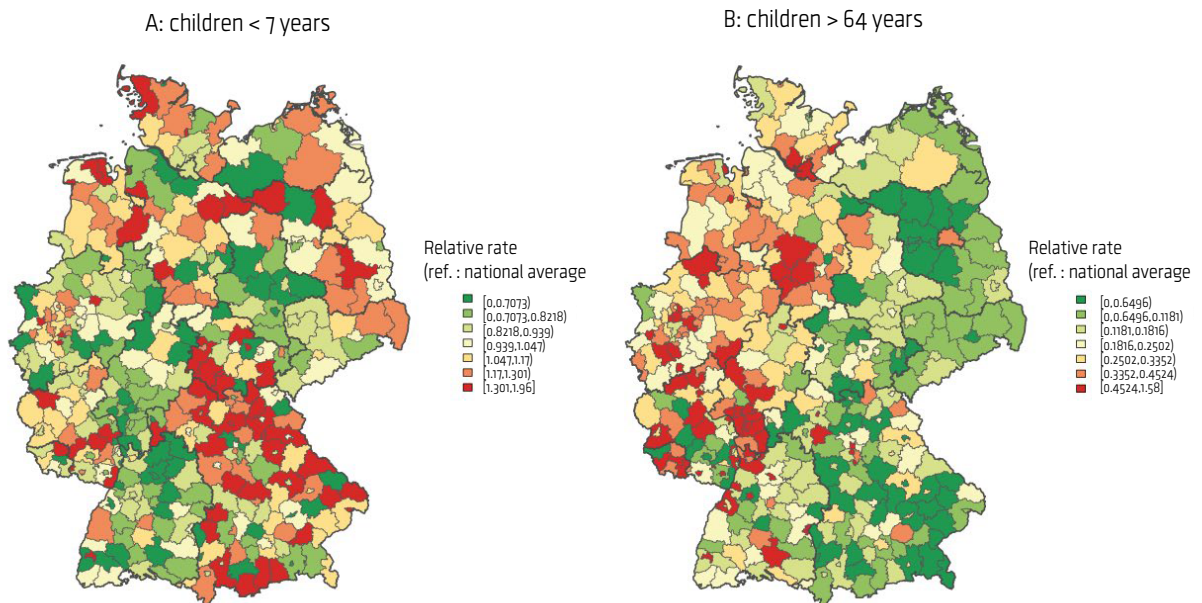
A: national average = 14%
B: national average = 6%

Data source: German Federal Statistics Office. Authors' own calculations and illustrations.

3. The issue: main features of good practices in financing health services

This section highlights selected approaches of federal states to financing health services for asylum seekers that can be regarded as good practices with respect to the above-mentioned health system functions.

a. Financing of the entry medical examination

The entry medical examination varies with respect to operational aspects and content within and between the 16 federal states *(12)*. It is conducted by different providers (public health physicians, commercial providers, nongovernmental organizations, office-based physicians, and regular providers including hospitals) that are either contracted by state authorities (the Ministry of Internal Affairs or the Ministry of Social Affairs) or perform the tasks as part of their duties within the public health service.

In some federal states, contracting out is based on the Catalogue of Tariffs for Physicians and as such entails higher costs. Only a few federal states have initiated statewide standards for financing the entry medical examination. In North-Rhine Westphalia, for example, state authorities and the regional Association of Statutory Health Insurance Physicians negotiated a unified statewide catalogue of services and fees for the entry medical examination based on the Uniform Value Scale of the statutory system *(13)*.

The statewide contract overcomes decentralization and fragmentation in the financing of the entry medical examination. As such, it presumably contributes to the standardization of both the content of the examination and of reimbursement processes. However, systematic evaluations of the impact of such regulations are lacking due to shortcomings of the health information system, which lacks standardized collection of financial and morbidity data among asylum seekers while they are accommodated in reception centres.

b. Financing of individual care

In 2005, the city state of Bremen introduced electronic health cards for asylum seekers to overcome the bureaucracy of the voucher system and channel financial flows through the efficient system of the health insurance funds. Based on the Social Code Book Chapter V, the welfare authorities register asylum seekers with the local health insurance fund and pay a lump sum per capita to cover administrative costs (10 euros per capita per month) *(14)*.

The health insurance funds issue a health card to asylum seekers who can seek care directly without applying for a health voucher *(15,16)*. Health insurance funds reimburse health-care providers for their services and charge the state authorities based on the Uniform Value Scale. The city state of Hamburg adopted this model in 2012. Since then, the introduction of electronic health cards has been discussed throughout the country *(17)*, but adoption and implementation have been heterogeneous *(14)*.

With the introduction of electronic health cards, several federal states have implemented reforms to cover the costs of health care at the federal-state level, thus increasing risk-pooling capacity in the system and reducing the financial burden for communities at lowest levels of administration.

As of the end of 2017, four states (Berlin, Brandenburg, Thuringia and Schleswig-Holstein) had implemented the electronic health cards and continued to carry the costs at the federal-state level. The states started implementation in 2016 *(14)* and evaluations are still in progress.

Three states (North Rhine-Westphalia, Rhineland-Palatinate and Lower Saxony) introduced the electronic health card in single communities and did not implement higher structures in financing, except for single lump payments and regulations to cover exceptionally high costs for individuals on a case-by-case basis *(14)*. It is each community's responsibility to approve or disapprove the implementation of electronic health cards for asylum seekers. As a result, in North-Rhine-Westphalia only 24 (of 396) communities have introduced electronic health cards; of these, one has abandoned this system to reintroduce a voucher system *(18)*. In Rhineland-Palatinate *(19)* and Lower Saxony *(20)*, only three of 2305 and one of 944 communities, respectively, have adopted this reform.

As of the end of 2017, seven states (Bavaria, Baden-Württemberg, Hesse, Mecklenburg-Vorpommern, Saarland, Saxony and Saxony-Anhalt) opposed the introduction of electronic health cards for asylum seekers and stopped further negotiations for the time being *(14,17)*. In these states, asylum seekers must still apply personally at the local welfare agency for a health voucher.

The main objection brought forward by the states and communities that did not implement electronic health cards is the assumed increase of costs, especially in regions in which health insurance funds invoice additional administrative costs for asylum seekers. However, there is yet no evidence in support of this argument *(21)*. The existing evidence shows that health-care costs per capita either stagnate after introduction of electronic health cards *(9,15,22)* or drop when asylum seekers can access the regular health system directly without barriers to access and legal restrictions on entitlements *(8)*.

4. Impact and lessons learned

Few of the above-mentioned financing reforms have been rigorously evaluated with respect to the performance of the financing system. In Bremen, health expenditures for asylum seekers in 2009, 2011 and 2012 were reported to range between 2159 euros and 2392 euros per capita per year *(14)*. In Hamburg, health expenditures for asylum seekers in 2014 were about 2400 euros per capita per year. According to an evaluation of the welfare agency of the state of Hamburg, health-care costs for asylum seekers remained stable after the introduction of electronic health cards (179 euros per capita per month before introduction, versus 175 euros per capita per month after) *(23)*.

Overall, administrative costs of the authorities could be reduced by 1.6 million euros per year by ceasing the voucher bureaucracy and using the efficient structures of the statutory health insurance funds *(9)*. This conclusion is also supported by a time series analysis (1994–2013) of aggregate national data on health expenditures among asylum seekers in Germany: per capita expenditures for asylum seekers in the regular statutory system were on average 40% lower than per capita expenditure for asylum seekers with restricted entitlements after controlling for differences in age, sex, continents of origin and type of housing. Furthermore, restrictive health-care policies were associated with higher per capita health expenditures among asylum seekers *(8)*.

Despite Bremen's introduction of electronic health cards more than ten years ago, and despite positive experiences by states who have adopted the model, system-wide implementation is staggeringly slow. This is mainly due to the decentralized health-care system, and the lack of leadership and mandates at the national level to standardize health-care financing for asylum seekers *(21)*. The roll-out of a model that has proven feasible and cost-effective has been impeded by the political objections of decision-makers and discussions on additional administrative costs raised by regional health insurance funds *(17)*.

A lesson learned from this inadequately implemented health policy reform is that health policy for migrants is strongly influenced by migration policy considerations aimed at the deterrence of future asylum seekers. Both the legitimacy and the effectiveness of such deterrence policies are, however, questionable *(21)*.

As a result of decentralized decision-making, the financing landscape has become extremely heterogeneous in Germany. How extensively this affects health system performance remains unclear. However, the few existing pieces of evidence show that it would be wise to use the regular system of health-care financing and risk pooling instead of setting up fragmented parallel systems at different administrative levels for minority groups based on their residence status.

References

1. The world health report. Health systems financing: the path to universal coverage. Geneva: World Health Organization; 2010 (http://apps.who.int/iris/bitstream/handle/10665/44371/9789241564021_eng.pdf;jsessionid=CEC15109F384A373DEBF-126E52C11A0F?sequence=1, accessed 14 October 2018).

2. Bosswick W. Development of asylum policy in Germany. Journal of Refugee Studies. 2000;1;13:43–60. doi: 10.1093/jrs/13.1.43.

3. Statutory health insurance [webpage]. Berlin: GKV-Spitzenverband; 2018 (https://www.gkv-spitzenverband.de/english/statutory_health_insurance/statutory_health_insurance.jsp, accessed 14 October 2018).

4. Busse R, Blümel M. Germany: health system review. Health Syst Transit. 2014;16(2):1–296.

5. Uber uns [About us] [website]. Berlin: Verband der Privaten Krankenversicherung; 2016 (in German) (https://www.pkv.de/verband/ueber-uns/, accessed 14 October 2018).

6. FAQ: Zugang zum Arbeitsmarkt für geflüchtete Menschen [Frequently asked questions: access to the labour market for refugees] [website]. Nuremberg: Bundesamt für Migration und Flüchtlinge; 2018 (in German) (http://www.bamf.de/DE/Infothek/FragenAntworten/ZugangArbeitFluechtlinge/zugang-arbeit-fluechtlinge-node.html, accessed 14 October 2018).

7. Pross C. Third class medicine: health care for refugees in Germany. Health Hum Rights. 1998;3:40–53.

8. Bozorgmehr K, Razum O. Effect of restricting access to health care on health expenditures among asylum seekers and refugees: a quasi-experimental study in Germany, 1994–2013. PLoS One. 2015;10:e0131483. doi: 10.1371/journal.pone.0131483.

9. Burmester F. Medizinische Versorgung der Leistungsberechtigten nach §§ 4 und 6 AsylbLG über eine Krankenkasse [Statutory health insurance companies and their role according medical care for asylum seekers in Hamburg]. Public Health Forum. 2015;23:106–8 (in German). doi: 10.1515/pubhef-2015-0039.

10. Bozorgmehr K, Szecsenyi J, Stock C, Razum O. Europe's response to the refugee crisis: why relocation quotas will fail to achieve "fairness" from a health perspective. Eur J Pub Health. 2016;26:5–6. doi: 10.1093/eurpub/ckv246.

11. Bozorgmehr K, Wahedi K. Reframing solidarity in Europe: Frontex, frontiers, and the fallacy of refugee quota. Lancet Public Health. 2017;2(1):e10–e11. doi: 10.1016/S2468-2667(16)30036-6.

12. Wahedi K, Noest S, Bozorgmehr K. Die Gesundheitsuntersuchung von Asylsuchenden: Eine bundesweite Analyse der Regelungen in Deutschland; As. 62 Asylverfahrensgesetz. [Health examination of asylum seekers: a nationwide analysis of state policies in Germany: § 62 of the asylum law]. Bundesgesundheitsblatt Gesundheitsforschung Gesundheitsschutz. 2017;60(1):108–17 (in German). doi: 10.1007/s00103-016-2489-2.

13. Medizinische Versorgung von Asylbewerbern in Landeseinrichtungen [Medical care of asylum seekers in state institutions]. KVNO aktuell 11. Düsseldorf: Kassenärztliche Vereinigung Nordrhein; 2015 (in German).

14. Wächter-Raquet, M. Einführung der Gesundheitskarte für Asylsuchende und Flüchtlinge: Der Umsetzungsstand im Überblick der Bundesländer [Introduction of the health card for asylum seekers and refugees: an overview of the status of implementation in the federal states]. Gütersloh: Bertelsmann Stiftung; 2016 (in German).

15. Jung, F. Das Bremer Modell – Gesundheitsversorgung Asylsuchender [The Bremen model – health care for asylum seekers]. Bremen: Gesundheitsamt Bremen; 2011 (in German).

16. Mohammadzadeh Z, Jung F, Lelgemann M. Gesundheit für Flüchtlinge – das Bremer Modell [Health for refugees – the Bremen model]. Bundesgesundheitsblatt Gesundheitsforschung Gesundheitsschutz. 2016;59:561–9 (in German). doi: 10.1007/s00103-016-2331-x.

17. Hyde R. Refugees need health cards, say German doctors. Lancet. 2016;388:646–8. doi: 10.1016/S0140-6736(16)31346-0.

18. Gesundheitskarte für Flüchtlinge [Health cards for refugees]. Düsseldorf: Ministerium für Arbeit, Gesundheit und Soziales des Landes Nordrhein-Westfalen; 2018 (in German) (https://www.mhkbg.nrw/gesundheit/versorgung/Gesundheit-skarte-fuer-Fluechtlinge/index.php, accessed 14 October 2018).

19. Elektronische Gesundheitskarte für Flüchtlinge in Rheinland-Pfalz [Electronic health cards for refugees in Rhineland-Palatinate] [webpage]. Mainz: Ministerium für Soziales, Arbeit, Gesundheit und Demografie des Landes Rheinland-Pfalz; 2018 (in German) (https://www.mags.nrw/gesundheitskarte-fuer-fluechtlinge, accessed 14 October 2018).

20. Einführung der elektronischen Gesundheitskarte für Flüchtlinge: Antwort der Landesregierung auf die Mündliche Anfrage [Introduction of the electronic health card for refugees: response of the state government to the question]. Niedersächsisches Ministerium für Soziales GuG; 2018 (in German) (http://www.ms.niedersachsen.de/aktuelles/presseinformationen/einfuehrung-der-elektronischen-gesundheitskarte-fuer-fluechtlinge-147046.html, accessed 14 October 2018).

21. Bozorgmehr K, Razum O. Refugees in Germany – untenable restrictions to health care. Lancet. 2016;388:2351–2. doi: 10.1016/S0140-6736(16)32131-6.

22. Bozorgmehr K, Mohsenpour A, Saure D, Stock C, Loerbroeks A, Joos S et al. Systematische Übersicht und „Mapping" empirischer Studien des Gesundheitszustands und der medizinischen Versorgung von Flüchtlingen und Asylsuchenden in Deutschland (1990–2014) [Systematic review and evidence mapping of empirical studies on health status and medical care among refugees and asylum seekers in Germany (1990–2014)]. Bundesgesundheitsblatt Gesundheitsforschung Gesundheitsschutz. 2016;59:599–620 (in German). doi: 10.1007/s00103-016-2336-5.

23. Burmester F. Auswirkungen der Zusammenarbeit mit der AOK Bremen/Bremerhaven aus Sicht der Behörde für Arbeit, Soziales, Familie und Integration [Effects of the cooperation with the AOK Bremen/Bremerhaven from the point of view of the Department of Labour, Social Affairs, Family and Integration of Hamburg]. Hamburg: Behörde für Arbeit, Soziales, Familie und Integration der Freien und Hansestadt Hamburg; 2016 (in German).

5

Germany:
optimizing service provision to asylum seekers

Author information

Kayvan Bozorgmehr, Head of Research Group, Department of General Practice and Health Services Research, University Hospital Heidelberg, Germany

Oliver Razum, Professor, Department of Epidemiology and International Public Health, School of Public Health, Bielefeld University, Germany

Stefan Noest, Professor, Department of General Practice and Health Services Research, University Hospital Heidelberg, Germany

1. Introduction

Germany received more than 476 000 asylum applications in 2015 *(1)* out of a total of 890 000 individuals who were registered entering the country *(2)*. Between 2010 and 2014, Germany ranked first with respect to the number of asylum applications in both absolute (434 260 applications) and relative terms with respect to the country's gross domestic product (GDP) per capita (9.9 applications per US$ 1 GDP per capita) *(3)*. Relative to its population size, it ranked 13th worldwide with 13 applications per 1000 inhabitants *(3)*.

Peaking numbers of asylum seekers in the 1990s led to a fundamental and restrictive reform of the asylum policy in Germany *(4)*. Since 1993, the Asylum-Seekers' Benefits Act (AsylbLG) has governed asylum seekers' entitlements to essential welfare services (for example, housing, food, clothing), and access to the labour market and health-care services.

During the first 15 months of their stay, asylum seekers are entitled to health-care services for acute and painful conditions, vaccinations, preventive care, and check-ups for children and maternity care services during pregnancy and childbirth. Access to further services may be granted upon request on a case-by-case basis, conditional on individual assessments by welfare agencies and public health authorities *(5,6)*. While entitlements are governed by national frameworks, they are subject to local interpretation. The organization of service provision is decentralized

and subject to strong heterogeneity with respect to models of care delivery, coordination, purchasing, reimbursement processes and the role of different actors.

This case study presents and discusses selected good practices in health service organization that have evolved in Germany to respond to the local health needs of newly arrived asylum seekers. It builds on empirical research *(7),* a systematic review of the scientific landscape on health-care provision to asylum seekers in Germany *(8)*, grey literature and media reports.

2. Context

a. The German health-care system

The German health-care system is a statutory social health insurance system with an opt-out option to private health insurance. It also contains elements of a tax-funded system. The system is characterized by the self-governance of designated professional bodies and by pronounced decentralization and fragmentation in both governance and service delivery *(9)*.

Individual health-care providers are contracted by health insurance funds and organized in the Association of Statutory Health Insurance Physicians to ensure provision of both primary and specialized care to the population. There is no mandatory gate-keeping system in place: ambulatory care is mainly provided by office-based, single-handed, specialized physicians, while inpatient care is provided by hospitals *(9)*. The system is well developed and resourced, but fragmentation reduces performance with respect to the provision of high-quality care across sectors *(10)*.

b. Asylum regulations and mandates for health care

Individuals who seek asylum must register in a field office of the Federal Office for Migration and Refugees. They must then undergo a mandatory entry medical examination, which is primarily focused on the detection of infectious diseases and is based on national and state-level regulations. The examination hence varies in form and content between the 16 federal states *(11)*. Applying for asylum is conditional on completion of this examination.

While a decision on their application is pending, asylum seekers are accommodated in reception centres for up to six months. State-level authorities (for example, ministries of internal affairs or ministries of social affairs) have the mandate to ensure health-care provision for asylum seekers while they are staying in reception centres. After their transfer to districts, cities and communes, this mandate lies with the local authorities. After a waiting period of 15 months (as of March 2015), the mandate to ensure care shifts to the local Association of Statutory Health Insurance Physicians *(5)* (see Fig. 1).

Fig. 1. Simplified overview of asylum process and entitlements to health care in Germany[4]
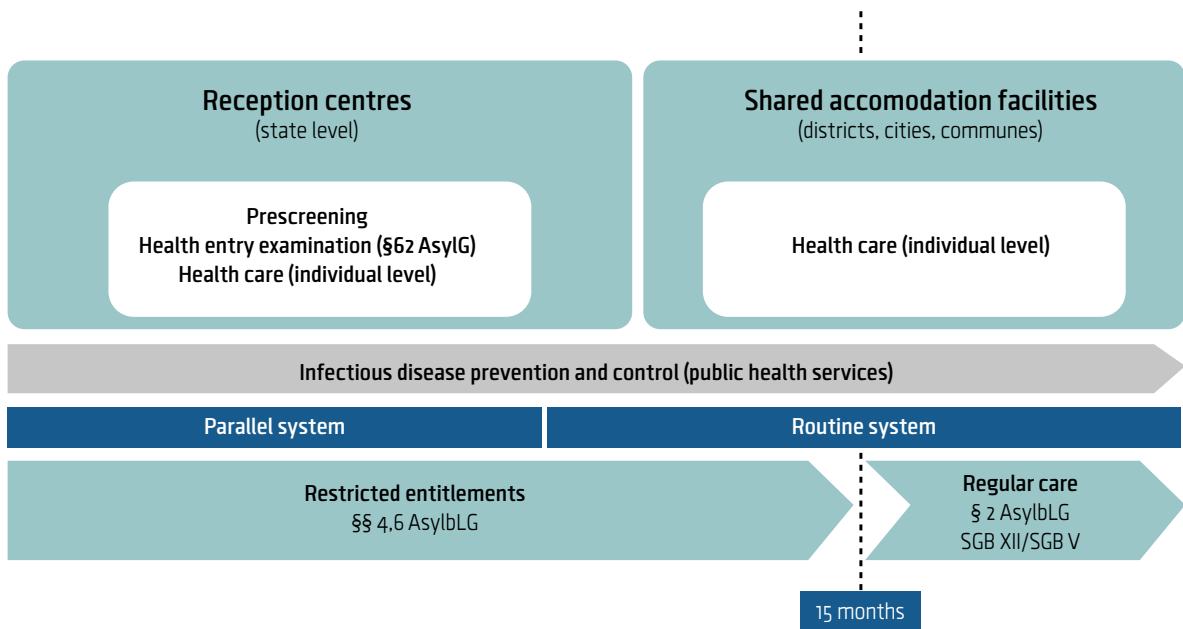
c. Health-care implications for asylum seekers

The national-level policy underlying the AsylbLG states that "the responsible authority" has the mandate to ensure provision of care. Studies show that at the local level this responsibility is mainly understood as a financial responsibility to cover incurring costs of care (7). No guidelines or regulations exist regarding the operational aspects of health-care provision – that is, who should provide what type of care for whom and when. These aspects of provision of care are not governed by national- or state-level regulations (except for the entry medical examination as a public health measure).

As such, the operational practices of care provision are very diverse and characterized by fragmentation and discontinuity of care. In routine health care, services are provided exclusively by local structures and actors of the general health-care system. There are neither special structures nor specific measures or services in place to serve asylum seekers (such as onsite provision of care in accommodation facilities or outreach).

The role of public health services in care provision is limited to upholding standards of hygiene and to infection control. Interpretation services by professional interpreters may be provided upon request on a case-by-case basis. A nationwide survey of public health authorities showed that this form of health-care organization was in place in the majority of districts in Germany in 2015 (7).

---

4   AsylG: Asylum Law; AsylbLG: Asylum-Seekers' Benefits Act; SGB XII: Social Code Book Chapter XII; SGB V: Social Code Book Chapter V.

3. The issue: optimizing service provision to asylum seekers

The initiatives to address the health-care needs of asylum seekers that have evolved in the policy environment outlined above can be categorized according to the type of health-care providers involved, their coordination and governance systems, the role of public health services, and financing aspects.

a. Public health initiatives

The following practice of care has been deployed in Bremen since the 1990s *(12)*. Primary care physicians employed by public health services provide care to asylum seekers onsite in reception centres and in large accommodation centres after transfer. Asylum seekers may utilize the regular service provided by office-based physicians outside these facilities, but descriptive case series show that the acceptance of the onsite service is high due to its accessibility. Treatment for acute needs is provided, medications are prescribed and referrals to the regular system are made where needed. The proportion of referrals to health-care providers outside reception centres has decreased over time, indicating that onsite provision of care has been able to effectively address an increasing proportion of reasons for encounter *(12)*.

Provision of care for individual needs has been directly linked to the reception process: asylum seekers undergo an entry medical examination that is not only concerned with a limited set of infectious diseases, but also considers other health-care needs *(12)*. Linking entry medical examinations with care provision for broader primary care needs reduces fragmentation and increases continuity of care.

Evaluations of this model have been repeatedly performed since the 1990s *(12–14)*. Analyses of reasons for encounter among asylum seekers consistently show a primary care spectrum: diseases of the respiratory tract, skin diseases, dental problems, gastrointestinal complaints, pain/neuralgia, accidents, psychosomatic complaints and cardiovascular diseases constituted the main health problems *(12–14)*.

A high prevalence of unspecific symptoms has been reported as a sign of high mental stress and a high tendency for somatization *(14)*, and the high need for (nonmedical) psychosocial support is seen as the reason behind health-care utilization. However, addressing mental health needs and overcoming language barriers with professional interpreter services remain challenges a decade after the introduction of this model *(13)*. The services are financed through public funds granted to public health services to organize health care.

This approach to organizing health care has also been in place in Hamburg since 2015 *(15)*. There, public health services have contracted general practitioners as employees to provide care in more than 30 reception centre facilities across the city. Proactive planning and monitoring of the health workforce is based on transparent criteria to achieve coverage of one physician and one nurse per 1000 asylum seekers in facilities.

To respond to the health-care needs of a large number of newly arrived asylum seekers, public health services (in the scope of a public–private partnership) established shipping containers as health-care facilities with standardized infrastructure near reception centres and accommodation facilities *(16)*. Every container has been equipped with medication based on WHO essential drug lists *(15)*. Interpretation services, financed by donations, have been

implemented on a routine basis using an information technology-based video interpretation service. Primary care physicians treat acute needs and make referrals to routine health-care providers where needed.

Elements of such a model can also be found in several rural areas in eastern Germany where physicians employed by public health services provide individual care for asylum seekers within the scope of their routine duties *(7)*. This approach has been chosen in rural areas with shortages in health services in order to complement existing routine care structures.

b. Private-provider initiatives

These initiatives are characterized by services in which private care providers fill the gap left in the absence of specific services provided by the statutory health-care system in the initial phase of arrival (the first 15 months). Health care is mainly provided by personnel of private for-profit (that is, commercial) or private nonprofit entities (for example, nongovernmental organizations (NGOs), faith-based organizations or volunteer organizations).

An example of this type of care can be found in Munich, where a nonprofit NGO was founded to provide primary and specialist care in a large reception centre *(17)*. This was based on the initiative of individuals who negotiated with the regional state authorities in order to improve care for increasing numbers of asylum seekers in the facilities. The workforce is hired by the NGO and reimbursed by the authorities on a per-hour basis.

Other examples of this type of practice include outreach services in large accommodation facilities provided by mobile clinics of Ärzte der Welt (Doctors of the World) in Munich *(18)*. Health services are provided in agreement with the responsible authorities. These were projected as a temporary provision to fill existing gaps in the statutory system. Outreach services are offered several times per week in order to reach individuals with acute or chronic health-care needs who would otherwise be left undiagnosed. Services and medicines are covered by donations, European Union funds and partly by contracts with authorities.

This model also includes volunteer organizations and (nonorganized) individuals who provide onsite medical care in Berlin *(19)* and in many other areas of Germany for newly arrived asylum seekers. This model also includes for-profit commercial entities that hire physicians to provide their services in reception centres and accommodation facilities.

c. Initiatives of statutory providers

These initiatives have mainly been realized to serve the needs of asylum seekers in reception centres. They are based on structures and organizations of the regular statutory system, but comprise additional efforts to meet the primary care and specific needs of asylum seekers. Main providers are hospitals or networks of primary care practitioners. Individual ambulatory care providers usually need to reorganize beyond the existing bodies of the Association of Statutory Health Insurance Physicians to form legal entities enabling reimbursements for services.

Examples include the interdisciplinary clinic in Patrick Henry Village in Heidelberg *(20,21)*, the integrated care clinic in the reception centre in Freiburg *(22)*, and the refugee clinics in Dresden *(23,24)*, Chemnitz and Leipzig *(25)*. These clinics provide onsite interdisciplinary services (primary care and general practice, gynaecology, paediatric care and, partly, mental health services).

In Heidelberg, former barracks of the United States Army were used to accommodate more than 6000 asylum seekers in summer 2015. The responsible state authorities hired a commercial care provider to provide primary care services onsite for a few hours per day. In light of increasing numbers of asylum seekers, the services did not manage to meet existing needs; this led to high utilization of the ambulatory care services of surrounding hospitals (26), including in cases of ambulatory care sensitive conditions (27).

To improve the situation, the local physicians' association, the university hospital, medical students and public health services formed a coalition to develop and implement an onsite interdisciplinary clinic and entered into negotiations with state authorities. After six months of negotiation and planning, the clinic opened in February 2016. Health-care providers from the regular statutory system and physicians of the university hospital have implemented a shift system to provide primary care (five days per week), and specialized care in gynaecology (two days per week) and paediatrics (three days per week) onsite (21). Furthermore, two midwives provide antenatal and postnatal care (two days per week). The university hospitals also provides mental health services onsite (two days per week).

Nonprofessional interpreters are organized and reimbursed by state authorities to provide services for the most commonly used languages. However, language barriers remain due to continual changes in the composition of the asylum seeker population (21).

In Chemnitz, Dresden and Leipzig, the Association of Statutory Health Insurance Physicians opened clinics for asylum seekers on the campuses of university hospitals. In Dresden, specialist services are coordinated by a designated care manager (funded by donations) who supports the organization of interpreters, the arrangement of referrals and appointments, and communication with authorities to receive any required approvals and health-care vouchers (28).

After the transfer of asylum seekers to districts, cities and communes, onsite arrangements in accommodation centres serve asylum seekers' specific needs by reorganizing existing structures of health-care delivery through the joint efforts of public health services (taking a coordinative role) and statutory care providers delivering health care. This model has been implemented in districts in southern Germany (Baden-Württemberg and Bavaria) to ensure vaccination coverage (29) or overall access to health services (30,31) in large and/or remote accommodation facilities.

In Reutlingen (a district in Baden-Württemberg), public health services organized onsite vaccination programmes in cooperation with physicians of the statutory system. Public health services provided vaccines and the overall infrastructure to implement onsite treatment rooms in accommodation centres meeting standards and regulations, and implemented a simplified way to reimburse physicians for their services in order to reduce bureaucratic efforts for each single physician caring for asylum seekers. A retrospective evaluation shows that vaccination coverage in accommodation centres that implemented this model was considerably higher than in accommodation centres served by the routine system (29).

4. Impact and lessons learned

Health service responses to the specific needs of asylum seekers are heterogeneous in Germany and vary within and between federal states. Many initiatives have emerged, sometimes within a short timeframe, to address the specific needs of asylum seekers in reception centres and large accommodation facilities. These initiatives differ not only with respect to the infrastructure of health-care delivery, but also with respect to governance, coordination, the role of purchasers and providers, and the composition of the workforce. The examples above illustrate the different approaches. However, rigorous external evaluations of the different initiatives are lacking. Evidence of their impact is based on narrative or descriptive reports, which are mostly case series, situational reports or media reports published by the providers in order to raise public awareness of local activities.

Available health-care services had to be adapted quickly to the increased needs brought about by the unexpected increase in the number of asylum seekers in 2015. From this perspective, in all above-mentioned activities, health care was (re-)actively (re-)organized to improve the responsiveness and availability of services. Many initiatives emerged as ad hoc solutions to the local challenges faced in 2015 (exceptions include several places *(12,17)* where respective initiatives have been implemented for a decade or more).

The ad hoc nature of responses has been criticized for neglecting existing international standards for addressing the health and humanitarian needs of asylum seekers *(32)*. From a long-term perspective, the performance of the models may differ with respect to the health system goals of providing high-quality, effective and efficient health care. The immediate benefits of any given response must be weighed against aspects of sustainability and quality in the long run.

Furthermore, the body of evidence on health-care provision to asylum seekers in Germany shows that the specific health needs of asylum seekers are not always sufficiently addressed by existing structures *(7,8,33)*. Rigorous evaluations are needed in the future to assess the different models with respect to quality accessibility, patient centeredness/acceptability and overall effectiveness *(34)*.

References

1. Das Bundesamt in Zahlen 2015. Asyl, Migration und Integration [The Federal Office in numbers 2015. Asylum, migration and integration]. Nuremberg: Bundesamt für Migration und Flüchtlinge; 2016 (in German).

2. 890.000 Asylsuchende im Jahr 2015. Pressemitteilung vom 30.09.2016 [890,000 asylum seekers in 2015. Press release from 30.09.2016]. Berlin: Bundesministerium des Innern; 2016 (in German) (https://www.bmi.bund.de/SharedDocs/pressemitteilungen/DE/2016/09/asylsuchende-2015.html, accessed 11 November 2018).

3. Asylum trends 2014. Levels and trends in industrialized countries. Geneva: United Nations High Commissioner for Refugees; 2015 (http://www.unhcr.org/statistics/unhcrstats/551128679/asylum-levels-trends-industrialized-countries-2014.html, accessed 11 November 2018).

4. Bosswick W. Development of asylum policy in Germany. Journal of Refugee Studies. 2000;13:43–60. doi: 10.1093/jrs/13.1.43.

5. Bozorgmehr K, Razum O. Effect of restricting access to health care on health expenditures among asylum-seekers and refugees: a quasi-experimental study in Germany, 1994–2013. PLoS ONE. 2015;10:e0131483. doi: 10.1371/journal.pone.0131483.

6. Razum O, Bozorgmehr K. Restricted entitlements and access to health care for refugees and immigrants: the example of Germany. Global Social Policy. 2016;16(3):321–4. doi: 10.1177/1468018116655267.

7. Bozorgmehr K, Noest S, Thaiss MH, Razum O. Die gesundheitliche Versorgungssituation von Asylsuchenden [Health-care provisions for asylum seekers: a nationwide survey of public health authorities in Germany]. Bundesgesundheitsblatt Gesundheitsforschung Gesundheitsschutz. 2016;59:545–55 (in German). doi: 10.1007/s00103-016-2329-4.

8. Bozorgmehr K, Mohsenpour A, Saure D, Stock C, Loerbroeks A, Joos S et al. Systematische Übersicht und „Mapping" empirischer Studien des Gesundheitszustands und der medizinischen Versorgung von Flüchtlingen und Asylsuchenden in Deutschland (1990–2014) [Systematic review and evidence mapping of empirical studies on health status and medical care among refugees and asylum seekers in Germany (1990–2014)]. Bundesgesundheitsblatt Gesundheitsforschung Gesundheitsschutz 2016;59:599–620. (in German). doi: 10.1007/s00103-016-2336-5.

9. Busse R, Blümel M. Germany: health system review. Health Syst Transit. 2014;16(2):1–296.

10. Szecsenyi J, Broge B, Eckhardt J, Heller G, Kaufmann-Kolle P, Wensing M. Tearing down walls: opening the border between hospital and ambulatory care for quality improvement in Germany. Int J Qual Health Care. 2012;24:101–4. doi: 10.1093/intqhc/mzr086.

11. Wahedi K, Noest S, Bozorgmehr K. Die Gesundheitsuntersuchung von Asylsuchenden: Eine bundesweite Analyse der Regelungen in Deutschland; As. 62 Asylverfahrensgesetz [Health examination of asylum seekers: a nationwide analysis of state policies in Germany: § 62 of the asylum law]. Bundesgesundheitsblatt Gesundheitsforschung Gesundheitsschutz. 2017;60(1):108–17 (in German). doi: 10.1007/s00103-016-2489-2.

12. Mohammadzadeh Z. Das Bremer Erstuntersuchungsprogramm für Asylsuchende. II [Initial health examination programme for political asylum seekers in Bremen. II] Das Gesundheitswesen. 1995;57:462–6 (in German).

13. Mohammadzadeh Z, Jung F, Lelgemann M. [Health for refugees – the Bremen model]. Bundesgesundheitsblatt Gesundheitsforschung Gesundheitsschutz. 2016;59:561–9 (in German). doi: 10.1007/s00103-016-2331-x.

14. Jung F. Das Bremer Modell – Gesundheitsversorgung Asylsuchender [The Bremen model – health are for asylum seekers]. Bremen: Gesundheitsamt Bremen; 2011 (in German).

15. Jakubowski E, Rau C, Quellhorst S, Sothmann P, Plenge-Bonig A, Niessen J. Medizinische Versorgung von Flüchtlingen: Chancen und Herausforderungen in Hamburg – ein Praxisbericht [Health care for refugees: challenges and opportunities in Hamburg]. Gesundheitswesen. 2017;79:599–604 (in German). doi: 10.1055/s-0043-101513.

16. Refugee First Response Center. World premiere in Hamburg: medical first aid centre, with live video translation service [website]. Hamburg: Refugee First Response Center; 2016 (http://refugeefirstresponsecenter.com, accessed 11 November 2018).

17. Alberer M, Wendeborn M, Löscher T, Seilmaier M. Daten von drei verschiedenen medizinischen Einrichtungen im Raum München aus den Jahren 2014 und 2015 [Spectrum of diseases occurring in refugees and asylum seekers: data from three different medical institutions in the Munich area from 2014 and 2015]. Deutsche medizinische Wochenschrift. 2016;141:e8–15 (in German). doi: 10.1055/s-0041-106907.

18. München: Ärzte der Welt mobil fährt erste Einsätze [Munich: Doctors of the World mobile clinic drives first mission]. New York: Doctors of the World; 2016 (in German) (http://www.aerztederwelt.org/projekte/projekt-details/article/muenchen-aerzte-der-welt-mobil-faehrt-erste-einsaetze.html, accessed 11 November 2018).

19. Jonitz G. Medizinische Notversorgung kann nicht nur Aufgabe Freiwilliger sein [Emergency medical care cannot be just a volunteer task]. Berlin: Der Tagesspiegel; 2016 (https://www.tagesspiegel.de/berlin/fluechtlinge-in-berlin-medizinische-notversorgung-kann-nicht-nur-aufgabe-freiwilliger-sein/12499360.html, accessed 11 November 2018).

20. Riemer S. Neue Ambulanz in Patrick Henry Village: Kürzere Wege für kranke Flüchtlinge [New ambulance in Patrick Henry Village: shorter waits for sick refugees]. Heidelberg: Rhein-Neckar-Zeitung; 2016 (in German) (https://www.rnz.de/nach-richten/heidelberg_artikel,-Heidelberg-Neue-Ambulanz-in-Patrick-Henry-Village-Kuerzere-Wege-fuer-kranke-Fluech-tlinge-_arid,169204.html, accessed 11 November 2018).

21. Nikendei C, Huhn D, Adler G, von Rose PB, Eckstein TM, Fuchs B, et al. Entwicklung und Implementierung einer Mediz-inischen Ambulanz in einer Erstaufnahmeeinrichtung für Asylsuchende des Landes Baden-Württemberg. [Development and implementation of an outpatient clinic at an initial reception centre for asylum seekers in the German federal state of Baden-Wuerttemberg]. Z Evid Fortbild Qual Gesundhwes. 2017;126:31–42 (in German). doi: 10.1016/j.zefq.2017.07.011.

22. Lange B, Stete K, Bozorgmehr K, Camp J, Kranzer K, Kern W et al. Gesundheitsversorgung geflüchteter Menschen – Eine kurze Übersicht mit einem Schwerpunkt auf Infektionserkrankungen. [Health care of refugees – a short review with a focus on infectious diseases]. Dtsche Med Wochenschr. 2016;141:772–6 (in German). doi: 10.1055/s-0042-107178.

23. Hinze D, von Woelfel U. Die Flüchtlingsambulanz Dresden – Ein Modellprojekt interdisziplinärer Zusammenarbeit [The refugee ambulance in Dresden – a model of interdisciplinary collaboration]. Dresden: Kassenärztliche Vereinigung Sachsen; 2016 (in German) (https://www.kvs-sachsen.de/fileadmin/data/kvs/img/Mitglieder/KVS-Mitteilungen/2016-07-08/s_10.pdf, accessed 11 November 2018).

24. Dresden: Flüchtlingsambulanz arbeitet auch 2017 weiter [Dresden: refugee outpatient clinic continues to function in 2017]. Berlin: Deutsches Ärzteblatt; 2016 (in German) (https://www.aerzteblatt.de/nachrichten/71206/Dresden-Fluechtlingsam-bulanz-arbeitet-auch-2017-weiter, accessed 11 November 2019).

25. Praxis zur ambulanten ärztlichen Versorgung von Flüchtlingen [Practice for outpatient medical care for refugees]. Dresden: Freistaat Sachsen; 2016 (in German) (https://www.medienservice.sachsen.de/medien/news/199384, accessed 11 November 2018).

26. Straßner C, Gewalt SC, Becker von Rose P, Lorenzen D, Szecsenyi J, Bozorgmehr K. Quality circles to identify barriers, facilitating factors, and solutions for high-quality primary care for asylum seekers. BJGP Open. 2017;1(3):BJGP-2017-0112. doi: 10.3399/bjgpopen17X101133.

27. Lichtl C, Lutz T, Szecsenyi J, Bozorgmehr K. Differences in the prevalence of hospitalizations and utilization of emergency outpatient services for ambulatory care sensitive conditions between asylum-seeking children and children of the general population: a cross-sectional medical records study (2015). BMC Health Serv Res. 2017;17:731. doi: 10.1186/s12913-017-2672-7.

28. Lotse ebnet Flüchtlingen Wege zu spezialärztlicher Versorgung am Uniklinikum [Care coordinator paves the way for refugees to access specialized medical care at the university hospital]. Dresden: Universitätsklinikum Carl Gustav Carus; 2015 (in German) (https://www.uniklinikum-dresden.de/de/presse/aktuelle-medien-informationen/lotse-ebnet-fluechtlingen-wege-zu-spezialaerztlicher-versorgung-am-uniklinikum, accessed 11 November 2018).

29. Brockmann SO, Wjst S, Zelmer U, Carollo S, Schmid M, Roller G et al. ÖGD-Initiative zur Verbesserung der Durchimpfung bei Asylsuchenden [Public health initiative for improved vaccination for asylum seekers]. Bundesgesundheitsblatt Gesundheitsforschung Gesundheitsschutz. 2016;59:592–8 (in German). doi: 10.1007/s00103-016-2335-6.

30. Koch-Widmann A. Flüchtlinge im Enzkreis: Arztsprechstunde im Asylheim [Refugees in Enzkreis: doctor's consultation in asylum accommodations]. Stuttgart: Stuttgarter Zeitung; 2015 (in German) (https://www.stuttgarter-zeitung.de/inhalt.fluechtlinge-im-enzkreis-arztsprechstunde-im-asylheim.00cc2258-61ab-4845-8a5c-49274e0d4e88.html, accessed 11 November 2018).

31. Schwienhorst EM, Stich A. Medizinische Versorgung von Flüchtlingen und Asylbewerbern – Erfahrungen aus dem Würzburger Modell [Medical care of refugees and asylum seekers – experiences from the Wuerzburg Model]. Flugmedizin, Tropenmedizin, Reisemedizin. 2015;22:116–21 (in German). doi: 10.1055/s-0035-1557101.

32. Gardemann J, Wilp T. Gültigkeit international verbindlicher, normativer und technischer Standards der Flüchtlingshilfe auch in den deutschen Erstaufnahmeeinrichtungen [The Humanitarian Charter and minimum standards in humanitarian response are applicable in German refugee facilities]. Bundesgesundheitsblatt Gesundheitsforschung Gesundheitsschutz. 2016;59:556–60 (in German). doi: 10.1007/s00103-016-2330-y.

33. Kühne A, Gilsdorf A. Ausbrüche von Infektionskrankheiten in Gemeinschaftsunterkünften für Asylsuchende 2004–2014 in Deutschland [Infectious disease outbreaks in centralized homes for asylum seekers in Germany from 2004–2014]. Bundesgesundheitsblatt Gesundheitsforschung Gesundheitsschutz. 2016;59:570–7 (in German). doi: 10.1007/s00103-016-2332-9.

34. Quality of care: a process for making strategic choices in health systems. Geneva: World Health Organization; 2006 (http://apps.who.int/iris/handle/10665/43470, accessed 11 November 2018).

6 Mental health and psychosocial support services

to unaccompanied migrant minors in Hamburg and Bremen, Germany

Author information

Eva Niessen, Intern, Division of Health Systems and Public Health, WHO Regional Office for Europe

Elke Jakubowski, Senior Adviser for Policy and Strategy, Division of Health Systems and Public Health, WHO Regional Office for Europe

Key messages

- The mental health of unaccompanied minors (UAMs) of migrant origin may be worsened as a consequence of traumatic past experiences in their country of origin or during their journey, but also due to a difficult legal and social environment in the host country. Responding to the mental health needs of UAMs is often a challenge for health professionals.

- Long waiting periods for UAMs with mental health conditions following their reception are sometimes unavoidable due to a lack of capacity. Such postponement, however, may lead to chronicity of mental conditions which in turn will likely complicate treatment. Greater flexibility should be sought for the fast recruitment of additional capacity when needed.

- Service provision of mental health and psychological support services often involves the work of nongovernmental organizations and volunteers. Public supervision as well as public co-funding is essential in order to increase sustainability and ensure quality of service.

- The availability of health information is key to the provision of continuous health services to UAMs. Strong data protection regulations, however, pose difficulties for the documentation of sensitive information, such as the individual mental health conditions of UAMs. It is important to systematically convey to UAMs the importance of keeping health documentation, especially regarding vaccinations. The provision of information about the health services available to UAMs in the host country is also vital in order to prevent false expectations.

- Overcoming both linguistic and cultural barriers in the diagnostic and treatment stages requires mental health professionals to be familiar with cultural sensitivities.

- In the context of a rapid increase of newly arrived UAMs, early efforts must focus on developing local strategies and plans for providing post-acute care in routine settings. These strategies need to feed into regular service planning in primary care centres.

- Establishing outcome measures to assess the quality of the mental health services provided to UAMs remains an important task. Intermediate outcome measures may include information on the reduction of symptoms, satisfaction of the patient, social and linguistic integration, school grades and drop-out rates, among others.

1. Introduction

This case study reports on the provision of mental health and psychosocial support services to unaccompanied minors (UAMs) of migrant origin up to the age of 18 in the two city states of Hamburg and Bremen, Germany. It focuses on the situation in autumn 2016. The example from Hamburg focuses on institutional outpatient and inpatient mental health services for UAMs with symptoms of mental health conditions, whereas the example from Bremen focuses on mental health and broader psychological support services provided in the context of the assisted living programme for UAMs.

The coordination, organization and provision of health services to migrants is devolved to the 16 federal states in Germany. In November 2015, a new law came into force that aimed at improving accommodation, care, supervision and support for UAMs and at regulating their distribution across Germany. Federal states are, however, free to accept a higher number of UAMs according to their assessment of individual cases. In Hamburg, 1557 UAMs were registered in 2015 *(1)*. About half of them were redistributed to other federal states, following the national distribution formula. In July 2016, the number of UAMs in Hamburg amounted to 851 overall. Bremen hosted a total of 2600 UAMs in 2015, a number well above the distribution formula for Bremen *(2)*.

This case study is based on available literature and interviews with health and other professionals involved in the coordination, provision and monitoring of health services for UAMs in Hamburg and Bremen. The information provided is not a complete account of the situation, but exemplary. It is important to note that the number of UAMs arriving in Hamburg and Bremen was highly dynamic between 2014 and 2016. This case study will complement the information provided in the two additional cases on optimizing service provision and the financing of health services provided to asylum seekers in Germany.

2. Context

After a UAM has reached his or her final destination, the federal state's local youth welfare office is responsible for clarifying their legal status and ensuring guardianship, as well as for examining and meeting health service needs and educational requirements. Financing of health services for UAMs beyond the diagnostic stage at reception in both Hamburg and Bremen is provided by the authority of social affairs for up to 15 months. Thereafter, UAMs are eligible to obtain a health insurance card funded by the national social health insurance scheme; this follows the so-called Bremen model, which was first established there.

In both Hamburg and Bremen, a plethora of voluntary private and civil society initiatives provide various types of support projects and services to UAMs.

a. Governance arrangements for UAMs in Hamburg
Coordination in Hamburg is the responsibility of a central coordinating body, which was established in 2015. It is formed of representatives of the two senate authorities for internal affairs and social affairs, which are responsible for the coordination of initial reception (internal affairs) and housing (social affairs) for all asylum seekers and refugees arriving in Hamburg. A steering group, chaired by the authority of health and consumer protection and

made up of the authorities for internal and social affairs (the public providers of accommodation) and the public health offices of two of the districts in Hamburg, is responsible for the coordination of health service provision for refugees and asylum seekers.

Public funding for health services for newly arrived asylum seekers is shared between the authorities for internal and social affairs.

b. Governance arrangements for UAMs in Bremen

The authority for internal affairs in Bremen is responsible for overseeing residence, asylum rights and integration. It supervises the implementation and enforcement of federal legislation by the local immigration authorities. The authority for social affairs is responsible for social affairs of foreigners, including asylum seekers and refugees, as well as for integration, and is a prominent actor in providing services to UAMs in Bremen. As in Hamburg, the youth office is responsible for meeting housing and educational needs as well as for providing social and health services, the latter of which is coordinated with the health authority of Bremen.

3. The issue: providing mental health and psychosocial support to UAMs

a. Institutional outpatient and inpatient mental health service provision to UAMs in Hamburg

The first contact point with health services for UAMs takes place at the reception stage when the entry medical examination is provided. This examination takes place two to three days after UAMs have been registered by the youth emergency service for children and adolescents, and places special emphasis on detecting and preventing infectious diseases. UAMs 15 years of age or older receive an X-ray of the lung to exclude tuberculosis (TB). UAMs under 15 years of age with respiratory symptoms are offered a TB skin test. Vaccinations are provided to fill immunization gaps on a voluntary basis, and further blood or urine tests are offered in case UAMs suffer from symptoms of infectious disease.

Following the entry medical examination, the public health office of Hamburg Altona provides a more general anamnesis and medical examination in a special examination room for children and adolescents, which was designed in collaboration with the team from the youth emergency service. This examination provides a more comprehensive diagnostic baseline and is not limited to infectious diseases. At this stage, mental health and symptoms of post-traumatic stress disorder, such as sleep disturbance, nightmares, flashbacks and eating disorders, are diagnosed through medical anamnesis.

For symptomatic UAMs, the public health office of Hamburg Altona arranges referrals and further treatment throughout a designated network of family doctors, paediatricians, gynaecologists, child and adolescent health services, youth psychiatry clinics, and others. In 2015, up to 20 UAMs were examined per day. Since then, the number of examinations dropped to less than five on average per day following an overall decline of reception of UAMs in Hamburg. The capacity of the health department in autumn 2016 allowed for the examination of several thousand UAMs per year.

There are three institutional providers of outpatient and inpatient mental health services specifically designated for UAMs with mental health needs in Hamburg: the charitable foundation Children for Tomorrow at the University Medical Center Hamburg–Eppendorf (UKE), the paediatric and adolescent psychiatry services in Wilhelmsburg, and the paediatric and adolescent psychiatry services in Hamburg. Psychological support services are also provided by a multiprofessional team of social workers, educators, interpreters, and trauma and music therapists that operate in one of the 19 youth accommodations (which have 20–120 beds). The regional office for education and counselling provides and funds these services.

Children for Tomorrow maintains an outpatient centre for refugee children with the objective to support children and families who have been victims of war, persecution and organized violence. A foundation established by a former German tennis champion funds its offices and staff. In collaboration with UKE, the outpatient centre provides psychotherapeutic and psychiatric services for refugee children and adolescents up to 18 years of age. In autumn 2016, the centre had 280 UAMs under regular treatment and 180 UAMs on the waiting list. Of the UAMs on the waiting list, 40% were under 14 years of age. Services are funded by social health insurance according to the Bremen model. The authority for health and consumer protection provides co-funding for simultaneous interpretation.

The outpatient ambulance has its own building located on the UKE premises and is closely linked to other child health departments of UKE, such as the child and youth psychiatry, psychotherapy, and psychosomatic medicine departments. Referral is usually arranged either through the public health office of Hamburg Altona via health professionals working at the primary health centres at or close to the reception centres, by paediatricians (for UAMs in fostered family care) or by staff working at the youth accommodations that provide assisted-living programmes.

The initial diagnostics in the outpatient centre consist of three sessions: a conversation between the UAM and a child and adolescent psychiatrist; a general anamnesis; and a mental health screening. For further treatment, the outpatient centre provides two types of mental health services: social psychiatry services and psychotherapy services.

The social psychiatry service encompasses one *Kassensitz* (these licences are granted to physicians to establish a registered practice under social health insurance regulation by the regional physicians' association) and a team comprised of a medical doctor, several psychologists, art therapists, music therapists, social pedagogues, and pedagogues specialized in working with children and adolescents. Within this service, patients receive medicines, social counselling, and support with housing and school attendance.

The aim of psychosocial counselling in the outpatient centre is to help refugee children and adolescents cope with psychosocial stress as well as acute psychosocial crises. These may include difficulties with social and youth offices, the asylum procedure or other aspects of life. In cooperation with the patient, social pedagogues develop suitable strategies and personalized plans that help him or her to cope with stressful situations, make decisions and feel empowered to take action in their lives. Furthermore, social pedagogues provide educational counselling.

Staff of the outpatient centre are in touch with the teachers of UAMs and provide advice in case of problems related to learning, the behaviour of UAMs and their classmates, bullying, etc. Individual needs of UAMs are analysed,

school recommendations are provided and, if needed, extra tuition is arranged. In addition, UAMs receive support related to developing their professional orientation. Through connections with various companies in Hamburg, the outpatient centre provides support for the application process for internship positions and, if possible under the asylum law, training positions. If necessary, assistance is provided to both the young people and the companies at the beginning of the training.

Psychotherapy is provided by approbated psychotherapists on a weekly basis for up to three years, which is unique in Germany. Therapeutic treatment in the outpatient centre can vary from low-threshold medicines-supported treatment to high-frequency treatment in combination with regular psychotherapy. A main focus of the therapeutic work is the treatment of post-traumatic stress disorders. Various therapeutic methods such as behavioural therapy, systemic therapy and depth psychology, eye movement desensitization and reprocessing psychotherapy, and art therapy are applied.

The therapeutic art programme contributes to raising self-esteem, strengthening the formation of identity in exile, and dealing with traumatizing experiences such as loss of family members, abuse, and witnessing violence in war zones or during migration. It uses photography, for example, as a creative orientation tool to enable young people to visualize their own identity.

Staff of the outpatient centre are recruited through a competitive selection process with a focus on cultural sensitivity. Cultural competence training to staff is provided in the outpatient centre, which also provides regular training seminars for other health professionals working with refugees and migrants.

b. Psychosocial support services to UAMs living in youth accommodations in Bremen

Different voluntary youth services are currently providing assisted-living programmes for UAMs in youth accommodations in Bremen, with the overall aim of helping UAMs become more independent by facilitating their social and cultural integration. UAMs receive daily support such as individual counselling, support for school attendance, advice for finding traineeship positions after school, and assistance with legal issues during the asylum-seeking process.

The youth welfare office in Bremen is responsible for the registration and allocation of UAMs to voluntary youth welfare organizations and for assisted-living services. Depending on the housing services of the organization, UAMs can live together with individual supervisors and other adolescents from Germany or with other UAMs only.

Depending on the individual needs of the UAM, psychosocial support interventions may consist of assisted-living counselling, therapeutic residential community care or intensive individual psychological care. The number of hours allotted for interventions is adjusted following consultation with the various members of the youth accommodation's professional support team.

In addition, the case manager of the youth welfare office, the supervisor of the voluntary youth welfare organization and each UAM come together to create a personalized aid plan that sets goals and targets for individual care, such as those related to well-being, integration into school or working life, and autonomy. The aid plan captures the number of hours of individual supervision as well as, for instance, support for the asylum-seeking process and

support for school attendance. In case the UAM needs psychotherapy support, the case manager either transfers him or her to a therapeutic residential community or refers him or her to the Department for Child and Adolescent Psychiatry of the General Hospital of Bremen Ost. Another well-known institution providing psychosocial support in Bremen is Refugio e.V., which takes new patients twice a year.

In addition to defining the specific goals of supervision of the UAM, the aid plan serves as a guide during supervision and acts as a tool with which interventions can be evaluated. In the case that the goals in the aid plan are not met by the end of the intended period, interventions can be extended.

The teams working in the youth accommodations consist mainly of social workers, psychologists, pedagogues, music therapists and educators. For special appointments, interpreters can be employed by the voluntary youth welfare organization. Supervision sessions and team meetings on difficult cases are held on a weekly basis. Training on how to deal with the trauma of UAMs, for instance, is supported financially by the voluntary youth welfare organization.

Mental stabilization of patients with trauma is a crucial part of the therapy included in the aid plans for UAMs in Bremen. Furthermore, daily support and stabilization are considered crucial for their integration process. Having a relationship of trust with a supervisor and someone who is available on a daily basis is especially important, since therapy is often only offered on a weekly basis.

The number of UAMs who receive support varies across different voluntary youth welfare organizations. The Hans Wendt Foundation, for instance, provides assisted living in three different houses with 7–16 beds.

Overall, since the capacity of the voluntary youth welfare organizations to provide psychotherapy for UAMs is very limited, the organizations transfer those who need such treatment to the centres for child and adolescent psychiatry and other outpatient centres of psychotherapists in Bremen; however, data on the volume of these referrals are currently unavailable. Ensuring adequate psychosocial services to meet the needs of all UAMs in Bremen is a challenge. Cooperation among voluntary youth welfare organizations is becoming more and more common, yet competitive behaviour remains an issue.

4. Impact and lessons learned

The relatively high number of newly arrived UAMs between autumn 2015 and autumn 2016 posed challenges but also opportunities for health services provision in both Hamburg and Bremen. The need to provide services related to accommodation, education, health care and social care, for instance, fostered enhanced coordination among the authorities responsible for internal affairs, social affairs and health in both Bremen and Hamburg, and created new platforms for interinstitutional and interdisciplinary exchange. In addition, broad public, social and media support enabled the mobilization of additional voluntary and public funding as well as professional resources. This has in part strengthened local public health infrastructure, such as in the case of Hamburg.

The differences in service infrastructure, capacity and response strategies related to the increased demand for both mental health and psychosocial support services to UAMs at regional and local levels has generated more information about options for meeting future demands arising from new migration dynamics.

In the area of health information, in some instances UAMs were encouraged to keep a personal health booklet with basic information such as the results of the anamnesis, weight, size, and vaccination history with the objective of improving access to information on prior conditions and treatments by health service providers. However, documentation has been a challenge in the 15 months after reception and usually has to be requested from other providers. Even if UAMs have been advised to keep their documentation and vaccination passes, they may discard these if they feel they could cause disadvantages for formal application procedures, including regarding asylum.

A key challenge lies in linguistic and cultural barriers across the whole chain of service provision to UAMs. For instance, gender sensitivities have arisen in cases where female health professionals were to examine male UAMs, and vice versa. Male UAMs who come from a culture where it is frowned upon to look at women often feel uncomfortable having a female supervisor or therapist, and therefore experience difficulties engaging with them. Showing consideration for the cultural mindset and values of the UAM, on one hand, and insisting on upholding those of the host country and community, on the other hand, is challenging for both the supervisor/therapist and the UAM, and impacts on the work of building a relationship.

Linguistic barriers play an important role during service provision and supervision. Often, interpreters can only be employed for official appointments. The supervisor and the UAM must therefore use creative means to communicate in group accommodations – for example, internet-based translation tools. Interpreters are especially valuable at the diagnostic stage, but it should also be noted that the absence of interpretation services can provide important incentives for UAMs to learn the local language.

The misconceptions of UAMs with respect to their expectations of support in domains beyond mental health services, such as housing, is partly related to linguistic barriers and partly to cultural factors.

Waiting times for UAMs with mental health conditions following their reception has been an issue in Hamburg and Bremen. Waiting times usually lead to delays in mental health services provision to UAMs with mental health conditions. These delays can lead to chronicity of mental conditions, which in turn will likely complicate treatment.

Overall, UAMs seem to be comparatively well taken care of in both Hamburg and Bremen. Concerns remain about the point in time when UAMs turn 18 and supervision and support suddenly phase out. In addition, there are uncertainties as to the extent to which the mental health needs of migrant children and adolescents that are accompanied by their parents are sufficiently covered.

References

1. Unbegleitete minderjährige Ausländer. Inobhutnahme und Erstversorgung im Landesbetrieb Erziehung und Beratung. Juli 2018 [Unaccompanied minors. Taking into care and providing initial care in the Land Office for Education and Counselling. July 2018]. Hamburg: Landesbetrieb Erziehung und Beratung; 2018 (in German) (https://www.hamburg.de/content-blob/2672526/d32090f6b090b8cc7fcf94db9c6398d8/data/doku-2010.pdf, accessed 25 November 2018).

2. Zugang und Aufnahme von Flüchtlingen in Bremen [Access and reception of refugees in Bremen]. Bremen: Senatorin für Soziales, Jugend, Frauen, Integration und Sport; 2015 (in German).

7 Contingency plan to strengthen the capacity

of the regional health system of Sicily, Italy, to manage large influxes of refugees and migrants

Author information

Antonio Chiarenza, Chair of the Task Force on Migration, Equity and Diversity of the Health Promoting Hospitals and Health Services Network; Head of Research and Innovation, Clinical Governance, Local Health Authority of the Istituto di Ricovero e Cura a Carattere Scientifico, Reggio Emilia, Italy

Valentina Chiesa, Department of Medicine and Surgery, Unit of Biomedical, Biotechnological and Translational Science, University of Parma, Italy

Key messages

- In the context of the arrival of large numbers of refugees and migrants to the Italian region of Sicily, the Regional Health Authority of Sicily and the WHO Regional Office for Europe created the first public health contingency plan for migration in the WHO European Region. The plan aims at redefining the role of the health sector in the area of migration and health and enhancing its coordination with health and non-health actors, thus improving health governance by advocating for whole-of-government responsibility for health.

- The contingency plan was developed on the basis of the results of three missions conducted between March 2011 and October 2013 to assess the capacity of the health system to respond to and manage the impact of the sudden influx of refugees and migrants in Sicily. An intersectoral working group was established for the development of the contingency plan.

- Key components of the contingency plan include: the identification of the main stakeholders involved in the rescue and reception of refugees and migrants, and the description of their roles and responsibilities within an operational plan; a description of the main medical conditions encountered; an overview of the relevant legislation; and a detailed description of the information flows between all actors involved.

- Key challenges in the implementation of the contingency plan include: existing language and cultural barriers, and an increasing need for cultural mediators; the health consequences of long stays in reception centres; and the lack of an adequate health information system.

- Following the positive experience in Sicily, the Regional Health Authority partnered with the Regional Office to improve public health capacity in the face of large-scale migration in other European countries through initiatives such as the Knowledge Hub on Health and Migration.

1. Introduction

Italy is one of the European countries most affected by the arrival of large numbers of refugees and migrants in the past few years. This situation is particularly challenging in the Sicily region, which represents a southern doorway into Europe *(1,2)*. Traditionally, non-health sectors have been responsible for the overall management of migration, including the provision of health services in migrant reception centres. The management of the health services provided in these centres does not fall within the purview of the national health system and, therefore, it is not the responsibility of the Ministry of Health. Services within the reception centres – including shelter, food and health – fall under the jurisdiction of the Ministry of Interior, and are managed by nongovernmental organizations and the

Red Cross. As a consequence, the health sector's awareness and ownership of the health of refugees and migrants is frequently inadequate.

In order to respond to this situation, the Regional Health Authority of Sicily developed a public health contingency plan for migration *(2,3)* (see Fig. 1) aimed at improving the health sector's role in providing health care to this vulnerable group by reinforcing the idea that health is a whole-of-government responsibility.

Fig. 1.   Regional public health contingency plan for migration *(2)*

This case description draws from reports on the migration situation in Italy; relevant toolkits and reports on strengthening health-system capacity to manage large influxes of refugees and migrants; reports on the development of the contingency plan as well as the contingency plan itself; and an interview with Francesco Bongiorno, the regional coordinator of the contingency plan.

2. Context

a. Current situation

Due to its geographical position, Italy represents one of the main points of entry for refugees and migrants into Europe. The large-scale arrival of refugees and migrants to Italian coasts still represents a public health challenge: between 1 January and 30 September 2016, 132 043 people arrived in Italy by sea, and approximately 67% of them arrived in Sicily *(1)* (see Fig. 2). In the first 9 months of 2016, as in previous years, the vast majority of people arriving in Italy were men (70%), while adult women accounted for 14% of the total *(1)*. In the same period, 19 001 unaccompanied children arrived in Italy by sea, making up 14% of all sea arrivals; this represents a significant increase from 2015, when the number of unaccompanied minors was 7% of the total *(1)*. In 2016, approximately 30%

of new arrivals disembarked in 4 operational hotspots: Lampedusa, Pozzallo and Trapani (in Sicily), and Taranto (in the Apulia region). The remaining 70% arrived in other seaports *(1)*.

Fig. 2. Sea arrivals from 1 January to 30 September 2016 to Italy per region of disembarkation *(1)*
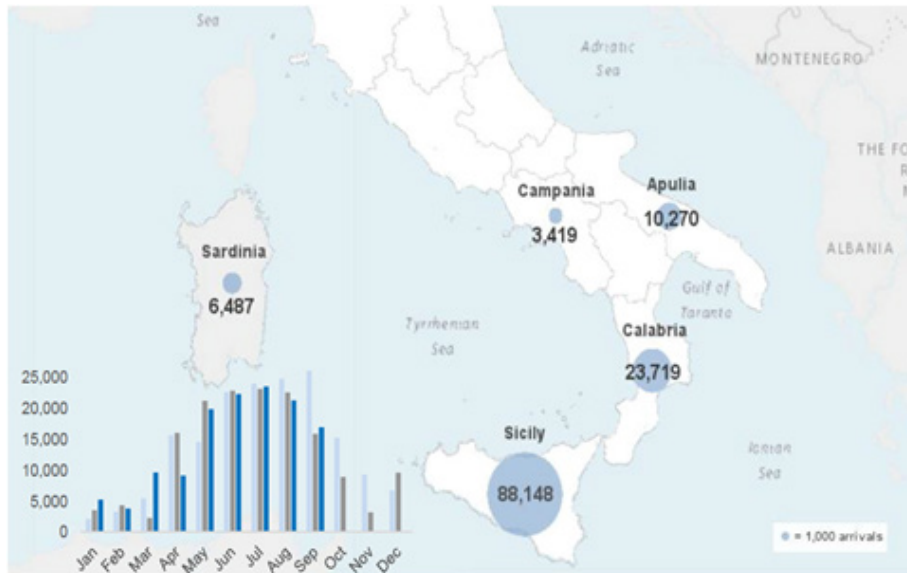
b. Context of the creation of a contingency plan

The contingency plan was developed and implemented on the basis of the results of three missions jointly organized by the Italian Ministry of Health, the Regional Health Authority of Sicily and the WHO Regional Office for Europe and conducted between March 2011 and October 2013. The missions aimed at assessing the preparedness and capacity of the health system to respond to and manage the sudden influx of refugees and migrants to the small islands of Lampedusa and Linosa *(4,5)*. During these missions, the WHO *Toolkit for assessing health system capacity to manage large influxes of refugees, asylum seekers and migrants (6)* was developed on the basis of the WHO *Toolkit for assessing health-system capacity for crisis management (7)*, and used to interview the main actors involved and to assess the impact of policies and interventions.

In addition, consultation meetings were organized and the Public Health Aspects of Migration in Europe (PHAME) project of the Regional Office, financed by the Ministry of Health of Italy, was created. The contingency plan, developed within the PHAME project, set out to redefine the role of the health sector in the area of migration and health and its coordination with non-health actors, thus improving health governance by advocating for whole-of-government responsibility for health. The impact that the naval operations Mare Nostrum and Triton had on the management of arrivals, as well as on the public health response, also catalysed the development of the contingency plan *(2)*.

When the Regional Health Authority of Sicily and the Regional Office joined forces to develop the contingency plan, they established an intersectoral working group for its preparation. This step was of paramount importance due to the fact that non-health-sector agencies, such as the Ministry of Interior, have full control over the provision of services at the reception centres, including health services.

On 3 October 2014 – the first anniversary of the Lampedusa tragedy in which 360 migrants died at sea – the contingency plan was officially made public (2,3).

3. The issue: designing a public health contingency plan for migration in Sicily

a. Aims and purpose

The contingency plan presents the preparative and preventive actions necessary for an effective and coordinated approach in order to transform the management of a significant influx of refugees and migrants from an emergency response to a more comprehensive and systematic one. It identifies the roles and responsibilities of the main actors involved, including the Regional Health Authority and non-health-sector agencies, in order to:

- ensure efficient management of the situation using the resources, rescuers and means of intervention available;

- strengthen organizational aspects to ensure an effective response to the health needs of large influxes of refugees and migrants; and

- develop a two-way flow of information between the central and peripheral systems, and define procedures for coherent communication.

The contingency plan is intersectoral in nature and encompasses a wide range of different agencies and professionals. Actors involved vary from government representatives and decision-makers to professionals working in the field, such as health workers of the Peripheral Offices for Maritime, Air and Transborder Health (USMAF), the Italian Red Cross, Emergency and Doctors Without Borders. The health workforce includes medical doctors, nurses, paediatricians, cultural mediators, psychologists and anthropologists. The contingency plan provides a complete and detailed description of the roles and responsibilities of each actor, and of how the different parties should interact.

The operational plan (see Fig. 3) gives an idea of how all the parts operating on different hierarchical levels should contribute synergistically to form a systematic and programmatic response to large influxes of refugees and migrants in the region.

Fig. 3. Operational plan *(3)*
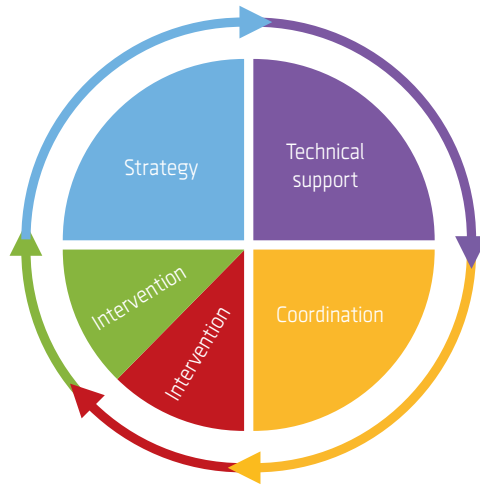
The strategic director plans, makes decisions and manages strategically in order to protect public health, the health of everyone involved in the disembarkation and the health of the resident population. The strategic director reports directly to the Regional Department of Health.

The regional coordinator is responsible for the technical coordination provided by the Regional Department of Health to all institutions involved in the contingency plan. The regional coordinator defines the operational coordination of all health interventions related to the arrival and reception of migrants, and monitors the activities of the regional health system in order to ensure the effectiveness of the contingency plan.

The health coordinator of the provincial health unit – Azienda Sanitaria Provinciale (ASP) – coordinates health interventions at the provincial level from disembarkation to reception centres, liaising with the regional technical support unit, the health services and the focal persons designated by the hospitals.

Local coordinators take care of the health management of migrants in their own territory (during disembarkation, at reception centres and in hospitals).

Regional technical support provides technical and administrative support to the coordinator of the plan.

Intervention (I) refers to the structures responsible for implementing health interventions in the contingency plan as indicated by the local coordinators.

Intervention (II) refers to the structures (Italian Red Cross, Emergency, Doctors Without Borders and voluntary associations) implementing health interventions planned in the contingency plan as indicated by the health coordinator of the ASP.

The contingency plan also describes in detail the roles and responsibilities of the main coordinators involved. Technical forms contain contact details, such as telephone numbers and addresses, and specify information flows between the various parties. Coordination levels are grouped as follows.[5]

- Coordination at regional level: regional health councillor, regional coordinator, head of technical area of public health, head of technical area of disaster management, head of technical area of basic health care, head of technical area of control and monitoring, head of technical area of hospital network, head of communication;

- Coordination at provincial level: regional coordinator, ASP medical directors, hospital medical directors, head of national communication, ASP coordinators for disembarkation, ASP coordinators for reception centres;

- Coordination at disembarkation level: ASP medical director; ASP coordinator for disembarkation; ASP coordinator for dock assistance and triage; person in charge for the Italian Red Cross, Emergency and Doctors Without Borders; person in charge of voluntary associations; person in charge of the emergency medical service (118); head of the hospital network;

- Coordination at reception-centre level: ASP medical director; ASP coordinator of reception centres; ASP coordinator for disembarkation; those in charge of voluntary associations and international organizations; person in charge of primary care and specialist care; person in charge of prevention services; head of emergency medical services; representative of the Italian Society of Migration Medicine; local communication manager.

b. Stakeholders involved

Many stakeholders with different roles and responsibilities are involved in the management of large influxes of refugees and migrants in Sicily (see Table 1). Services are provided by the public sector, civil society, nongovernmental organizations and charities, and are supported by regional, national and international organizations.

The contingency plan targets all actors involved in the public health response to migration from the following levels in order to reach all stakeholders and define roles and responsibilities.

- National level: Presidency of the Council of Ministers, Ministry of Health, Ministry of Interior, Ministry of Labour and Social Policy, Italian Red Cross;

- Regional level: Presidency of the Region, Civil Protection Department, Juvenile Court, Regional Department of Family and Social Policies, Regional Department of Health, Emergency, Doctors Without Borders, regional volunteer associations;

- Provincial level: health authorities of the Regional Health Authority, local offices of the island, police stations;

- Local level: mayors of the municipalities of Sicily.

---

5   For a detailed description of roles and responsibilities of the main coordinators involved, consult the contingency plan *(2)*.

Table 1. Main medical activities conducted at different stages of the rescue and reception process *(3)*

Place	Activities	Purpose	Expected results	Responsible
At sea Military ship	Triage	Assessment of vital signs and identification of critical health issues based on regional guidelines for emergency medical service	Assignment of a priority code/colour	Ministry of Health, Navy
Port Ship at docks	Rapid, targeted clinical examination based on International Health Regulations (IHR) (2005) *(8)*	Checking for signs and symptoms related to diseases that could represent an international public health threat (IHR)	Possible need for hospitalization and WHO notification	USMAF
Port/quay	Rapid and general clinical examination	Revaluation of vital signs and initial assessment of overall health status	Possible need for hospitalization and/or individual medical documentation	ASP coordinator for disembarkation coordinates the Italian Red Cross, Emergency, Doctors Without Borders
Extraordinary reception centre	Complete primary care visits and syndromic surveillance	Diagnosis and treatment of common diseases, possible request of specialist visits and hospital admissions, epidemiological surveillance	Complete individual medical documentation	ASP coordinator of reception centres
Extraordinary reception centre	Sanitary inspection	Monitoring of sanitary conditions	Certification of eligibility	ASP coordinator of reception centres

Procedures for the different operating phases are as follows.

i. Health care in reception centres

Several types of reception centres are in place in Italy, including in Sicily, such as identification and expulsion centres (closed facilities) for irregular migrants waiting to be sent back to their countries of origin, and centres for asylum seekers (open facilities) *(2)*.

Reception centres provide standard services related to personal support, such as clothing, bedding, personal hygiene, health care, psychosocial care, cultural mediation, food, cleaning and hygiene, maintenance, legal support and administrative assistance *(5)*. Italian law outlines a three-tier reception system, including:

- first assistance facilities (called CPSAs) to provide initial accommodation for 48 to 72 hours after landing;
- first-line reception facilities, including first reception centres (called CPAs) and regional hubs; and
- second-line reception facilities (called SPRAR centres, run by the National Association of Italian Municipalities).

If no places are available in first- or second-line reception centres, migrants are accommodated in temporary facilities, also known as extraordinary reception centres (CASs). In Sicily, migrants are hosted in government facilities (already at full capacity). In response to the recent increase in numbers of asylum seekers, the country is setting up a growing number of CASs. These are identified by the Territorial Offices of the Government.

ii. Health care at the dock and transportation to temporary reception centres

Medical doctors of USMAF check any suspected cases of disease in accordance with the IHR before disembarkation at the dock and before referral to the centres. Once at the dock, the ASP coordinates triage activities and supports the Italian Red Cross, Emergency and Doctors without Borders. The ASP coordinator of the CAS manages the activities of the emergency medical service as well as the medical examinations.

iii. Rescue at sea and transport

Medical doctors of USMAF carry out an initial triage on military ships at the time of rescue. Alternatively, this may be carried out by the Order of Malta's Italian Relief Corp when present. Individuals assigned a red or yellow code are referred to the nearest port by boat or, in extreme cases, by military helicopter. Upon arrival at the port, the emergency medical service (118) is called for transportation to hospital (see Fig. 4).

c. Other components of the contingency plan

The contingency plan also includes a useful description of syndromic surveillance, immune prophylaxis, and an emergency plan in case of infectious diseases caused by class IV agents. Other emergency medical conditions such as hypothermia, frostbite and heatstroke/sunstroke are described so they can be recognized and treated appropriately.

Finally, the contingency plan includes an overview of key legislation as well as a detailed definition of the information flows between all actors. It concludes with dedicated sections on assistance to non-European Union citizens and to unaccompanied minors.

Fig. 4. Disembarkation assistance model *(3)*

MEDICAL STAFF (USMAF AND CISOM)

GAZEBO - WAITING

WC WC
WC WC WC

MEDICAL DOCTORS, NURSES CULTURAL MEDIATORS

MEDICAL DOCTORS, PAEDIATRICIANS, NURSES CULTURAL MEDIATORS

TENT FOR MEN

TENT FOR WOMEN AND CHILDREN

TENT FOR OBSERVATION

HEALTH-CARE AREA

CLOTHING DISTRIBUTION

WC WC WC

FOOD DISTRIBUTION

IDENTIFICATION BY POLICE
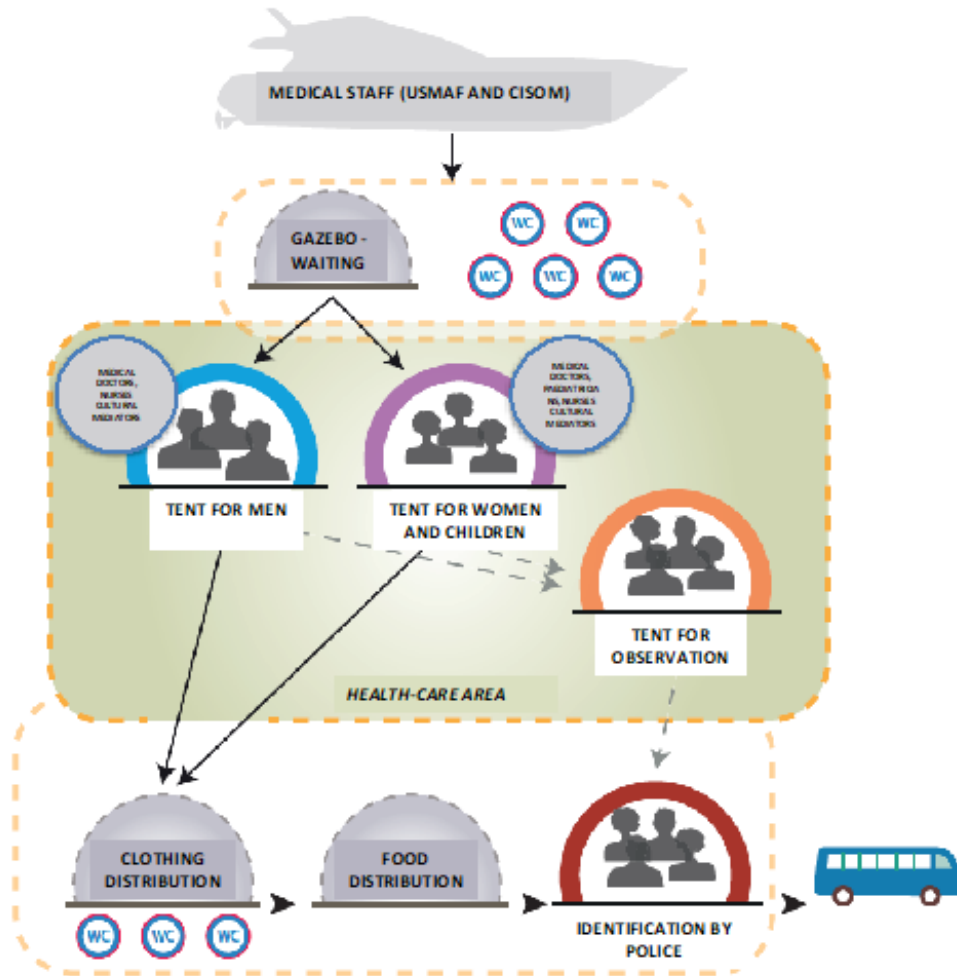
d. Funding and resources

Francesco Bongiorno, the regional coordinator of the contingency plan, explained that a specific budget was not assigned for its development; rather, the contingency plan represents an ad hoc response to the public health issue of the migration influx to Sicily. It is supported by regional policies, and was developed by the Regional Health Authority of Sicily together with a task force of experts from the Regional Office.

e. Monitoring system

According to Francesco Bongiorno, the ASPs monitor the implementation of the contingency plan. One indicator used in its evaluation system is the number of migrants accessing the emergency department after disembarkation – this has greatly decreased in recent years.

4. Impact and lessons learned

Sicily has become the southern doorway to Europe for thousands of people fleeing conflict and war, or seeking opportunities to improve their lives. For many years, the Sicilian region has cooperated with WHO to improve the public health response to migration. It successfully addressed a major public health challenge by developing the first intersectoral contingency plan of its kind in 2014. This transformed the management of migration from an emergency response to a comprehensive and systematic one.

Francesco Bongiorno noted that key added values of the contingency plan include its identification of all the phases of the reception process, its definition of the roles and responsibilities of the different actors, and its inclusion of their contact information. He identified the following challenges in the implementation of the contingency plan.

- The number of cultural mediators has been inadequate both during disembarkation and in hospitals. Cultural mediators and health professionals interacting with refugees and migrants lack specific training Communication barriers are among the biggest obstacles to providing migrants with comprehensive and high-quality health services. A large number of adequately trained professional interpreters as well as intercultural mediators is necessary.

- Overly long stays in reception centres result in organizational and health-related consequences. Reception centres do not feature optimum hygienic and sanitary conditions, and extended stays could have implications on migrants' health status. Long stays represent a bottleneck in the region, and point to the fact that the Sicilian migration challenge should be more effectively shared with other Italian regions.

- No adequate system is in place in Sicily for the exchange of medical information. The absence of a unified and coordinated system containing information on patients' clinical status and illness and treatment history means that every time a patient accesses a hospital or moves to another centre, information on their health status must be collected again. Documentation is an important aspect of centralized coordination: patients' information (documents, medical records, clinical background, treatments, etc.) should travel with them.

b. Transferability of the contingency plan to other settings

Based on the positive example of Sicily and thanks to the more systematic and programmatic approach to the management of migration flows, the application of this model to other settings/countries could be of value. Sicily's contingency plan is the first of its kind in the WHO European Region, and can be implemented in other Italian regions or European settings depending on local contexts and the resources available.

Large population movements pose significant challenges to health systems, and necessitate capacity-building mechanisms to improve resilience. The Regional Health Council of Sicily partnered with the Regional Office to help improve migration capacity in other European countries. In November 2016, the two agencies launched the Knowledge Hub on Health and Migration *(9)* with the financial support of the Regional Health Council. The Knowledge Hub, a virtual platform of knowledge and evidence on migration, provides a scientific and capacity-building forum to develop and improve public policies and interventions to address the health needs of migrants and the public health implications of migration in the European Region.

The Knowledge Hub will support work on issues related to health and migration by:

- providing online training and a summer school to improve the skills of professionals working on the different health aspects of migration (such as migrants' health profiles and needs and the importance of cultural sensitivity in the provision of health care);

- giving professionals access to a network of experts and the opportunity to contribute their local experience to the international discussion;

- bringing together different sectors (such as education and social affairs) that have a major impact on the health of refugees and migrants; and

- dispelling myths and misconceptions around health and migration through a platform for evidence-based interventions *(9)*.

The Knowledge Hub will also contribute to improving other European countries' preparedness and capacity, promoting people-centred health systems and reducing health inequalities within the migrant population.

c. Funding and advocacy

Advocacy efforts – such as participation in national and international conferences, interviews, publications and visibility in the media – can increase overall awareness of migrant-related issues and may contribute to ensuring adequate levels of funding from the national and international community. This is a major factor in providing efficient services and resources for refugees and migrants.

Contingency plan to strengthen the capacity of the regional health system of Sicily, Italy, to manage large influxes of refugees and migrants

81

References

1. United Nations High Commissioner for Refugees (UNHCR). Italy – sea arrivals, UNHCR update #7. September 2016. Geneva: UNHCR; 2016 (https://reliefweb.int/sites/reliefweb.int/files/resources/2016_09_UNHCRCountryUpdateItaly–September2016_V6.pdf, accessed 20 November 2018).

2. WHO Regional Office for Europe, Ministry of Health of Italy, Regional Health Authority of Sicily. Piano di Contingenza Sanitario Regionale Migranti. Modalità operative per il coordinamento degli aspetti di salute pubblica in Sicilia [Regional health contingency plan for migrants. Operating procedures for the coordination of public health aspects in Sicily]. Palermo: Regional Health Authority of Sicily; 2017 (in Italian) (http://pti.regione.sicilia.it/portal/page/portal/PIR_PORTALE/PIR_LaStrutturaRegionale/PIR_AssessoratoSalute/PIR_Pianocontingenzasanitarioregionalemigranti/piano%20contingenza%20 A4–2017_Definitivo.pdf, accessed 11 November 2018).

3. Adozione del Piano di Contingenza Sanitario Regionale Migranti. Decreto 23 settembre 2014 [Adoption of the regional health contingency plan for migrants. Decree No. 23 of September 2014]. Palermo: Gazzetta Ufficiale della Regione Siciliana; 2014 (In Italian) (http://www.gurs.regione.sicilia.it/Gazzette/g14-42o/g14-42o.pdf, 20 November 2018).

4. Second assessment of migrant health needs: Lampedusa and Linosa, Italy. Copenhagen: WHO Regional Office for Europe; 2012 (http://www.euro.who.int/__data/assets/pdf_file/0010/184465/e96796.pdf, accessed 20 November 2018).

5. Sicily, Italy: assessing health–system capacity to manage sudden large influxes of migrants. Joint report on a mission of the Ministry of Health of Italy, the Regional Health Authority of Sicily and the WHO Regional Office for Europe. Copenhagen: WHO Regional Office for Europe; 2014 (http://www.euro.who.int/__data/assets/pdf_file/0007/262519/Sicily–Italy–Assessing–health–system–capacity–manage–sudden–large–influxes–migrantsEng.pdf?ua=1, accessed 20 November 2018).

6. Toolkit for assessing health system capacity to manage large influxes of refugees, asylum seekers and migrants. Copenhagen: WHO Regional Office for Europe; 2016 (http://www.euro.who.int/__data/assets/pdf_file/0018/325611/Toolkit–assessing–HS–capacity–manage–large–influxes–refugees–asylum–seekers–migrants.pdf?ua=1, accessed 11 November 2018).

7. Strengthening health system emergency preparedness. Toolkit for assessing health–system capacity for crisis management. Part 1. User manual. Copenhagen: WHO Regional Office for Europe; 2012 (http://www.euro.who.int/__data/assets/pdf_file/0008/157886/e96187.pdf, accessed 11 November 2018).

8. International Health Regulations. Geneva: World Health Organization; 2005 (http://apps.who.int/iris/bitstream/handle/10665/246107/9789241580496–eng.pdf;jsessionid=E265082DBC9E38162DB29CC75BD2DE2E?sequence=1, accessed 11 November 2018).

9. WHO Regional Office for Europe, Ministry of Health of Italy, Regional Health Council of Sicily, European Commission. Knowledge Hub on Health and Migration [website]. Copenhagen: WHO Regional Office for Europe; 2018 (http://www.euro.who.int/en/health–topics/health–determinants/knowledge–hub–on–health–and–migration/about, accessed 11 November 2018).

8

The provision of migrant-friendly health care in Reggio Emilia, Italy

Author information

Antonio Chiarenza, Chair of the Task Force on Migration, Equity and Diversity of the Health Promoting Hospitals and Health Services Network; Head of Research and Innovation, Clinical Governance, Local Health Authority of the Istituto di Ricovero e Cura a Carattere Scientifico, Reggio Emilia, Italy

Valentina Chiesa, Department of Medicine and Surgery, Unit of Biomedical, Biotechnological and Translational Science, University of Parma, Italy

Key messages

- Reggio Emilia is one of the provinces with the highest percentage of migrants in Italy. At the beginning of 2016, migrants accounted for 12.7% of its entire population. Migrants residing in Reggio Emilia come from a wide variety of countries and cultural and ethnic backgrounds.

- Several structural changes in the health-care sector in Reggio Emilia have been implemented in order to ensure that such diversity does not negatively impact the ability of migrant patients to access health care and have their health needs met. These structural changes were implemented through the participation of the province in the Migrant-Friendly Hospital project in 2002–2005.

- A needs assessment was conducted to collect information on the barriers and costs related to migrants' access to health care, as well as on the potential benefits of making migrant-friendly services available. This information was used to develop a migrant-friendly strategy. A steering committee was designated to manage and monitor the implementation of the strategy.

- A series of migrant-friendly interventions were put in place, including an ad hoc health-care centre for migrant family health; language and mediation support; health information and promotion interventions; training for health professionals; and partnerships and networks aimed at promoting intersectoral action and community participation. Several equity standards were identified and used to develop a self-evaluation tool to assess the interventions.

1. Introduction

Lack of migrant-friendly health systems is the single most important factor impacting access to health services and quality of care for migrants. With no structural preparation for handling the diverse needs of migrant populations, the health sector faces challenges that can represent real problems for service organization and delivery. Unless services are adapted to new needs through the establishment of new information strategies and language support services, and through the incorporation of innovative actions and policies into regular management procedures, the very organization of service delivery may become a barrier to migrants.

Inadequately adapted health systems lead to a number of organizational dysfunctions. For example, unmet health needs tend to converge in emergency departments; unmet language needs tend to slow procedures down; and services that have not been adapted to specific needs create uncertainties for staff and managers.

The Azienda Unità Sanitaria Locale of Reggio Emilia (AUSL RE) adopted a "whole organizational approach" with the aim of implementing a comprehensive process of change and adaptation of services in order to respond appropriately to the needs of migrants and other vulnerable groups. This required management support and policy

development in health service organization in order to enhance the capacity of health service providers, managers and administrators to address the health issues associated with migration, and to deliver quality health services in a comprehensive, coordinated and equitable fashion.

This case description draws from participant experience, reports and research in order to present and discuss the AUSL RE's process of developing migrant-friendly services and organization.

2. Context

The AUSL RE is the statutory provider of health and social care in the province of Reggio Emilia in the central part of northern Italy. It covers the province of Reggio Emilia, which lies at the geographical centre of the Emilia–Romagna region and is one of Italy's most industrialized areas. The province is divided into 45 municipalities and has a population of approximately 533 000 people spread over 2291 square kilometres spanning both hills (the Apennines) and plains (the Po Valley).

The AUSL RE has approximately 6737 employees working in six health districts plus the Presidio Ospedaliero, a complex organization consisting of six hospitals. AUSL RE activities are organized into 14 departments: three for territorial activities, nine for hospital activities, and two for technical and administrative activities. Each department has a manager responsible for the level of quality of the services provided.

a. Demographic aspects

During the last 20 years, the rapidly growing migrant population has made Reggio Emilia one of the Italian provinces with the highest percentage of migrants per capita. At the beginning of 2016, the migrant population accounted for 12.7% of its entire population. The number of registered migrants in the province of Reggio Emilia was 68 004, including 1532 asylum seekers who applied for refugee status *(1)*. This number increases if irregular migrants are included.

One particular feature of migration in Reggio Emilia is the variety of migrants' countries of origin: the province is home to people from 140 countries who speak a total of nearly 200 languages. In comparison with the few migrant groups that arrived during the initial phase of immigration in this area, migrant groups today are younger, smaller, more transient, more socially stratified, less organized and more legally differentiated. In this new situation, the very idea of diversity, which originally related to small numbers of relatively homogeneous ethnic groups, has radically changed to include other dimensions such as immigration status, gradations in rights and entitlements, migration history, and socioeconomic status.

Another distinguishing feature of migration in Reggio Emilia is the regional policy aimed at facilitating the social integration of migrant groups. This has clearly resulted in increasing numbers of migrant family units settling down in the province. This trend is evident in the growing presence of migrant women and migrant children, and in higher levels of permanent residency among migrants in Emilia–Romagna.

b. Health policy context

The growing number of migrants in Reggio Emilia has had a clear impact on the provision of health services. Issues include, for example, the tendency to resort to accident and emergency services rather than primary care, the inappropriate use of hospital services, and increasing difficulties in communication and understanding. Faced with this new situation, the AUSL RE initially reacted with a series of emergency measures, such as the creation of a dedicated health service for migrants, the production of multilingual written information and the use of interpreters in dedicated services. These immediate responses ensured the provision of treatment and care for those migrants who sought health services, even those of irregular status.

However, the opportunity for a more structured response to migrant needs arrived with the participation of the province in the Migrant–Friendly Hospital project from 2002 to 2005. The innovative aspect of this project was its introduction of the idea that to improve responsiveness, we must take measures to improve the knowledge and behaviour of individual patients and providers, and to improve the overall organization of service delivery *(2,3)*.

3. The issue: organizational development of migrant-friendly health care

For the AUSL RE, participation in the Migrant–Friendly Hospital project provided the opportunity to define a more comprehensive and structured response to migrants' needs, initiating a process to develop migrant–friendly health-care organization and improve the quality of interventions. An overall migrant-friendly strategy was developed and progressively implemented in the AUSL RE. Essential to its success was the commitment of the chief executive, governing body and senior managers to ensuring effective implementation of the interventions and to releasing the necessary resources.

In order to convince senior management of the need for developing and implementing a migrant–friendly strategy, it was important to produce evidence. To this end, a local situation analysis was conducted to determine the number of migrants among the resident population, the number of migrants receiving care at the health services, the languages for which translation was needed, migrant and staff needs, and patients' countries of origin. The analysis also determined:

- the disadvantages of not having migrant-friendly services in terms of ensuing costs and human implications, including unnecessary visits, missed appointments, unnecessary diagnostic tests, miscommunication issues, incorrect diagnosis and treatment, lengthy visits, and inequality of care;

- the advantages for the organization of making migrant-friendly services available, including increased quality of care, increased accessibility of services, reduced number of unnecessary visits and diagnostic tests, and consequent cost reduction; and

- the advantages for patients of having migrant-friendly services, including increased access to health services and quality of care, increased equality of care, better communication with providers, fewer medical errors and empowerment to control their own care.

The migrant-friendly strategy became part of the overall organizational policy of the AUSL RE. An ad hoc steering committee was established at the centre of the organization to oversee its overall management, implementation and monitoring. The steering committee consisted of health service management and staff representatives (nurses, medical doctors, administrative staff); representatives of service users and the community; and representatives of specific relevant departments such as quality management, human resources, communication, primary health care, social work and health promotion. In order to facilitate the effective implementation of the migrant-friendly strategy throughout the province of Reggio Emilia, local coordination groups were established in each health district *(4)*.

Implementation of the strategy encompassed two main steps:

- implementing and evaluating a general process of organizational development in the AUSL RE, creating appropriate structures, processes and services able to respond to the needs of a diverse population; and

- implementing and evaluating migrant-friendly interventions aimed at the specific health-care needs of migrants and other vulnerable groups.

a. Organizational development in the health services of Reggio Emilia

The specific objective of the overall organizational development was to ensure the incorporation of the concepts and principles of migrant friendliness and equity into both management and quality management. It determined that a becoming migrant-friendly organization means striving for more equity through sensitivity to and acceptance of diversity, and by compensating for disadvantages.

Implementing migrant friendliness is not about privileging the underprivileged; rather, by increasing quality for the most vulnerable, quality for all patients improves through more personalized services that take the individuality of each person into account. Investments in increased responsiveness to the needs of populations at risk is an important step towards overall quality assurance and development.

To support implementation, a self-evaluation tool was used to evaluate processes and services against a set of equity standards and to stimulate improvements. The following five main areas were identified as important aspects to monitor and measure against the standards *(5)*.

- Equity in policy: this area aims to define how the organization should develop policies, governance and performance monitoring systems that promote equity in health care for migrants and other vulnerable groups.

- Equitable access and utilization: this area aims to encourage the organization to address barriers that prevent or limit migrants and other vulnerable groups from accessing and benefitting from health services.

- Equitable quality of care: this area aims to ensure that the organization develops services that are responsive to the diverse needs of patients and families along the whole care pathway, ensuring a safe environment and continuity of care.

- Equity in participation: this area aims to support the organization in developing equitable participatory processes that respond to the needs and preferences of migrants and other vulnerable groups.

- Promoting equity: this area aims to encourage the organization in promoting equity in the wider environment through cooperation, advocacy, capacity-building, and the dissemination of research and effective practices.

These equity standards are used to systematically assess migrant-friendly interventions such as interpreting services, informational materials and staff training, as well as the core processes of the organization. Every two to three years, an assessment team comprising internal and external stakeholders is established to conduct assessments against each standard. On the basis of information gathered through the assessment process, the steering committee identifies areas for improvement and develops an action plan for equity improvements. The action plan is then integrated into the management system.

b. Migrant-friendly interventions aimed at specific health-care needs of migrants and other vulnerable groups
On the basis of the needs and organizational analysis, the following interventions were developed and implemented in the AUSL RE.

- A dedicated health service for irregular migrants and asylum seekers, called the centre for migrant family health (Centro per la Salute della Famiglia Straniera, or CSFS), aims at ensuring access to health care for people at risk of exclusion because of lack of legal status (such as irregular migrants, asylum seekers in the process of seeking asylum and those denied asylum).

- A coordinated language and communication support service for all professionals and patients aims at addressing linguistic and communication barriers to accessing health services.

- Patient information and empowerment, including information and health promotion interventions, aims at improving users' knowledge on how to navigate the system and how to self-manage their health situations.

- Staff training aims at ensuring effective and sensitive responses to migrants' health needs.

- User and community involvement initiatives, including partnerships and networks, aims at promoting greater involvement among service users and communities.

Each migrant-friendly intervention is assigned to a subgroup of the steering committee responsible for the development, implementation and evaluation of measures. These are displayed in Fig. 1 and described in detail below.

i. Development of a dedicated health service for irregular migrants and asylum seekers

According to Italian legislation on health care for foreign nationals who are not regularized with the national health-care system,[6] access for migrants with irregular status includes: prenatal and maternity care; health care for minors; vaccinations; preventive medicine programmes; and prevention, diagnosis and treatment of infectious diseases. Additionally, three categories of irregular patients are covered by law and can also be treated beyond emergencies: minors up to 18 years of age, pregnant women (up to six months after birth) and patients with diagnosed infectious diseases.

It is important to note that, while the legal framework for access to and provision of health care is almost the same across Italy, regions interpret it differently. In the AUSL RE, the provision of health care for migrants with irregular status is ensured by the CSFS, which works in partnership with the Caritas clinic "Querce di Mamre", a local non-governmental organization (NGO).

The activities of the CSFS and Caritas are formalized through an official agreement. The AUSL RE provides the NGO with pharmaceuticals and dental materials, and covers all costs for electricity, heating, cleaning and waste disposal. The CSFS employs health professionals (four general practitioners, 10 nurses, three paediatricians, two gynaecologists and three obstetricians), six intercultural mediators, one psychologist and two social workers. Services provided include: general medicine, internal medicine, tuberculosis care, obstetrics and gynaecology, paediatrics, dental care, psychology and social support. It ensures connections with other services of the AUSL RE and Ospedale Santa Maria Nuova (a city hospital) for specialist care, psychiatric and psychological care, vaccinations, and surgery (see Fig. 2). It runs projects with the local authority, including dental care projects with the dental school, and projects to provide care to sex workers and the Roma population.

ii. A coordinated language and communication support service

The health service of Reggio Emilia covers urban as well as rural areas with hospital and primary care services. To better serve these areas, a community-based interpreting service was created using intercultural mediators with interpreting competencies.[7] The development of partnerships with other local services addressing the specific needs of migrants was also encouraged. A stepwise approach was adopted for the development of a language support service covering all health services of the AUSL RE.

Interpreting and intercultural mediation were initially made available in three hospital departments (obstetrics/gynaecology, paediatrics, and accident and emergency services) that volunteered for the pilot project and where there was a greater need for language services. They were subsequently extended to the whole province of Reggio Emilia, including hospitals and health district services.

---

6   Legislative Decree No. 286 of 25 July 1998, Article 35.

7   The role of the intercultural mediator is defined by the Regional Decree of Emilia-Romagna, D.G.R. No. 1576/2004. Available at: http://www.integrazionemigranti.gov.it/Attualita/Approfondimenti/approfondimento/Pagine/Mediazione/EmiliaRomagna_scheda.aspx.

Fig. 1. Migrant-friendly health services in the AUSL RE


```
                    ┌─────────────────────────┐
                    │   Health service        │
                    │   management            │
                    └─────────────────────────┘
                              ↑↓

        ╔═══════════════════════════════════════════════╗
        ║        Overall organizational development      ║
        ║    Developing migrant-friendly healt-care services  ║
        ║              Steering committee                ║
        ╚═══════════════════════════════════════════════╝
```

Migrant-friendly service #1
Dedicated service for undocumented migrants

Migrant-friendly service #2
Language support service

Migrant-friendly service #3
Information and health promotion

Migrant-friendly service #4
Staff training and education

Migrant-friendly service #5
Service-user and community involvement

Fig. 2. Health-care provision for irregular migrants in the AUSL RE

Local health unit of Reggio Emilia

3 entry points

Migrant-friendly services: interpreting, cultural mediation multilingual information materials, staff training

Dedicated service for undocumented migrants

Caritas clinic

City hospital

Public health department

Targeted projects

Primary care

Targeted projects

Local authority, community services, voluntary sector

In this phase, the AUSL RE decided to involve external social cooperatives and voluntary associations in order to foster community participation and provide opportunities to migrants for career development as intercultural mediators. At present in the province of Reggio Emilia, the intercultural mediation services are provided in the main city hospital, five provincial hospitals, six health districts (primary care and community care), the CSFS and Caritas.

Given the large geographical size of the province, service coordination at the central level links to each health district. The central coordination system encompasses the booking system; the list of cultural mediators and the languages available; evaluations of the intercultural mediators; and the registry of the number of hours per intercultural mediator, per district and per facility. A clear organizational policy sets out how interpretation and intercultural mediation are defined in order to ensure effective access to and utilization of services. This includes written procedures and guidelines on interpretation, translation and intercultural mediation; staff guidelines for organizing interpreters or communication support; training courses for staff on how to work with an interpreter; and a documentation system to control the budget and the quality of the service.

A total of 22 intercultural mediators in the AUSL RE cover the most common languages: Chinese (four interpreters); Arabic and French (six); Ukrainian and eastern European languages (three); Albanian (two); Romanian (one); Hindi, Urdu, Punjabi and Creole (four); Ghanaian (one); and Nigerian (one). There is also the possibility of expanding the programme to offer less commonly spoken languages. The most commonly requested languages are Chinese (26%), Arabic (23%), Indo-Pakistani languages (23%), eastern Europe languages (9%), Ghanaian (9%) and Albanian (6%). Less-frequently required languages include Spanish, Portuguese, Macedonian, Turkish, Tagalog and Tamil.

Different types of intercultural mediation services are available, including onsite interventions, scheduled interventions, urgent interventions (within 40 minutes), over-the-phone interventions, and interpretation services and written translation. In all hospitals of the AUSL RE, intercultural mediators are available onsite, for telephone consultation, for translation upon request from the wards, and to inform, listen to and support patients. Intercultural mediators are also available onsite in community-based facilities, in particular for antenatal care services. In other services, intercultural mediation interventions are scheduled upon request on a weekly basis.

iii. Patient information and empowerment

The AUSL RE has developed an organizational policy for improving users' knowledge on how to navigate the system and how to self-manage their health situations. Specific interventions are in place to ensure migrants receive information concerning their entitlements to services and on the use of health services to empower them to assume control over decisions and actions concerning their own health. These include the provision of language-appropriate and migrant-sensitive written material, and the use of intercultural mediators and/or community health educators to facilitate health promotion and education programmes (6). Types of interventions include the following.

- Environmental interventions include the use of intercultural mediators, translated signage, brochures and discharge instructions. All hospitals also provide migrant-friendly food menus and multilingual information on ward routines.

- Informational interventions are used to make migrants aware of their rights and to improve their familiarity with access pathways, how hospital services work and discharge procedures (in particular for women's health services, for paediatric services and for emergency outpatients).

- Education and empowerment interventions include appropriate health education programmes are provided for migrant patients who suffer chronic conditions. Community health educators or cultural mediators are employed to provide outreach interventions, particularly to support access to appropriate health education (such as mother and child care) and prevention programmes (such as cancer screening and vaccinations).

- Health literacy strategies involve engaging intercultural mediators in the planning, implementation and evaluation of educational and informational interventions.

- Networking and intersectoral interventions focus on making alliances with stakeholder organizations such as social work departments, schools, law enforcement and immigration agencies, local authorities, and voluntary organizations are established to work towards the common goal of providing adequate information for migrant communities.

These interventions are communicated to migrants and asylum seekers through the following channels.

- Seminars and talks, including information sessions and presentations in the languages spoken by migrant patients, are held with an interactive approach to allow migrants to intervene.

- Written materials in different languages include technical documents (such as preparations for a diagnostic test), legal documents (such as informed consent slips), and information leaflets on how to navigate the health system and access services.

- Web-based information covers how to register with the national health service, the organization and functioning of health services, and migrant-friendly services.[8]

- Local networks disseminate information about the health services available through intercultural mediators and other allies from local migrant communities, as well as through relationships, friends and social networks.

iv. Staff training

The AUSL RE developed a comprehensive programme aimed at ensuring that staff at all levels and across all disciplines receive ongoing education and training in order to improve their capacity to respond adequately to the needs of migrants. The training is designed so as to link the individual developments of the workforce to organizational development and adaptation in order to maximize access to and quality of health care (7).

---

8 Available at: https://www.ausl.re.it/fasi-della-vita/migranti.

This is done by linking training to organizational policies and procedures. Even if participation is not mandatory, training is strongly championed by the management of the AUSL RE. Participation is also connected to professional development, learning opportunities and performance reviews through the assignment of continuing medical education credits.

Where necessary, a training project team is made responsible for the design and content development of the training courses. The training development process is negotiated with senior and department-level management, and is planned in cooperation with all relevant stakeholders, such as local NGOs, migrant representatives and staff representatives, in order to ensure that training content and design reflect the specific needs of health services and migrants.

The educational content of training programmes aims at improving awareness of and sensitivity to culturally diverse backgrounds; knowledge about key areas, such as migration, morbidity patterns and rights to health care; the application of knowledge; and inter- and intrapersonal communication skills among the targeted workforce *(8)*.

v. Service-user and community involvement

Information, education and empowerment are fundamental elements in the health-care process and in hospital assistance, both for the identification of needs and for the definition of solutions. The involvement of migrant patients and communities is therefore essential to identifying both the obstacles to and the potential resources for serving a multiethnic community. Involving patient and community organizations to promote access through the production of publicity materials is a crucial step towards building good relationships between health-care organizations and communities.

One component of the overall migrant-friendly strategy is therefore aimed at developing equitable participatory processes that respond to the needs of migrants. This makes it possible to identify and prioritize migrants' health needs and define and implement solutions in a mutually acceptable way. Service-user and community involvement includes the following steps.

- To identify migrant groups and subgroups who should be involved in participatory interventions, statistical data are supplemented with information on existing community-based networks, migrant associations and organizations.

- Inclusive communication methods, such as the provision of information about involvement opportunities in different languages and the employment of intercultural mediators and/or community health educators, are used to improve participation.

- Interventions to support effective participation, such as transport arrangements, accessible venues, convenient timing for events and the provision of general assistance, are identified and adopted.

- User and community participation are monitored and evaluated in order to assess, prevent and eliminate potential barriers to participation, and to detect which service users are most and least satisfied.

Finally, in addition to valuing relationship building with migrants and minority communities, the AUSL RE seeks to form alliances with stakeholder organizations such as social work departments, schools, immigration authorities, unions, voluntary organizations and social cooperatives, etc., to work towards the common goal of migrant communities' empowerment and the provision of adequate information and support. To this end, the AUSL RE participates in intersectoral interventions aimed at addressing the wider social determinants of migrants' health.

4. Impact and lessons learned

The implementation of a comprehensive process of change in the organization of the AUSL RE proved to have a positive impact on the culture, structures and processes of health service provision for migrants and other vulnerable groups. Improvements in access to health services and quality of care are evident in all sectors of service provision for migrant residents of Reggio Emilia, as well as for asylum seekers and undocumented migrants. In particular, undocumented migrants' right to access health care has been established through the provision of more than 3500 medical consultations and treatments every year in the CSFS.

The coverage of intercultural mediation service has become progressively available in all health and social services of Reggio Emilia, with an increase of interventions from 7000 in 2006 to more than 13 000 in 2016. Several information and education interventions addressing migrant users and communities have been provided in hospitals, health services and migrant community settings. Migrant participation and community involvement proved to be fundamental in identifying health-care needs and evaluating the quality of health services and information. Training programmes aiming at improving intercultural competence among staff at all levels have been systematically implemented and are now a permanent component of the organization's training strategy.

In 2015, a training programme was implemented in all hospitals and health districts of the province of Reggio Emilia and repeated several times in order to reach the largest audience possible; in total, almost 800 health professionals (20% of total health staff) attended a training course.

Finally, the involvement of top management in the development and implementation of the migrant-friendly strategy helped to keep the issue of migrant health and health care high on the organizational policy agenda.

The AUSL RE's adoption of a project-management approach to the development of effective interventions has led to its participation in several international projects, including: the 2007 European Cooperation in Science and Technology (COST) action Health and Social Care for Migrants and Ethnic Minorities in Europe (HOME) *(9)*, the 2008 Nowhereland project *(10),* the 2013 Equi-Health project *(11),* the 2011 COST action Adapting European Health Systems to Diversity (ADAPT) *(12),* the 2013 Training Packages for Health Professionals to Improve Access and Quality of Health Insurance for Migrants and Ethnic Minorities Including the Roma (MEM-TP) project *(13),* and the 2016 Supporting Health Coordination, Assessment, Planning, Access, to Health Care and Capacity Building in Member States under Particular Migratory Pressure (SH-CAPAC) project *(14).*

We would like to conclude by sharing what we have learned, in the hope this will prove useful for colleagues and organizations beginning to respond to diversity in health services. Those who are approaching the task of improving

hospital and health services for diverse migrant populations should adopt from the very outset a global and structured approach and strive for more than contingent solutions limited to responding to emergencies. In this sense, the model put forward by the Migrant–Friendly Hospital project could be of assistance.

It is advisable to adopt a method that enables the monitoring and evaluation of the overall process of organizational development, and the identification of priority areas for specific and effective action. Where to begin? The area of communication is, without doubt, the highest priority, not only because the availability of intercultural mediation and interpreting services produces immediate results, but also because communication is a *conditio sine qua non* for effective measures of empowerment, for the development of cultural competence and for patient education.

The provision of migrant-friendly health care in Reggio Emilia, Italy

References

1. Osservatorio regionale sul fenomeno migratorio. L'immigrazione straniera in Emilia-Romagna: edizione 2017 [Regional Observatory on Migration. Foreign immigration in Emilia-Romagna: 2017 edition]. Bologna: Social Policy Department of Emilia-Romagna; 2017 (in Italian).

2. Karl-Trummer U, Krajic K. Migrant friendly hospitals: organizations learn sensitivity for differences. In: Björngren C, Cattacin S, editors. Migration and health: difference sensitivity from an organizational perspective. Malmö: Malmö University; 2007:42–61.

3. Bischoff A, Chiarenza A, Loutan L. "Migrant-friendly hospitals": a European initiative in an age of increasing mobility. World Hosp Health Serv. 2009;45(3):10–12.

4. Chiarenza A. Servizi sanitari Migrant-friendly ed aperti alle diverse culture: l'esperienza dell'azienda USL di Reggio Emilia [Health services that are migrant-friendly and open to different cultures: the experience of the AUSL RE]. In: Baraldi C, Barbieri V, Giarelli G, editors. Immigrazione, mediazione culturale e salute [Immigration, cultural mediation and health]. Milano: Franco Angeli; 2008:47–59 (in Italian).

5. Cattacin S, Chiarenza A, Domenig D. Equity standards for health care organisations: a theoretical framework. Diversity and Equality in Health and Care. 2013:10(4):249–58.

6. Nuffield Institute for Health. Application and management of the community health educator model. Handbook for practitioners. Leeds: University of Leeds; 2002.

7. Chiarenza A, Horvat L, Lanting K, Ciannameo A, Suurmond J. Addressing health care for migrants and ethnic minorities in Europe: a review of training programmes. Health Education Journal. 2018;00(0):1–15. doi: 10.1177/0017896918793164.

8. Horvat L, Horey D, Romios P, Kis-Rigo J. Cultural competence education for health professionals. Cochrane Database Syst Rev. 2014;5(5):CD009405. doi: 10.1002/14651858.CD009405.pub2.

9. Health and Social Care for Migrants and Ethnic Minorities in Europe (HOME) [website]. Brussels: European Cooperation in Science and Technology (COST); 2018 (https://www.cost.eu/actions/ISO603/#tabs|Name:overview, accessed 11 November 2018).

10. Health Care in Nowhereland. Improving services for undocumented migrants in the EU [website]. Brussels: European Hospital and Healthcare Federation; 2018 (http://www.hope.be/contact-page/, accessed 11 November 2018).

11. The Equi-Health project: fostering health care for migrants, the Roma and other vulnerable groups [website]. Brussels: Equi-health; 2018 (http://equi-health.eea.iom.int/index.php/contact-us2, accessed 11 November 2018).

12. Adapting European Health Systems to Diversity (ADAPT) [website]. Brussels: European Cooperation in Science and Technology (COST); 2018 (https://www.cost.eu/actions/IS1103/#tabs|Name:overview, accessed 11 November 2018).

13. Training Packages for Health Professionals to Improve Access and Quality of Health Insurance for Migrants and Ethnic Minorities Including the Roma (MEM-TP) project [website]. Granada: Andalusian School of Public Health (EASP); 2014 (https://www.mem-tp.org, accessed 11 November 2018).

14. Supporting Health Coordination, Assessment, Planning, Access, to Health Care and Capacity Building in Member States under Particular Migratory Pressure (SH-CAPAC) project [website]. Granada: Andalusian School of Public Health (EASP); 2016 (https://www.sh-capac.org, accessed 11 November 2018).

9 New Scots:

integrating refugees into Scottish communities

2014–2017

Author information

Liv Stubbe Ostergaard, Research Associate, Danish Research Centre for Migration, Ethnicity and Health, Department of Public Health, University of Copenhagen, Denmark

Allan Krasnik, Professor, Danish Research Centre for Migration, Ethnicity and Health, Department of Public Health, University of Copenhagen, Denmark

Key messages

- In Scotland, agencies across sectors have come together to develop a common strategy and implementation programme to improve their coordination in supporting the integration of refugees and asylum seekers into communities. This initiative, known as New Scots, has been led by the Scottish Government, the Convention of Scottish Local Authorities and the Scottish Refugee Council.

- The programme is divided into different thematic areas, each led by a thematic group. It counts on the participation of a wide variety of stakeholders, including representatives from service providers, third-sector organizations, local authorities and government directorates, as well as members from the refugee community.

- The programme's strategy was developed through a consultation process involving all stakeholders. Local implementation has benefitted from a high degree of autonomy. No specific funding was attached to the delivery of the objectives; all organizations involved, however, provided resources in terms of workforce and infrastructure. They agreed on a set of indicators for integration to monitor progress and identify existing gaps.

- Stakeholders identified three main objectives for the health dimension: improving the responsiveness of health services to the needs of refugees and asylum seekers; taking integration into account in the development of people-centred services; and increasing the awareness of rights and entitlements among service providers and among refugees and asylum seekers.

- The main challenges throughout the development and implementation of the strategy were: engaging high-level political representatives from the health sector; maintaining the continuous engagement of representatives of the refugee community, especially when no funding was allocated to support it; and assessing progress without funding for evaluations.

- The New Scots programme proved to be particularly valuable in 2015, when Scotland welcomed around 1200 Syrians. There is strong commitment to continue the programme after 2017 by revising the strategy and its implementation to apply lessons learned and overcome the aforementioned challenges.

1. Introduction

In Scotland, a national, multiagency strategy and implementation programme to integrate refugees and asylum seekers was developed. The programme is divided into the following thematic areas: needs of dispersed asylum seekers; employability and welfare rights; housing; education; health; and communities and social connections. The action plans for each thematic area set out specific objectives, how they will be achieved and which organizations will be involved.

The strategy and implementation programme are partnership-based and outcome-focused, and will be implemented over a three-year period (2014–2017). The Convention of Scottish Local Authorities (COSLA), the Scottish Refugee Council and the Scottish Government are leading implementation in partnership with other relevant agencies and representatives of community organizations. The action plans within the strategy are grounded in refugees' and asylum seekers' experiences of life in Scotland, and developed in consultation with these community groups to ensure that their needs and aspirations are central to the plans. Delivering the programme and monitoring progress are also undertaken in partnership.

The purpose of the strategy is to coordinate the efforts of all organizations working with refugees and asylum seekers in Scotland to support them to rebuild their lives and make a full contribution to society. The programme adopts a holistic approach to health and integration. It focuses on multilevel partnerships and the inclusion of refugees and asylum seekers in the development and implementation of the programme.

This case description is based on information from the New Scots strategy *(1)*; implementation and progress reports from years 1 and 2 *(2,3)*; and an interview with Alison Strang, Senior Research Fellow at the Institute for Global Health and Development at Queen Margaret University, Scotland, and Chair of the Core Group leading the New Scots refugee integration strategy for 2014–2017. The Government of the United Kingdom commissioned Alison Strang to do research in 2003–2004 to look at refugees' and communities' experience of integration, which resulted in the Indicators of Integration framework.

2. Context

a. Demographic aspects

The Government of Scotland, devolved from the United Kingdom, is responsible for domestic policies, whereas the Government of the United Kingdom is responsible for international policies, including immigration. In the 1999 Immigration Act, the Government of the United Kingdom introduced a programme for dispersing people seeking asylum across the United Kingdom, which resulted in increased numbers of refugees and asylum seekers arriving in Scotland. Up until then, most refugees were in the south-east of the country, which links up to mainland Europe.

At that time, the Scottish population was declining. Concerns were growing about workforce shortages and the depopulation of remote areas. In addition to the legal and moral duty to provide protection to people fleeing persecution, Scotland recognized the contribution that refugees could make to Scottish society. With this background, the

country initiated efforts to make refugees and asylum seekers feel welcome and to encourage them to stay after receiving their legal status.

Results from the 2011 census showed that Scotland reached its highest-ever population of 5 295 403 that year. These figures also show that Scotland is becoming more ethnically diverse, with an increased number of residents born outside of the United Kingdom. The minority ethnic population in Scotland has doubled since 2001 from 2% to 4% *(1)*. Current figures show that there are around 2400 asylum seekers in Scotland.

It is very difficult to ascertain precisely how many refugees have been granted some form of refugee status and remain in Scotland; the Scottish Refugee Council estimates, however, that there could be as many as 20 000 *(1)*. According to Home Office statistics up to 30 June 2016, Scotland welcomed a third of the total number of refugees arriving to the United Kingdom under the expanded Syrian Resettlement Programme *(4)*.

Information regarding the gender breakdown of refugees and asylum seekers in Scotland is not fully available. The Home Office provides information about the gender of only the main asylum applicant, and not of other members of the family who may arrive later through family reunion programmes. Approximately one fifth of all main applicants arrive as part of a family, and one third of all main applicants are female. Around 250 young people (aged under 18) seeking asylum recently arrived in Scotland unaccompanied by their parents or legal guardian.

b. Health policy context

The Scottish Government's *Achieving sustainable quality in Scotland's healthcare – a 20:20 vision (5)* identifies the need for a health-care system with integrated health and social care, and a focus on prevention, anticipation, supported self-management and reduction in health inequalities. The right to health provides a useful way to approach inequality by framing health as a human rights issue. The right to health encompasses not only the right to health care, but also the right to other determinants of health, such as education, employment, income and housing. Good health is critical to integration because it enables greater social participation and engagement in activities such as volunteering, employment and education.

People with refugee status have the same right to access health services as nationals. The provision of health services is devolved to the Scottish Government, which has directed the National Health Service (NHS) Scotland to provide services to all refugees and asylum seekers, including people whose claims for asylum have been refused. Access to good-quality health care is especially important to people who may arrive in Scotland with physical or mental health problems associated with the reasons that forced them to seek asylum. This includes gender-based violence, sexual violence, torture and other degrading treatment.

The experience of seeking asylum and associated social isolation can exacerbate existing mental health problems, or create new ones. A range of specialist health-care services have been developed in Glasgow to meet the needs of refugees and asylum seekers, including the Compass Mental Health Team, the Bridging Team within the Greater Glasgow and Clyde Health Board, and voluntary-sector services such as Freedom from Torture. Agencies such as the Mental Health Foundation and Rape Crisis are also working closely with the Scottish Refugee Council.

3. The issue: integrating refugees into Scottish communities

a. Development of the strategy

Two main actors have long engaged with refugee and migrant issues in Scotland: the Scottish Refugee Council and COSLA.[9] In 2012, these organizations met with equality specialists from the Scottish Government to discuss the development of a national policy for the integration of refugees. Key to the strategy was holistic thinking that aimed to ensure that services across Scotland consider the needs of refugees in a joined-up way. They stressed that the strategy should underline the Scottish Government's commitment to integration from the day someone seeking asylum arrives in Scotland, rather than the day they obtain refugee status.

In developing the New Scots strategy, the Scottish Government, COSLA and the Scottish Refugee Council undertook a programme of work designed to map current refugee integration activities in Scotland, to promote working in partnership, and to identify and promote the adoption of practical solutions to address the integration needs of refugees and asylum seekers. The process was driven by the understanding that integration consists of many interrelated aspects and involves whole communities. They designed a participatory process for developing the strategy that included people across sectors as well as community members.

The work was carried out through a series of meetings that helped to develop a more strategic approach to supporting refugees and asylum seekers in Scotland.[10] Each meeting gathered representatives from service providers, third-sector organizations, local authorities and government directorates, as well as refugees and asylum seekers who provided their views on behalf of the community groups they represented.

The groups used a framework called Indicators of Integration *(6),* developed by Alastair Ager, Director of the Institute of Global Health and Development at Queen Margaret University, Scotland, and Alison Strang, as a means of evaluating Scotland's progress towards integrating refugees, and also as a means of identifying gaps in provision. Participants were encouraged to think about how their work cuts across these domains. For example, an agency that exists to provide health services is likely to be active within the health domain, but may also be contributing either deliberately or inadvertently to refugees' ability to find and keep employment, and to build social connections.

Six thematic meetings and workshops also took place between December 2012 and May 2013. These covered housing, health, education, employment and welfare, community and social connections (drawn from the Indicators of Integration framework), and the needs of newly arrived asylum seekers. Relevant agencies were invited to participate. The meetings used an interactive toolkit – Ketso *(7)* – to explore what was working well in terms of refugee integration, opportunities for further development and current challenges. Each of these themed meetings yielded a series of outcomes that the working group determined could be delivered over a three-year period, and action plans that would contribute towards achieving them.

---

9   The Scottish Refugee Council is a nongovernmental organization conducting campaigning and advocacy activities as well as service provision. COSLA is an umbrella organization for local governments in Scotland.

10   The majority of refugees and asylum seekers were in the Glasgow area. Although the strategy was national, in practice it was geographically focused.

The core group then looked at the outcomes and identified key objectives, and engaged with stakeholders who had already been involved in the consultation processes. They placed an emphasis on the objectives that were backed by the commitment and agreement of key stakeholders across sectors. This was followed by a process of consultation and refinement in which the different teams for implementation were developed. When the strategy was launched, it had already been sanctioned by key gatekeepers.

In the health strand, the working group identified the following three main health objectives based on the priorities that emerged from the consultation processes.

i. The planning and delivery of health services in Scotland should be informed by the needs of asylum seekers and local communities, leading to greater integration.
Since refugees and asylum seekers in Scotland have access to health services, the action plan focused on ensuring that they understand their entitlements and are supported to access the specific services that are appropriate to their needs. This requires that practitioners understand the rights and entitlements of refugees and asylum seekers, and that communication between them is improved.

ii. An understanding of refugee integration pathways should be embedded in all health-related strategies, leading to more person-centred services.
Health services should be developed by taking into account the needs and experiences of refugees and asylum seekers. Involving refugees and asylum seekers in public engagement is critical to ensuring that access issues are understood and addressed, and that opportunities for health improvement are taken. Many refugees come from cultures where peer support is strong, and this offers opportunities for self-management and collective advocacy. This is in line with existing efforts by NHS Scotland to develop a more person-centred approach to care. To support this, the working group suggested exploring the potential for conducting a holistic and gendered health-needs assessment for refugees and asylum seekers to inform the implementation of health and social-care integration and mental health strategies.

iii. Refugees and asylum seekers should be supported to fully understand their rights and entitlements. Service providers should be increasingly aware of how to meet their needs.
The Scottish Refugee Council conducted a survey among refugees and asylum seekers about their health-care needs (8). Results showed that many refugees felt they had a good understanding of the range of health services available to them, but some also demonstrated misunderstandings about the appropriate use of services (for instance, using accident and emergency services rather than contacting an out-of-hours general practitioner (GP) service). Registration with GPs was high among refugees and asylum seekers in the study, and experiences of accessing health services were good.

b. Implementation of the strategy
The strategy was taken forward from 2014 to 2017 and led by COSLA, the Scottish Government and the Scottish Refugee Council and in partnership with the agencies involved in developing the strategy. Its implementation mechanism has a network structure that aims to maintain, develop and refresh the relationships that were formed throughout the development of the strategy. The structure consists of a core group and six thematic working groups, each with a chair.

The core group is cross-sectoral. It consists of the chairs of each working group, and community and refugee organizations. Each working group is formed around one of the themes: needs of dispersed asylum seekers; employability and welfare rights; housing; education; health; and communities and social connections. The working groups identify a number of specific outcomes and related action plans as well as actors responsible for each action plan (champions). The role of the champions is to implement the actions and to develop specific indicators and measurements. Data about refugees' and asylum seekers' integration from the Holistic Integration Service led by the Scottish Refugee Council are used to inform each of the working groups. The actions identified to deliver on each of the outcomes may change as work progresses and circumstances change. Implementation and progress reports are published each year.

NHS Health Scotland, the Scottish Refugee Council, NHS Greater Glasgow and Clyde, and the Mental Health Foundation are leading implementation of the health dimension of the strategy. The health strand has not had a key government stakeholder to chair the working group. Much of the health engagement has come from the third sector. From the public sector, NHS Scotland has been engaged throughout.

c. Monitoring and evaluation

The leader of each thematic working group was tasked with bringing together the available data to demonstrate the impact of the different actions set out in the strategy. As no specific funding for evaluating the programme as a whole was available, the core group had to rely on the information received from each of the working groups. In the implementation and progress reports, a traffic light system was developed in which each of the action points was given a colour related to degree of completion and the team's effectiveness in achieving these goals (see Fig. 1).

d. Organization and funding

The strategy is led by a core group that meets on a quarterly basis and oversees its implementation. This group has committed to ensuring the effective delivery of the strategy and to providing leadership in the policies and practices related to the integration of refugees and asylum seekers. The chair of each of the six thematic working groups takes forward the relevant action plans. Each working group involves representatives of the organizations that have committed to taking the action plans forward. Since the launch of the strategy, a number of new organizations have become involved and committed to helping take forward actions in their specific area of expertise.

"This strategy hasn't been developed, agreed and then delivered top-down across the country. It has been a mix of bottom-up as well as top-down sharing of information about initiatives and good practices that were happening in different sectors."

– Alison Strang

Senior Research Fellow at the Institute for Global Health and Development at Queen Margaret University, Scotland, and Chair of the Core Group leading the New Scots refugee integration strategy for 2014–2017

Fig. 1. Traffic light monitoring system from Year 2 of New Scots
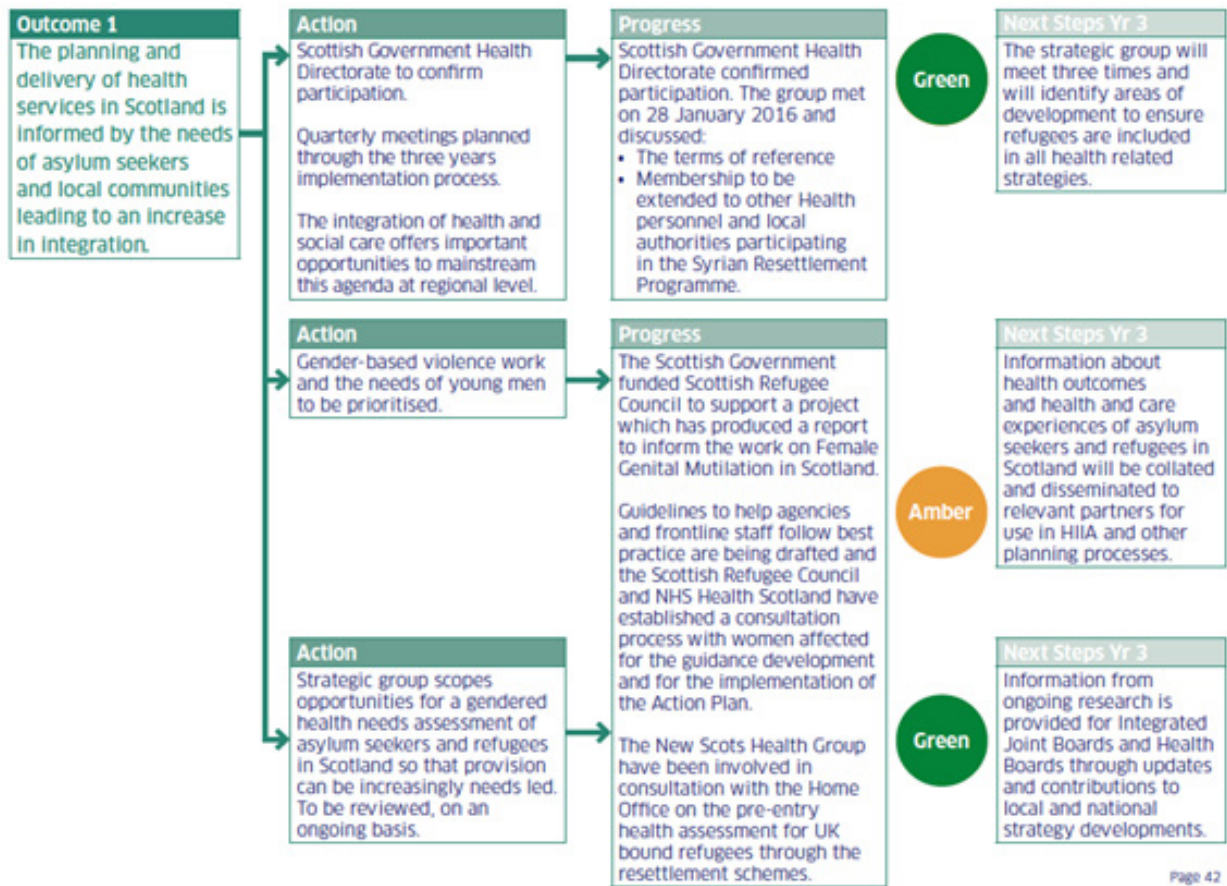
Source: reproduced by permission of the publisher from the Scottish Government *(3)*.

The strategy has not had a hierarchical, top-down structure, and there is no specific authority tasked with carrying out the strategy process by itself. Authorities are involved within the different sectors, but there is also a high degree of autonomy (for instance, each region has its own health board). Each locality has been able to decide how they spend their budget and run activities.

No funding has been attached to the delivery of specific objectives. The achievement of the objectives depends on voluntary participation, voluntary collaboration, relationship building and knowledge sharing. All organizations involved have provided resources in terms of work force, venues for conferences and staff to facilitate events.

> *"It wasn't a question of 'we have got this budget, how should we spend it?' It was about collaborating, recognizing that a lot of what people were doing in the different sectors was contributing towards integration and refugees' and asylum seekers' well-being. We wanted to identify those actions and see how we could work better across sectors to deliver more effectively."*
>
> **– Alison Strang**

4. Impact and lessons learned

The following information is based on the progress reports conducted for the first two years of implementation.

a. Achievements

Overall, the key achievement of the strategy has been better coordination and collaboration among different sectors and organizations involved in the integration of refugees and asylum seekers. Cross-sectoral relationships have been forged and embedded.

> *"There is now a strong sense of coherence to improve refugee integration across sectors. This was particularly valuable when Scotland suddenly received a large number of Syrians – a lot of new players benefitted from the fact that we already had a common understanding of integration. That made it quicker for them to hit the ground running."*
>
> **– Alison Strang**

The following progress has been reported from the health strand specifically.

- NHS Health Scotland, the Scottish Refugee Council, NHS Greater Glasgow and Clyde, and the Mental Health Foundation met on a regular basis to develop the framework for a strategic group. Together they identified key health policies and national plans with particular significance for achieving the aims of the New Scots strategy.[11]

- Scotland's National Action Plan to Prevent and Eradicate Female Genital Mutilation *(12)* was published in February 2016.

---

11 Key health policies used were Achieving Sustainable Quality in Scotland's Healthcare – a '20:20' Vision *(5)* and the Mental Health Strategy for Scotland 2012–2015 *(9)*. The group identified national plans such as Scotland's National Action Plan for Human Rights *(10)* and NHS Health Scotland's 2014–2017 delivery plan *(11)* as having mechanisms for co-production and programmes to reduce health inequalities.

- Information about asylum seekers' and refugees' health and dispersal plans from the New Scots strategy was included in the NHS Health Scotland actions to strengthen health-related service responses to equality and diversity.

- Information was included in the health inequalities impact assessment that formed part of a review of NHS resource allocation.

- Draft guidance was provided for the strategic needs assessment by integrated joint boards.

- Various papers of the Scottish Government's Health Division and Social Care Division considered equality and diversity.

- The Health Promoting Health Service is under ongoing development.

- A new strategy for mental health and maternity services is being developed and will be taken forward in the third year of the New Scots strategy.

- The NHS Greater Glasgow and Clyde North East Sector Health Improvement Team funded a health peer education project, which the Scottish Refugee Council ran in 2014 and 2015. The project established and tested an innovative model of health promotion that equips, mobilizes and supports refugees as peers with the aim of sharing knowledge and understanding, and planning collective action to maintain healthy lifestyles. Over 100 refugees and asylum seekers, predominantly from north and east Glasgow, benefitted from the project, either as peer educators (22), members of peer groups (>35), or by attending sporting events (>50). The evaluation of the programme was shared with key stakeholders in May 2015. It acknowledged the project as an innovative model of health promotion to support refugees in maintaining healthy lifestyles *(13)*.

b. Challenges

One key challenge related to the involvement of refugee groups. While strategic links were made by many partners, input from community and refugee groups was limited. Two refugee groups were involved, one of them a women's group. During the project, the women's group benefitted from extra funding for community development support as well as advice, which helped them to stay engaged with the strategy. The other group did not have any support, and only managed to keep engaged in the first period of the project.

"It has been challenging for the refugee groups to keep engaged with the policy process and feel that they are making an impact. Their frustrations have understandably come from the fact that policy processes are slow."

– Alison Strang

The health strand was one of the more challenging dimensions of the programme, and high-level engagement did not materialize prior to 2015. In the first year of implementation, the strategic group had difficulties identifying a Scottish Government Health Directorate lead. Thus, opportunities for wider strategies to be informed by the experience of the New Scots project were limited. Representation needs to be on a higher, strategic level. The first objective of the health strand – raising awareness among health providers about the needs of asylum seekers and refugees – proved especially challenging.

> *"There is a general commitment to person-centred services in health, and to clarifying what this means for refugees, and what pathways we need to provide for them. Is it enough to simply register them with a GP? How do we need to equip those GPs to be able to recognize and support the specific needs of refugees? How do we equip third-level health services like hospitals and so on, to be able to effectively provide person-centred services to someone with a refugee background? Those have been big challenges."*
>
> **– Alison Strang**

c. Lessons learned

In developing such an ambitious integration strategy and implementation programme as New Scots, it was especially important to identify the right people from different sectors to invest in it.

> *"Most sectors were represented by equality professionals who benefitted from participation in the project and the relationships that were formed. It is much easier to problem-solve when you know what the people within your own sector are doing, but also from other sectors."*
>
> **– Alison Strang**

The strategy was developed with the engagement of community members as well as service providers and policy-makers. It was also essential to have strong consensus about the importance of engaging refugee communities, and to have organizations such as the Scottish Refugee Council on board in the development and implementation processes. Overcoming the challenges related to engaging these communities could involve investing extra time in smaller meetings with groups of refugees to build relationships and confidence. One of the groups has also had community workers supporting their engagement, which has been fruitful.

Another positive outcome was the organization of a yearly conference to which a quota of refugees and asylum seekers are invited through the Scottish Refugee Council. Stakeholders from all sectors also participated.

Presentations update participants on the progress of the different thematic areas and about particular projects, such as the peer education programme. Facilitated table discussions also allow participants to explore particular topics together. Feedback from the strategic stakeholders that have attended the conferences shows that they appreciated the opportunity to discuss issues with representatives from refugee communities. The conferences also allow for the identification of new issues and opportunities to implement objectives.

Finally, funding for independent monitoring and evaluations would have been beneficial, as undertaking evaluations within the free-flowing, collaborative structure of the programme proved challenging.

d. Outlook for the future

The New Scots programme proved to be particularly valuable in 2015, when Scotland welcomed around 1200 Syrians through the Syrian resettlement programme. Many different players within the health sector across the country had to find ways to respond, and the existing understanding of integration, informed by a holistic approach, was very helpful.

The first phase of the New Scots programme ran until 2017. As this case study is being written, the implementation core group is in the process of planning the next steps of the programme. There is a strong commitment to continuing the programme after 2017 with a New Scots 2 strategy. This will count on the participation of the same players, but more emphasis will be placed on gathering greater geographic representation across the country. Another participatory phase will be carried out, in which new priorities will be identified and objectives set accordingly.

Alison Strang emphasizes that mapping the actions more comprehensively would be an opportunity to bring together knowledge of policies and practices that impact on refugee well-being and integration. However, this must be done in a manageable and meaningful way. Furthermore, more innovative work will be done on ongoing community engagement and participation, with a parallel process that refreshes those who can engage and contribute to the process.

The wheel structure composed of a core group and a set of working groups focusing on specific issues has worked well and will likely continue. More investment will be made in the secretariat of the initiative, as well as in conferences and process infrastructure. Directing funding through the different sectors, rather than to particular initiatives, has worked well and will also continue, as doing otherwise would change relationships among the actors.

References

1. New Scots: integrating refugees in Scotland's communities 2014–2017. Edinburgh: Scottish Government; 2013.

2. New Scots: integrating refugees in Scotland's communities. Year 1 implementation progress report. 2015. Edinburgh: Scottish Government; 2015 (https://ec.europa.eu/epale/sites/epale/files/new_scots_integration_refugees_in_scotland_communities._year_1.pdf, accessed 11 October 2018).

3. New Scots: integrating refugees in Scotland's communities. Year 2 implementation progress report. Edinburgh: Scottish Government; 2016 (https://www.gov.scot/resource/0049/00497690.pdf, accessed 11 October 2018).

4. Scotland welcomes refugees. Edinburgh: Scottish Government; 2016 (https://news.gov.scot/news/scotland-welcomes-refugees-1, accessed 11 October 2018).

5. Achieving sustainable quality in Scotland's healthcare – a '20:20' vision. Edinburgh: Scottish Government, NHS Scotland; 2011 (http://www.nhshighland.scot.nhs.uk/Meetings/MidHighland/Documents/20.2%20%20%20Achieving%20Sustainable%20Quality%20in%20Scotland%27s%20Healthcare%20-%20A%20%2720_20_%27%20Vision.pdf, accessed 11 October 2018).

6. Ager A, Strang A. Indicators of integration. Final report. London: Home Office; 2004 (http://webarchive.nationalarchives.gov.uk/20110218141321/http://rds.homeoffice.gov.uk/rds/pdfs04/dpr28.pdf, accessed 11 October 2018).

7. Ketso: the hands-on kit for creative engagement [website]. Manchester: Ketso; 2018 (http://www.ketso.com/, accessed 11 October 2018).

8. Mulvey G. In search of normality: refugee integration in Scotland. Final report. Glasgow: Scottish Refugee Council; 2013.

9. Mental health strategy for Scotland 2012–2015. Edinburgh: Scottish Government; 2012 (https://www.gov.scot/resource/0039/00398762.pdf, accessed 11 October 2018).

10. Scotland's national action plan on human rights 2013–2017. Edinburgh: Scottish Human Rights Commission; 2013 (http://www.snaprights.info/wp-content/uploads/2016/01/SNAPpdfWeb.pdf, accessed 10 October 2018).

11. Delivering a fairer healthier Scotland: our plan 2014–2017. Edinburgh: NHS Health Scotland; 2014 (http://www.healthscotland.com/uploads/documents/23240-Delivery%20Plan%202014-15%20(Final).pdf, accessed 11 October 2011).

12. Scotland's national action plan to prevent and eradicate female genital mutilation. Edinburgh: Scottish Government; 2016 (https://beta.gov.scot/publications/scotlands-national-action-plan-prevent-eradicate-fgm/, accessed 11 October 2018).

13. Strang A. Refugee peer education for health and well-being. Evaluation report. Glasgow: Scottish Refugee Council; 2015 (http://www.scottishrefugeecouncil.org.uk/assets/0000/9691/Peer_Education_Evaluation_Report_FINAL.pdf, accessed 11 October 2018).

10 Public health surveillance system
for refugees and migrants in Serbia

Author information
Line Neerup Handlos, Independent Consultant in Migrant Health

Ivan Zivanov, National Professional Officer, Public Health and Migration, WHO Country Office, Serbia

Key messages

- In the context of the arrival of large numbers of refugees and migrants to Serbia in 2015, the Institute of Public Health of Serbia (IPHS) created a public health surveillance system specifically designed for these population groups. The system aims at monitoring and analysing individuals' health status as well as environmental hazards in refugee centres and other locations.

- All refugees and migrants undergo a health screening upon their arrival to a refugee centre in Serbia, and may access further treatment at local health-care centres or the facilities of nongovernmental organizations when necessary. Health data are recorded manually at the centres, transferred electronically by the local public health authorities, and shared with the Ministry of Health and the WHO Country Office. Control measures are put in place when necessary and monitored accordingly.

- The public health surveillance system is focused on communicable diseases. Necessary improvements include monitoring for noncommunicable diseases as well, and disaggregating data by patients' sex, age and ethnic background to enable the comprehensive analysis of health status.

- The migration situation in Serbia drastically changed in 2016, when neighbouring countries closed their borders and Serbia went from being a transit country for most migrants to being a longer-term destination. This necessitated the allocation of more resources to meet the health needs of refugees and migrants. The situation benefitted from the already-designed public health surveillance system.

1. Introduction

The public health surveillance system of refugee and migrant health in Serbia was created in response to the arrival of a large number of refugees and migrants beginning in 2015. The system was introduced nationwide in September 2015.

Under the International Health Regulations *(1)*, all countries should have effective disease surveillance and reporting systems, and capacity for outbreak investigation, case management and response among refugee and migrant populations *(2)*. According to WHO, public health surveillance is the essential first stage in the planning, implementation and evaluation of public health practice. Such surveillance can:

- serve as an early warning system for impending public health emergencies;

- document the impact of an intervention or track progress towards specified goals; and

- monitor and clarify the epidemiology of health problems, to allow priorities to be set and to inform public health policies and strategies *(3)*.

Having reliable health-related data is not only required by law, but is also a prerequisite for designing appropriate preventive measures and allocating appropriate resources to treatment. Gathering reliable data in contexts of irregularity and changing conditions can be difficult, and sharing examples of how this can be done successfully is therefore important.

This case description is based on interviews with Ivan Ivanovic, Head of the Department of Informatics and Biostatistics at the Institute of Public Health of Serbia (IPHS); information provided by WHO Country Office staff involved in migrant health support and monitoring; a report by the IPHS; and reports by various United Nations and European Union agencies.

2. Context

The European Commission estimated that more than 815 000 refugees and migrants, primarily from Syria, Afghanistan and Iraq, passed through Serbia in 2015 *(4)*. Up until the spring of 2016, refugees and migrants who entered Serbia were primarily transiting through the country on their way from Greece to European Union countries in northern and western Europe. In general, people stayed only a few days in the country and very few applied for asylum in Serbia. Many deliberately avoided being registered by the Serbian authorities, as this would force them to apply for asylum in Serbia.

In 2016, when the countries neighbouring Serbia closed their borders to the entry of refugees and migrants, this situation changed drastically. By the end of 2016, very few refugees and migrants were allowed to cross the borders to Hungary and Croatia each day, and those who still wanted to continue their journey stayed for an average of six months in Serbia before crossing the border. By the end of 2016, 12 821 refugees and migrants had registered intent to seek asylum in Serbia that year, but few of them were ready to initiate the process; this resulted in 574 applications *(5)*.

Altogether, these circumstances resulted in a considerable increase in the number of migrants and refugees staying in Serbia by the end of 2016 compared to a year earlier. However, during the last months of 2016, the number of newly arrived refugees, asylum seekers and migrants in Serbia seemed to stabilize. According to the United Nations High Commissioner for Refugees, around 6400 migrants were registered in Serbia by the end of 2016; local non-governmental organizations (NGOs) estimate that the number was closer to 10 000 *(6)*.

Most refugees and migrants arriving to Serbia had transited through Bulgaria and the former Yugoslav Republic of Macedonia. Around 80% of them were accommodated in 13 governmental facilities, while the remainder stayed in Belgrade city centre or at the Hungarian border *(5–7)*. Serbia's shift from being a transit country to one in which migrants and refugees were staying on a longer-term basis changed the needs of its refugee and migrant population; significantly more resources were needed to cope with the situation in 2016 than in 2015.

3. Health system response

Following the increase in arrivals of refugees and migrants, the Ministry of Health of Serbia began collaborating with the WHO Country Office and the WHO Regional Office for Europe to strengthen the country's capacity to manage the public health challenges related to the influx *(8)*. A joint assessment was carried out in June 2015 using the WHO toolkit for assessing health-system capacity to manage large influxes of migrants *(8)*. The resulting recommendations included the need to collect information on migrants' health.

The development of a public health surveillance system to provide specific data on refugee and migrant health was necessary for the newly established national migrant health coordination mechanism. The mechanism consists of regular monthly meetings at which stakeholders in migrant health care (the IPHS and local institutes of public health, all service providers from the state and the NGO sector, and international organizations) discuss current issues. Based on the data provided by the public health surveillance system, the Ministry of Health allocates available resources to fill gaps or improve the quality of services.

The main challenges that the coordination mechanism needed to address related to the following.

- A funding gap results from the fact that the majority of refugees and migrants register intent to seek asylum but never initiate the asylum process. According to Serbian legislation, people under asylum protection are granted full access to health care financed by the national budget, while other foreigners have the right to emergency care only. To fill this gap, several NGOs provide primary health care and medicines with the support of external financing and in close cooperation with state health-care providers.

- Migrant routes are changing, creating the need to provide services in different locations. At the same time, some NGOs are modifying the volume and scope of services they offer based on the availability of donor funds; at times, resources have been constrained.

- In winter 2016 and early 2017, up to 2000 people were sleeping outside of refugee centres in severe winter conditions. Among them, outbreaks of body lice and scabies were persistent in 2016 and 2017. These outbreaks were in turn affecting the refugee centres. In 2016, body lice infestation was registered in 5075 people and scabies infestation in 1601 people *(9)*. In 2017, body lice infestation was registered on 7037 people and scabies infestation on 5944 people *(10)*. The system required timely information on outbreak locations in order to scale up the response.

- With prolonged stays, the morbidity profile changed. While the most common conditions among people staying for a short period of time were injuries and common communicable diseases, in 2016 and 2017 the number of people with noncommunicable diseases needing prolonged care increased. This was especially the case with mental ill health.

- While in 2015, most of people transiting through Serbia were Syrian Arabic-speaking nationals, in 2016 and 2017 the linguistic and cultural backgrounds of people arriving were more diverse, resulting in increased communication challenges and the need for interpreters and cultural mediators.

4. The issue: establishing a public health surveillance system for refugees and migrants

a. What is it?

The public health surveillance system of refugee and migrant health was introduced in 2015 in response to the large influx of refugees and migrants into Serbia. Its aim is in line with the core obligations of the IPHS: to preserve and improve the health of the Serbian population by, among other things, monitoring and analysing the population's health status as well as environmental health hazards. The public health surveillance system is built on the notion that refugees and migrants should be treated as equals to the domestic population.

The specific goals of the public health surveillance system are to:

- survey the incidence of communicable diseases among refugees and migrants and monitor the effectiveness of control measures;

- record what type and number of health services are provided to refugees and migrants as well as the cost of the treatments; and

- monitor environmental hazards as well as sanitary and hygiene conditions in the refugee centres.

The focus of the system is to record health data. Demographic data about the refugee and migrant population are recorded by the Ministry of the Interior. This data and information enable the IPHS to, among other things:

- identify risks of communicable disease outbreaks;

- monitor implementation of control measures aimed at preventing occurrence;

- implement surveillance of imported communicable diseases and repress diseases that have already occurred;

- monitor hazards regarding sanitary and hygienic conditions in refugee centres, and monitor how hygienic and prevention measures are implemented;

- monitor the work of health-care facilities and other organizations providing health services to migrants and refugees (number, type and geographical distribution); and

- keep records of the type and number of services provided, and resources spent on health care delivered to migrants and refugees *(11)*.

b. Who provides it?

The IPHS designed and implemented the public health surveillance system. It is responsible for coordinating the sharing of health data and the implementation of relevant follow-up actions.

c. How does it work?

In all refugee centres, NGO medical teams are present to provide basic medical checkups for all newly arrived people, including checkups for body lice and scabies infestation. NGO medical teams coordinate their work with local primary health-care centres and often are contractually related to them. In case there is an indication for further medical tests, the refugee or migrant is referred to a local health-care centre. Depending on the registered condition, the necessary health service is provided either by the NGO medical team in the refugee centre or by state health-care institutions on the primary, secondary or tertiary level.

The type and cost of the delivered treatments are registered by the provider using a paper template. The templates include a list of the most frequently registered conditions observed in refugee and migrant populations, namely: gastrointestinal diseases with or without diarrhoea, meningitis, acute infections of lower respiratory pathways, rash-causing fevers, haemorrhagic fever, fevers of unknown origin, infectious jaundice, injuries, pregnancy, delivery, miscarriage, animal bites, respiratory infections, behavioural disorders caused by alcohol use, behavioural disorders caused by drug use, conditions occurring as a consequence of violence and torture, and mental disorders *(11)*.

The templates are completed by all health-care providers, including NGO teams working within refugee centres, NGO teams working outside of refugee centres (such as the Doctors Without Borders clinic in Belgrade) and all state health-care providers. Once per week, the information is gathered and sent to the local institute of public health, which enters the data into an electronic database maintained by the IPHS. Weekly and monthly reports are prepared by the IPHS and shared with the Serbian Ministry of Health and the WHO Country Office in Belgrade.

The IPHS assesses the need for a response and presents its findings during the regular monthly coordination meetings. Guidelines on what diseases to respond to and how have been developed, and are similar to those for the domestic population. If a response is considered necessary, control measures are designed and implemented in the refugee centre.

After implementation, the effectiveness of the control measures is monitored and registered in the public health surveillance system. The IPHS created the software used to register health information specifically for this purpose. Representatives of the IPHS who enter the data into the database have received training in using the system, as have health personnel who handle the recording of conditions in the field.

d. What are the prerequisites?

A prerequisite for the public health surveillance system is the presence of reliable infrastructure for sharing data, as well as the presence of personnel who can train those handling the recording of data in the field. Further prerequisites are the availability of an electronic system to manage and analyse the health data.

e. How is it funded?

The public health surveillance system of refugee and migrant health is currently funded with resources from the existing budget of the IPHS.

f. Limitations of the existing system

The public health surveillance system has proven its value for providing epidemiological information for the whole country and specific locations. Yet, the following limitations still prevent comprehensive health status analysis.

- The public health surveillance system still uses the data collection template from 2015, which emphasizes communicable diseases and includes few noncommunicable health conditions.

- Data collection does not include information on the sex, age or ethnic background of the patient.

Since data are collected for patients with and without identity documents, double reporting may occur when the same patient receives care from several providers.

g. Future plans

Future plans for the public health surveillance system include implementing a strategy that makes it possible to pay special attention to vulnerable groups such as children, pregnant women and chronically ill individuals, as well as changes in the collection template to include more health conditions. Furthermore, plans are in place to improve the system so that data can be recorded electronically directly at the refugee centres and health-care facilities; and to produce daily reports of the entries as well as frequent analyses and publications of the findings.

5. Impact and lessons learned

The IPHS prepares regular monthly and annual reports with information on the health conditions registered and the number and type of services provided to the refugee and migrant population. According to the 2016 annual report, 153 783 health conditions were registered and 169 654 services were provided by 99 health-care institutions and NGOs *(9)*. In 2017, the number of registered conditions increased to 200 747 and the number of services provided increased to 234 212 by 92 health-care providers *(10)*.

The monthly reports were instrumental to the Ministry of Health's ability to plan and organize services with all health-care providers. This resulted in well covered health needs for this vulnerable population in spite of limited resources and obstacles caused by the unwillingness of refugees and migrants to request asylum in Serbia (or even to register).

Information provided by the public health surveillance system was also essential during body lice outbreaks in late 2016 and early 2017. At that time, the IPHS was providing daily and weekly reports with information on the number of cases registered for each location in the country, and providing data on the results of disinfestation measures implemented by the network of institutes of public health.

> *"The system gives a good overview of the situation, and it gives a good basis for deciding on how to handle potential issues."*
>
> **– Ivan Ivanovic**

The data enabled international donors to understand the needs of the system, and allowed WHO to provide better support to the country. Based on these data and with the support of a grant from the Delegation of the European Union to the Republic of Serbia, WHO is working jointly with national authorities including the IPHS and the Ministry of Health to:

- develop two sets of technical guidance, one related to communicable diseases and another related to mental health;

- develop three health-sector contingency plans for communities exposed to the largest migrant flows in bordering regions;

- develop and implement health awareness-raising activities on the most prevalent health issues registered (materials are now available in refugee centres and medical institutions);

- provide equipment for health institutions involved in the provision of health services with an emphasis on equipment for the prevention of communicable diseases and the provision of transport services; and

- train health workers to provide refugee/migrant-sensitive services and define intersectoral actions.

When refugees and migrants were primarily transitioning through Serbia and therefore staying very little time in one place, it was difficult to implement a public health surveillance system. The particular challenge at that time was the unwillingness of people to keep their identity documents, including medical records. These challenges lessened after the situation stabilized in 2016 and further health system strengthening and support for local health service providers could take place. This resulted in efficient health service delivery for refugees and migrants in Serbia.

Regarding the transferability of Serbia's public health surveillance system, it should be possible to implement the system in other settings experiencing large influxes of refugees and migrants. Further refinements to meet local challenges will enable the system to address some of the challenges of hosting refuges and migrants for prolonged periods.

References

1. International Health Regulations. Geneva: World Health Organization; 2005 (http://apps.who.int/iris/bitstream/hand le/10665/246107/9789241580496-eng.pdf?sequence=1, accessed 21 November 2018).

2. Migration and health: key issues [webpage]. Copenhagen: WHO Regional Office for Europe; 2018 (http://www.euro.who.int/ en/health-topics/health-determinants/migration-and-health/migrant-health-in-the-european-region/migration-and-health-key-issues, accessed 21 November 2018).

3. Public health surveillance [webpage]. Geneva: World Health Organization; 2018 (http://www.who.int/topics/public_health_ surveillance/en/, accessed 21 November 2018).

4. European Civil Protection and Humanitarian Aid Operations (ECHO). Serbia: facts and figures. Brussels: European Commission; 2016.

5. Europe refugee situation: Serbia 2016 in numbers [webpage]. Geneva: United Nations High Commissioner for Refugees (UNHCR); 2017 (https://data2.unhcr.org/en/documents/download/55029, accessed 21 November 2018).

6. Trapped in Serbia, migrants shelter in warehouse. London: Thompson Reuters: 2016 (https://widerimage.reuters.com/story/trapped-in-serbia-migrants-shelter-in-warehouse, accessed 21 November 2018).

7. UN strengthens its support to Serbia for hosting refugees and migrants in winter. Geneva: UNHCR; 2017 (http://www.unhcr. rs/en/dokumenti/saopstenja-za-medije/un-pojacava-svoju-podrsku-srbiji-koja-ce-tokom-zimskog-perioda-omoguci-ti-smestaj-izbeglicama-i-migrantima.html, accessed 21 November 2018).

8. Ministry of Health of Serbia, WHO Regional Office for Europe. Serbia: assessing health system capacity to manage sudden large influxes of migrants. Copenhagen: WHO Regional Office for Europe; 2015 (http://www.euro.who.int/__data/assets/ pdf_file/0010/293329/Serbia-Assessment-Report-en.pdf?ua=1, accessed 21 November 2018).

9. Извештај о здравственом надзору над популацијом избеглица, миграната, тражилаца азила и азиланата у републици Србији за 2016. Годину [Report on health surveillance of the population of refugees, migrants and asylum seekers in the Republic of Serbia for 2016]. Belgrade: Institute of Public Health of Serbia (IPHS); 2017 (in Serbian).

10. Извештај о здравственом надзору над популацијом избеглица, миграната, тражилаца азила и азиланата у републици Србији за 2017. Годину [Report on health surveillance of the population of refugees, migrants and asylum seekers in the Republic of Serbia for 2017]. Belgrade: IPHS; 2018 (in Serbian).

11. Report on strengthening national surveillance system in response to a large influx of refugees/migrants in Serbia. Belgrade: IPHS; 2016.

11

Training and accreditation programme
for Syrian health-care professionals in Turkey

Author information

Line Neerup Handlos, Independent Consultant in Migrant Health

Mehmet Ali Torunoglu, Vice President, Public Health Institution, Turkey

Craig Stuart Hampton, Health Sector Coordinator, WHO Country Office, Turkey

Serap Sener, National Professional Officer, WHO Country Office, Turkey

Key messages

- The Ministry of Health of Turkey implemented a training and accreditation programme for Syrian doctors and nurses living in Turkey. It aims at allowing these health professionals to treat other Syrian nationals, thus increasing the health system's capacity and overcoming cultural and linguistic barriers.

- The training and accreditation programme consists of an online registration system, a five-day theoretical training course and a six-week mentoring programme in a migrant health training centre. After successful completion of the programme, applicants practice for a year in a migrant health centre. Upon completion of the first year, they must pass a Turkish language exam in order to obtain a work permit that allows them to apply for positions under the same conditions as Turkish health professionals, although they can treat Syrian patients only. Upon completion of two years of service, they are permitted to provide services to all foreigners in Turkey.

- The main challenge in the implementation of the programme thus far relates to the validation of the medical credentials and previous employment of the Syrian health professionals applying to the programme, given that many institutions in their country of origin no longer exist.

- Migrant health centres have been established across Turkey to provide outpatient, maternal and child health services to the growing migrant population, including health education, vaccination and screening programmes. In addition, migrant health training centres are used as a platform for on-the-job training for Syrian health professionals.

1. Introduction

The training and accreditation programme for Syrian doctors and nurses in Turkey was initiated in 2013 as a response to the linguistic and cultural barriers encountered by non-Arabic-speaking Turkish health professionals when providing services to Arabic-speaking Syrian refugees with limited access to interpreters. These cultural barriers mainly emerged when Syrian refugees sought assistance directly at emergency care units in hospitals as opposed to primary care centres, thus bypassing the prescribed way of accessing health-care services in Turkey. Other countries have observed similar trends: in Denmark, for example, migrant patients seek health-care services at emergency units to a larger extent than native-born citizens (1). However, this tendency has not been confirmed in a broader European study (2). In addition to linguistic and cultural barriers, Turkey faced a lack of quality assurance for the services provided by Syrian health professionals.

In this context, the Turkish Ministry of Health saw potential in allowing some of the many Syrian doctors and nurses living in the country to officially provide patient care to the Syrian population staying in Turkey. To this end, in 2015,

the training and accreditation programme was designed. It consists of an online registration system, a five-day theoretical training course and a six-week mentoring programme in a migrant health training centre. When all parts of the programme are completed, the Syrian health professionals receive an authorization to apply for a Turkish work permit. If the permit is granted, they can apply for jobs under the same conditions as Turkish doctors and nurses, though they are only permitted to treat Syrian patients until they receive Turkish citizenship.

Programmes that allow migrant health professionals to provide health-care services without the standard authorization have only been implemented in a few countries. There are great expectations for the training and accreditation programme in Turkey to become an inexpensive and efficient alternative to expanding the existing health system's capacity. Such capacity increase is often crucial in the context of large influxes of refugees and migrants.

This case study is based on the professional experience of the authors as well as scientific articles, websites, reports and factsheets from various United Nations agencies.

2. Context

Turkey currently hosts the largest number of refugees and migrants of any country in the world – a total of 3 million by October 2016 *(3,4)*. Of these refugees and migrants, 2.7 million are Syrians. The majority are residing in host communities, and around 250 000 are being hosted in refugee camps *(3,5)*. The size of the Syrian refugee population and the rapidity with which refugees have entered Turkey have added considerable pressure to Turkish health-care facilities and service providers. As a result, a great number of informal and underground clinics engaging Syrian doctors and nurses emerged in the years following the immigration of large numbers of migrants and refugees. Some of the clinics were run in collaboration with Turkish and international nongovernmental organizations, and some were run autonomously. No systematic procedure was in place in these clinics to assess the qualifications of the Syrian health professionals or their performance.

In 2013, discussions were initiated at the Turkish Ministry of Health about the possibility of formalizing the procedure of allowing Syrian doctors and nurses to provide care to the Syrian population in Turkey. Participants suggested an accreditation programme that aimed at not only formalizing but also improving the process of inclusion of Syrian health professionals in the Turkish health system. The programme was intended to assess and ensure the qualifications of the Syrian health professionals, and to increase the number of health professionals serving the Syrian refugee population.

In 2015, a theoretical course was developed for the accreditation and training programme. The first version of the course focused on teaching medical skills. However, the evaluation of the first year showed that while the Syrian health professionals had little need for relearning medical skills, they had great need for a practical introduction to the Turkish health system. The programme was revised accordingly, and a new course format as well as a practical mentoring programme were implemented in the second half of 2016.

Concurrently with the implementation of the accreditation and training programme, migrant health centres were established all over Turkey. The centres provide outpatient, maternal and child health services including health

education, vaccination and some screening programmes. Furthermore, the establishment of migrant health training centres was planned in early 2017. Beyond providing health-care services to migrants, these training centres will offer a platform for on-the-job training for Syrian health professionals, with capacity to train 10 doctors and 10 nurses simultaneously. From the beginning of 2015 to the end of 2016, the Turkish Ministry of Health established 85 migrant health centres in Turkey; it plans to establish 175 more. Seven of these future centres will be migrant health training centres, the first being scheduled to open in January 2017.

Syrians were selected as the target group for the programme for three reasons:

- although they are still temporary residents, Syrian refugees are expected to stay for a relatively long time in Turkey and their health-care needs are therefore consistently large;

- a relatively large percentage of the Syrian population is trained in health professions; and

- the Syrian population tends to concentrate in specific areas across Turkey, unlike other nationalities of refugees who are more integrated in Turkish communities and thus more geographically spread out.

3. The issue: designing a training and accreditation programme for Syrian health professionals

a. What is it?

The Turkish training and accreditation programme for Syrian health professionals consists of an online registration system, a five-day training course and six weeks of on-the-job training during which the Syrian health professionals are mentored by Turkish health professionals in a migrant health training centre.

b. Who provides it?

The Turkish Ministry of Health carried out the planning and establishment of the migrant health training centres in collaboration with WHO. Yildirim Beyazit University's Family Medicine Department provides the theoretical course for the doctors, and Ankara University's School of Health Sciences provides the course for nurses.

c. How does it work?

Syrian doctors and nurses who are interested in becoming accredited to provide health care to the Syrian refugee population in Turkey undergo three steps: registration, a theoretical course and vocational training.

First, after registered themselves as persons under the temporary protection of Turkey, applicants must register their medical credentials and their curriculum vitae in an online system.

Second, when the documents are evaluated and approved by a commission consisting of medical professors from different universities, applicants undergo a five-day theoretical training course. Overall, this course aims at helping Syrian health professionals to adapt to the Turkish health system. It includes information on:

- the legislation of the Turkish health system;

- communication skills, including intercultural communication, conflict management and effective communication between patient and health professionals;

- occupational health including safety practices, with a focus on protecting workers' health;

- community health, including primary health care and the social determinants of health;

- data management, including methods of data entry, sharing and analyses;

- noncommunicable diseases and the health of older people, including how to control, diagnose, treat and monitor diseases;

- reproductive health for women, including pre- and postnatal care and counselling on contraception and sexually transmitted diseases;

- infant, child and adolescent health, including an introduction to the neonatal screening programme;

- control of communicable diseases, including the existing surveillance, reporting and notification systems;

- vaccine-preventable diseases, including immunization services provided at the primary care level and vaccine storage; and

- mental health issues, including self-help techniques and recognition of symptoms for secondary trauma and burnout.

The teaching methods used in the course include a combination of lectures, question-and-answer sessions, case studies and group discussions. The qualifications of participants are assessed by multiple-choice tests.

Finally, upon successful completion of the course, the Syrian health professionals are assigned to a migrant health training centre for a six-week vocational training. One Turkish doctor/nurse trains two Syrian doctors/nurses at a time.

After completing the vocational training, the Syrian health professionals are given a certificate of competency with which they can obtain employment at a migrant health centre. After a year of practicing, they undergo a Turkish language test and, if successful, receive a language competency document. This document allows them to obtain a work permit from the Ministry of Labour and Social Security, and to apply for positions under the same conditions as Turkish doctors, although they are only permitted to treat Syrian patients.

After two years' service, the Syrian health professionals will receive a certificate of equivalence that allows them to provide services to all foreigners in Turkey, although they are still not permitted to treat Turks. The accreditation procedure is shown in Fig. 1.

Fig. 1. Procedure of accreditation for Syrian health professionals in Turkey.

d. What are the prerequisites for running the training and accreditation programme?

The programme requires the availability of instructors who are able to teach the theoretical training course, and time and capacity among Turkish health professionals working at the migrant health training centres to train Syrians health professionals. It also requires the availability of a migrant health training centre for the vocational training. Finally, Syrian health professionals must possess valid documentation of their credentials. This last point is crucial for a quick registration procedure.

e. How is it funded?

The programme is funded by WHO, the Directorate-General for European Civil Protection and Humanitarian Aid Operations (ECHO) and the Bureau of Population, Refugees, and Migration of the United States Department of State. The price for the theoretical training is approximately 800 US dollars per person.

f. Future plans

In addition to the already-existing 85 migrant health centres, 175 centres will be built across Turkey. Furthermore, seven migrant health training centres will soon be established in Ankara, Istanbul, Gaziantep, Mersin, Sanliurfa, Hatay and Izmir. The programme received 300 million euros from the European Union to train 500 doctors and 500 nurses. As each pair of nurses and doctors can serve 4000 people, this expansion would allow the whole Syrian refugee population to access care with Syrian health professionals.

4. Impact and lessons learned

From 2014 until the end of 2016, 377 doctors and 179 nurses were trained through the training and accreditation programme. A comprehensive evaluation of the programme is planned.

The registration of Syrian refugees' medical credentials as well as their previous employment has proven to be the programme's main challenge, as refugees have often lost the necessary documents during the migration process. Additionally, the academic institutions from which they received their training sometimes no longer exist, making it impossible to validate their credentials. This poses a great challenge for the confirmation of the testimonials made by the Syrian health professionals. This issue is being addressed through individual interviews with all those who register in the programme.

Another challenge has been the realization that the migrant health centres, which originally hosted the vocational training, had inadequate capacity for this task. The introduction of the migrant health training centres is expected to compensate for this.

a. Transferability to other countries/settings

The training and accreditation programme could be transferred to any country hosting a large number of refugees for a long period of time. It should, however, be made clear that the programme should not establish a parallel health system for refugees. The aim of the programme is to overcome cultural and linguistic barriers, and to meet the need for extra health-care services in the period before refugees integrate fully in the country.

Germany is another country in the WHO European Region implementing a programme to make it faster for refugee health professionals to receive authorization to work in the country *(6)*. However, critics still describe the German procedures as slow and complicated *(7)*.

References

1. Nielsen SS, Hempler NF, Waldorff FB, Kreiner S, Krasnik A. Is there equity in use of healthcare services among immigrants, their descendents, and ethnic Danes? Scand J Public Health. 2012;40(3):260–70. doi: 10.1177/1403494812443602.

2. Georgia R, Anastasios K, Persefoni P, Giannoula F, Nikoleta B. Migrants' healthcare utilization in Europe: a comprehensive review of emergency room utilization and hospitalization. International Journal of Business and Social Research. 2015;5:19–27.

3. Reliefweb. UNHCR Turkey: key facts and figures, November 2016 [website]. Geneva: United Nations High Commissioner for Refugees; 2016 (http://reliefweb.int/report/turkey/unhcr-turkey-key-facts-and-figures-november-2016, accessed 11 December 2018).

4. Operation: Turkey. 2016 year-end report. Geneva: United Nations High Commissioner for Refugees; 2016 (http://reporting.unhcr.org/sites/default/files/pdfsummaries/GR2016-Turkey-eng.pdf, accessed 11 December 2018).

5. UNHCR Turkey: operational update January–June 2016. Geneva: United Nations High Commissioner for Refugees; 2016 (https://data2.unhcr.org/en/documents/details/51166, accessed 11 December 2018).

6. Braw B. Syrian doctors are saving German lives – and that's a problem. Washington DC: Foreign Policy; 2018 (http://foreignpolicy.com/2016/03/07/syrian-doctors-are-saving-german-lives-problem-refugee-crisis/, accessed 11 December 2018).

7. Witt J. German system to assess foreign doctors' skills too bureaucratic. Bonn: DW; 2016 (http://www.dw.com/en/german-system-to-assess-foreign-doctors-skills-too-bureaucratic/a-35935522, accessed 11 December 2018).

The WHO Regional
Office for Europe

The World Health Organization (WHO) is a specialized
agency of the United Nations created in 1948 with the
primary responsibility for international health matters
and public health. The WHO Regional Office for Europe
is one of six regional offices throughout the world,
each with its own programme geared to the particular
health conditions of the countries it serves.

Member States

Albania
Andorra
Armenia
Austria
Azerbaijan
Belarus
Belgium
Bosnia and Herzegovina
Bulgaria
Croatia
Cyprus
Czechia
Denmark
Estonia
Finland
France
Georgia
Germany
Greece
Hungary
Iceland
Ireland
Israel
Italy
Kazakhstan
Kyrgyzstan
Latvia
Lithuania
Luxembourg
Malta
Monaco
Montenegro
Netherlands
Norway
Poland
Portugal
Republic of Moldova
Romania
Russian Federation
San Marino
Serbia
Slovakia
Slovenia
Spain
Sweden
Switzerland
Tajikistan
The former Yugoslav
  Republic of Macedonia
Turkey
Turkmenistan
Ukraine
United Kingdom
Uzbekistan