2.1.5. Refugees, asylum-seekers and the right to health

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Setting the scene

Within the planet-wide phenomenon of human mobility (discussed in the last report in the wider context of experiences of migration) there is a particular category of person who, in the international literature, is often termed a "forced migrant". This term does not imply that some migrants have chosen, i.e. have not been forced conditioned in some way or another, to abandon their own country and community: anyone who moves like this must have had an undeniable reason for leaving, for being 'expelled'. The majority move for socio-economic reasons and these migrants, who flee from a situation of general hardship, are very different from those who have fled because of political persecution and/or torture.

The Geneva Convention (1951)* defined a *refugee* as a person who has been forced to leave their own country because of persecution for reasons of race, religion, nationality, membership of a specific social group or, because of their political opinions. Unlike migrants, refugees cannot return to their own country, as they could risk injury or death. In those countries where the condition "refugee" is recognised by the institutions, the laws, of the host country, these people can apply for refugee status. After applying they are considered an *asylum-seeker* until the authorities responsible decide whether they are a refugee or not.

The term refugee (or sometimes incorrectly, "*displaced person*") is, however, often used in a more generic way to denote someone who leaves their country because of external events (wars, invasions, revolts, natural catastrophes) and is temporarily hosted in a foreign country, staying there for "humanitarian protection".

The English term, Internally Displaced Person (IDP), is generally used only to describe those people who have left their homes for the same reasons as refugees, but who have not crossed an international frontier, so they are still in their own country.

Lastly, there are also *stateless persons*, which The New York Convention, 1954, termed a person who no State acknowledges as its citizen.

The scale of the phenomenon

The UNHCR (United Nations High Commissioner for Refugees) was set up in 1950. Since 2005, as well as looking after the rights of every person seeking asylum

* 145 States have signed either the Geneva Convention and/or the 1967 Protocol.

and ensuring that the rights of refugees are respected, the Agency has taken on the task of looking after displaced persons and managing camps and other emergency situations. According to the UNCHR Statistical Yearbook[1], by the end of 2006, almost 33 million people (32,861,285), in a variety of situations and with diverse legal statuses, came under their jurisdiction. Of these, about 10 million (9,877,707) were refugees; nearly 13 million (12,794,268) were protected and/or assisted internally displaced persons; asylum seekers numbered around 740,000 (740,165) and, there were almost 6 million stateless persons (5,805,943). The Centre for monitoring refugees of Norwegian Refugee Council has estimated that there are about 24.5 million displaced persons in the world today; this means that only half of those in need in this group are receiving some form of protection. Some people do manage to return to their own countries or places of origin. In 2006, more than 700,000 (733,622) refugees returned home, as did over one million eight-hundred thousand (1,864,171) displaced persons. The 4.3 million Palestinian refugees and displaced persons in the Occupied Territories and neighbouring countries (Lebanon, Syria and Jordan) do not come under UNCHR protection; instead they are cared for by UNRWA**, United Nations Relief and Works Agency for Palestinian Refugees in the Near East[1]. Estimates show that there are 1.5 million more refugees now in this area than in 2005, about 1.2 million of whom have fled from Iraq. As **Table 1** shows, with the exception of Colombia which has been torn by internal violence for decades, most refugees come from, and are hosted by, countries in Africa and the Middle East[2].

Table 1. Refugees and displaced persons in the world: country of origin, host country (2006).

Country of origin		*Host country*		*Displaced persons cared for by UNHCR*	
1. Afghanistan	2,107,519	1. Pakistan	1,044,462	1. Colombia	3,000,000
2. Iraq	1,450,905	2. Iran	968,370	2. Iraq	1,834,368
3. Sudan	686,311	3. USA	843,498	3. Uganda	1,586,174
4. Somalia	464,253	4. Syria	702,209	4. Sudan	§1,325,235
5. Dem. Rep. Congo	401,914	5. Germany	605,406	5. Dem. Rep .Congo	1,075,297

§ The total (estimated) number of displaced persons in Sudan is about 5 million.
Source: Caritas/Migrantes, Immigrazione Dossier Statistico 2007, data from: UNHCR, 2006 Global Trends: Refugees, Asylum-seekers, Returnees, Internally Displaced and Stateless Persons'.

Almost half the World's population of refugees is made up of women and children. It has been estimated that up to now about 25 million children have been forced to flee their homes.

** However, the UNHCR does care for Palestinian refugees in other states, for example in Iraq where, because they are perceived as having received favoured treatment under Saddam Hussein, they are now, as a group, being persecuted within the country.

Table 2 below, shows the number of refugees and asylum-seekers in 2006 in each of the European Union (EU) countries (at the time 25 countries).

Table 2. Refugees and asylum-seekers in the European Union (2006).

Country	*Population in thousands*	*Refugees 2006*	*Refugees per 1,000 pop.*	*Applications for asylum 2006*	*Applications for asylum per 1,000 pop.*	*Asylum application -% variation 2005/2006*
Austria	8,265,9	25,486	3.0	13,350	1.6	- 41%
Belgium	10,511,4	16,820	1.6	11,590	1.1	- 27%
Cyprus	766,4	924	1.2	4,550	5.3	- 41%
Czech Rep.	10,251,1	1,887	0.2	3,020	0.3	- 27%
Denmark	5,427,5	36,659	6.7	1,920	0.4	- 15%
Estonia	1,344,7	5	0.0	10	0.0	0%
Finland	5,255,6	11,827	2.2	2,290	0.4	- 36%
France	62,998,8	145,996	2.3	30,690	0.5	- 38%
Germany	82,438,0	605,406	7.3	21,030	0.3	- 27%
Greece	11,125,2	2,289	0.2	12,270	1.1	36%
Ireland	4,209,0	7,917	1.8	4,310	1.0	0%
Italy	58,751,7	26,875	0.4	10,348	0.2	11%
Latonia	2,294,6	21	0.0	10	0.0	- 50%
Lithuania	3,403,3	531	0.1	160	0.0	33%
Luxembourg	459,5	2,206	4.8	520	1.1	- 35%
Malta	404,3	2,404	5.9	1,270	3.1	9%
Netherlands	16,334,2	100,574	6.1	14,470	0.9	17%
Poland	38,157,1	6,790	0.2	4,220	0.1	- 38%
Portugal	10,569,6	333	0.0	130	0.0	18%
Slovakia	5,389,2	248	0.0	2,870	0.5	- 19%
Slovenia	2,003,4	254	0.1	520	0.3	- 72%
Spain	43,758,3	5,275	0.1	5,310	0.1	1%
Sweden	9,047,8	79,913	8.8	24,320	2.7	39%
UK	60,393,0	301,556	4.9	27,850	0.5	- 10%
Hungary	10,076,6	8,075	0.8	2,110	0.2	31%
EU 25	463,636,0	1,390,271	2.9	198,900	0.4	- 17%

Source: Caritas/Migrantes, Immigrazione Dossier Statistico 2007, data from: Eurostat; UNHCR, '2006 Global Trends: Refugees, Asylum-seekers, Returnees, Internally Displaced and Stateless Persons'; National Commission for the right to Asylum; UNHCR, 'Asylum Levels and Trends in Industrialized Countries'

In 2006, despite an increase in the numbers of uprooted persons in the world today, there was a 17% drop on 2005 in the numbers of those seeking asylum in EU countries. This trend can be seen in all industrialised countries and in the EU where, since 2002, there has been a similar drop in applications of 52% in the former and 53% in the latter. In 2006, in the EU, the number of new asylum seekers was the lowest it had been for the previous 20 years with the exception of Greece, Sweden (with a large number of Iraqi asylum seekers) and Malta.

Currently Italy*** hosts people from 40 different countries, mostly from the Balkan area (Albanians and Kosovans), from the Middle East (Kurds from Turkey and Iraq) and from the Horn of Africa. On 15th June 2007, there were 26,875 refugees and 886 stateless persons in Italy. The *Commissione Nazionale per il Diritto d'Asilo* (National Commission for the Right to Asylum) has reported that there were 14,053 applications for asylum in Italy in 2007 (there had been 10,348 in 2006): of the 13,509 applications examined in 2007, about 57% of asylum seekers were granted protection either because they were recognised as refugees (about 10%) or because they were offered humanitarian protection (about 47%).

Refugees' health problems

Before going into details, it should be remembered that the whole process of applying for asylum is anything but simple, starting from the complex initial application for recognition of refugee status. It is a slow, stressful process[§], made worse by the fact that the applicant lives with the fear, at times terror, of being rejected and sent back to the situation they have fled from. It should also not be forgotten that many of the applicants have arrived in the host country only because they put themselves at the mercy of the so-called "human traffickers" and so have run up debts that will hang like millstones around their necks in their future lives. Like all other types of migrant, asylum-seekers and refugees are not a homogeneous group; each has his or her own tale of experiences and personal expectations regarding health and health care.

Another aspect that cannot be neglected is a methodological question of the approach used to evaluate the trauma and health status of each refugee. A critical review, published in the Journal of the American Medical Association in 2002, analysed 394 published articles from the point of view of this question of methodology and found that most of the articles on the subject are either purely descriptive or include quantitative data gathered using tools that are either of limited value and reliability or, whose reliability/accuracy has never even been tested[3].

*** In Italy the right to asylum is guaranteed by art.10 comma 3 of the Constitution: "*A foreign national, who, in his/her own country is unable to exercise the democratic rights enshrined in the Italian Constitution, has the right to be given asylum in the territories of the Republic, under the conditions laid down by the Law*"

§ An article by Angela Burnett and Michael Peel published in the *British Medical Journal* in February 2001 (322: 485-8) highlighted the fact that the only application form provided in the UK for those who wish to obtain certificates of exemption and free medical prescriptions (HC1 form) is 16 pages long and only available in English and, furthermore, the certificate granted is only valid for six months.

In general, the basic health needs of the refugee population appear to be very similar to those of the population of the host country, even though the difficulties the former might have experienced in accessing healthcare assistance in their home countries could lead to under treatment of morbid conditions. Notwithstanding this, a UK study has revealed that one refugee in six has health problems that are serious enough to interfere with their everyday lives and two-thirds of them have suffered from anxiety or depression at some time[4]. Certain health problems, especially parasite and dietary/nutrition diseases, are determined by the conditions in the country the refugees have come from, thus vary widely from one group to another[5]. Some studies on the physical health problems of refugees have taken the prevalence of transmittable pathologies and of parasite diseases among refugee groups as variables and, among other data, have found that: in the USA, 5% of Koreans and 15% of Cambodians are positive for HbSAg, while in Spain, 21% of people from Sub-Saharan Africa are chronic carriers of Hepatitis B[5]; another variable, chronic-degenerative pathologies, was considered in an Australian study which then found gastrointestinal symptoms in 25% of a group of asylum-seekers[§§]; and, with different variables again, a UK study found high rates of diabetes, hypertension and coronopathies among Kosovan refugees in Britain[§§§]. Other studies have warned of the risks of psychotropic drug abuse and others report conditions of poor hygiene and, sometimes, malnutrition. In some situations it is very difficult to reconstruct the subjects' medical and immunological history. Many refugees also report non-specific muscle pain, headaches and backache and dental problems too are encountered to a differing degree in the diverse groups[6].

Unsurprisingly, the strong feelings of insecurity common among refugees, or a history of torture and abuse, will amplify and lengthen the course of any pathology found. These psychic aspects often seem to be the main protagonists in clinical examinations, with a wide range of symptoms and distress: depression, anxiety, panic attacks, agoraphobia, sleep disturbances (either difficulty sleeping or lethargy), headaches, memory and concentration problems, asthenia, generalised muscle and abdominal pain with no organic reasons, lack of self-esteem, suicidal tendencies and feelings of shame or guilt (especially when part of the family have remained behind in the country of origin and can no longer be contacted). The effects of terrible past experiences can be reinforced, in a vicious circle, by the person's current situation, which is often marked by economic, job and housing problems, by feelings of degradation or, by social and interpersonal isolation or even perceive hostility and racism. At the level of problems of social integration, many refugees are disoriented because of the loss of the social role and esteem they had "won" in their own society (doctors, teachers, lawyers and so on). This has an economic aspect too: training a doctor costs about £200,000 but a refugee doctor can be accredited to work in Britain at an average cost of £3,500[7].

[§§] I. Sinnerbrink, D.M. Silove, V.L. Manicavasagar et al., *Asylum seekers: general health status and problems with access to health care*, «Med J Aust» 1996, 165, pp. 634-637 (cited n.5 in bibliography).

[§§§] A. Burnett, *Guidelines for health workers providing care for Kosovan refugees*, Medical Foundation for the care of victims of torture, London 1999 (cited n. 6 in bibliography).

Even though symptoms of psychological stress are commonly found among refugees, this does not necessarily mean mental illness is involved. In the case of people who have survived torture and organised violence (violence for political reasons) there has often been a destructuring of the personality (the aim of torture, especially psychological torture is to incriminate and/or annul the subject) which requires the intervention of personnel specialised in psychotraumatology: experts are required to assess and diagnose PTSD, Post-Traumatic Stress Disorder). In 2008, Amnesty International estimated that there were at least 81 countries in which torture and maltreatment were regularly used; in at least 54 countries they are tried without any legal protection or guarantees and in at least 77 there is no free speech[8]. Torture can also leave functional and sensorial damage of varying seriousness (for example, epileptiform convulsions due to cranial trauma, otitis and perforation of the tympanum through being hit on the ears, problems of visus, because of injury or long periods in the dark or in constant light)[9].

Women are particularly vulnerable to violence: refugees leave behind them fathers, husbands and brothers who are often caught up in a war, who are killed, or imprisoned; women are often the victims of rape – now sadly used as a tactic for ethnic cleansing – or of other violence from soldiers. Yet, even in this situation where women are the most vulnerable, they are also often the only hope for their children's survival. Protection and assistance for women refugees is a priority for UNHCR, which has set up projects in many countries to look after the health and psycho-social welfare of women who have been subjected to violence[10].

The health care approach

Asylum-seekers and refugees often come up against diverse health care barriers: these could be simply a lack of information and/or difficulty of communication through lack of language; juridical and economic problems may hinder access to services, as may fear of confiding in medical personnel because of lack of trust or unfriendly attitudes among health care personnel.

From the above it would seem clear that refugee health care requires a strategy that is able to encompass and integrate health and social services and to involve all the necessary personnel. This inter-sectorial approach should be able: to gather accurate information on refugees at a local level; to ensure that they have equal access to services; and, to train and up-date specialist personnel. The refugees themselves must be involved, directly, in all these activities too[11].

Starting from the assumption that every asylum seeker could, in their past, have been subjected to torture or to another trauma, makes it clear that the following objectives are all essential: correctly identifying victims of violence; understanding the context in which the torture or trauma took place and reconstructing the impact it has had on the individual, the family and the community; evaluating the physical and mental health problems of those who have survived violence; working with patients to elaborate their treatment plans; being able to identify and refer patients to the correct health and welfare services; being aware of the effect these

themes can have on any personnel involved[12]. It should also be remembered that, since some refugees have been tortured by health service personnel – though often such personnel would have been acting under duress – this could complicate the way in which they relate to any treatment. In this situation, both the figure of the General Practitioner and the care with which the person's medical history of trauma has been reconstructed are crucial; this latter could be simplified by using a questionnaire, for example the *Hopkins Symptom Check-list-25* or the *Harvard Trauma Questionnaire* (HTQ). Clinical evaluation should produce a list of problems, in which the history of any trauma must be at the top, and those in charge of day to day health care should constantly bear in mind the effects of this trauma on the subject's everyday life during treatment[13].

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