CANADIAN COUNCIL FOR REFUGEES

Resettlement of refugees with medical needs

14 February 2008

Paper prepared for the Working Group on Resettlement, February 2008

INTRODUCTION

Every year, hundreds of refugees with specific medical needs are considered for resettlement. Some are resettled, others are not resettled for reasons relating to their medical condition. Some are refugees who need resettlement because of their medical condition. Others are refugees who need resettlement on other grounds, but who also have specific medical needs, or have accompanying family members with such needs.

UNHCR, states, NGOs and of course the affected refugees themselves all have experience of both the successes and challenges with respect to resettlement policies and practices for medical cases. The dramatic situation of Iraqi refugees, who show an unusually high rate of medical needs, reinforces the relevance of the issue, and the usefulness of studying how the successes can be multiplied and the challenges overcome.

This paper is prepared by the Canadian Council for Refugees, with contributions from several other resettlement NGOs, for discussion at the Working Group on Resettlement meeting in February 2008, with a view to advancing tripartite reflections on the issue. The opportunity for these reflections and further actions is strengthened by the Danish government's concurrent initiative of surveying states on their policies and practices with regard to refugees with medical needs.

The issue can be usefully divided into the following two aspects:

- **Selection and processing for resettlement**.
- **Post-arrival services**.

It should be noted that the two aspects are inter-related in various ways. For example, delays in processing can increase the post-arrival needs; conversely, effective post-arrival services may, by confirming the viability of resettlement as a solution, lead to changes affecting the selection of other refugees with medical needs.

Special attention needs to be paid to the issues faced by refugees with HIV/AIDS, in view of the specific barriers they face. Some of these barriers are not medical in nature and these challenges may be met through responses separate from quotas dedicated to medical needs.

The overall goal is to improve the availability and effectiveness of resettlement for refugees with medical needs, in terms of both selection/processing and post-arrival experiences. This goal is critical given the inherent vulnerability of refugees with serious health problems, a vulnerability which often places these refugees at greater risk of harm in a country of asylum. Fundamental to our considerations should be the over-riding need for protection for refugees.

This paper addresses the following challenges relating to **selection and processing**:

1) eligibility issues,
2) delays,
3) costs,
4) special rules/barriers for persons with HIV/AIDS, and
5) social factors in the resettlement countries.

Secondly, we address challenges relating to **post-arrival services:**

1) lack of advance information to service providers,
2) refugees' understanding of their medical situation on arrival,
3) privacy issues and
4) need for multi-disciplinary, refugee-sensitive services.

Special mention is also made of the different needs of refugee children, especially unaccompanied minors; however, significant further exploration of these issues should be undertaken as soon as possible.

OUTLINE OF CHALLENGES: SELECTION AND PROCESSING

1. Eligibility

Refugees with medical needs face various possible eligibility restrictions, depending on the country of potential resettlement.

a) Each country has its own **restrictions in relation to medical/health issues**, some based on legislated bars, some based on individual assessments, including with respect to potential costs. In some states there are discretionary powers to waive exclusionary provisions. While legislated bars have the disadvantage of being difficult or impossible to overcome, some of the non-legislated restrictions have the disadvantage of lacking transparency. Discretionary decisions can also lead to inconsistency and lack of transparency. This disadvantage is perhaps reflected in the high refusal rates of medical needs cases referred by the UNHCR. Not knowing clearly which cases will be refused, UNHCR is forced to do its referrals "in the dark", leading to lost time for the refugees whose cases are refused.

Is it possible for States to articulate more clearly what types of cases will be accepted?

b) It is understood that various factors, including the **availability of certain types of medical services** for citizens in the country, affect States' decisions on the types of medical cases they will accept. This does not negate the needs of the refugees for protection through resettlement.

Would it be possible to coordinate more effectively between States with a view to ensuring that for each type of medical need, there is at least one country that will accept such cases and, where necessary, that States focus on specific medical needs that correspond best to their capacity and expertise?

c) To what extent does a **lack of adequate or advanced medical screening** in countries of asylum affect the selection of refugees with medical needs? If refugees referred for resettlement on other grounds are found in the selection process to have medical needs, what are the consequences for the refugees? Does it hurt their chances for resettlement – or in some cases, increase their chances compared to the situation if they had been referred for medical reasons? A negative decision will impact on the family group as well as the refugee with medical needs and likely increase the protection needs and insecurity of the individual.

When a negative decision is rendered because of medical needs, can states coordinate to ensure that this family will be resettled by another state?

d) Some states do not commit to a certain resettlement quota of medical cases and the numbers may vary from year to year. Other countries provide places for medical resettlement needs cases through "Ten or More" and "Twenty or More" (TOM) programs, which allow for dossier submissions. The numbers are quite small – too small for the identified needs. Are annual commitments limiting numbers of medical cases resettled or are there goals that other states could emulate?

What would it take for participating countries to increase their TOM quotas? What would it take for non-participating countries to join the program?

e) Does the **failure to adequately assess and present health conditions** lead to a mistrust in resettlement countries because of the strain at present experienced in responding adequately to the cases whose conditions emerge after resettlement? Does this result in a reluctance to develop any or an increased specific commitment to medical cases?

f) Some countries have few policy bars to medical needs cases, but de facto exclude many such cases because the **long processing times** preclude them from being considered for refugees with urgent or semi-urgent needs.

Could such countries consider taking at least some more urgent cases and could they consider dossier referrals and/or expedited processing?

g) Some countries bar medical cases where the primary condition is a **psychiatric diagnosis**.

Are there additional supports that could be offered to help such countries feel more capable of resettling psychiatric cases?

h) What differences are there in the referral and selection of refugees with physical health needs as opposed to those with **mental health needs**? How many of each category are referred? What are the outcomes? Why do some states show reluctance to resettle refugees with mental health needs?

i) Where refugees face serious protection needs and also have medical needs, **how are their cases presented to states** for consideration for resettlement? Are they proposed primarily

on the non-medical grounds, in the hopes that the medical issues will be overlooked or underplayed?

j) To what extent do the perceived barriers to resettlement for refugees with medical needs lead to **refugees concealing health issues**? In some cases, early information about the health issues would not be relevant to the eligibility decision, but would facilitate the integration process.

k) Recent allegations of corruption in the use of x-rays for immigration medicals highlight the potential for **fraud** in the area of medical cases. More information on fraudulent practices and the vulnerability of medical case refugees should be explored as well as good practices for safeguarding against such fraud.

2. Delays

For some refugees with medical needs, resettlement is required on an urgent basis and delays are dangerous to their health. Medical needs cases can also involve special procedures that bring their own potential for delay.

a) Where States require interviews with the refugees, the **schedule of missions** may lead to delays.

What solutions are available to minimize this problem? Can more be done through cooperative efforts between States?

b) Can States commit to **timeframes** for decision-making on medical needs cases?

c) Would the appointment of a "**focal point**" for medical needs cases within each State facilitate rapid and effective communication between the State and the UNHCR? Would the appointment of a **"focal point" within UNHCR** also assist?

d) Is it possible to minimize and/or expedite **medical-related procedures** (e.g. requests for more information, IOM-UNHCR negotiations over fees)?

e) Can States expedite **non-medical procedures** (e.g. security clearances) for medical cases?

f) Are some delays related to discussions between **different levels of government** in the resettlement state? Could such challenges be alleviated through a focal point within the government responsible for liaising and problem-solving between the different players? Do some states have successful models for dealing with such challenges?

3. Costs

a) Although refugees with medical needs and their families have protection needs, the costs for their resettlement may be seen as a disincentive that in some eyes outweighs the protection factors. Direct costs are arguably much higher than for those who are resettled but with other needs. However, in addition to the direct costs for transportation, ongoing medical

care, and the engagement of a range of health service providers post-arrival, there are often **other factors that serve to offset the direct costs**. For example, we can take into consideration the strengths and potential of the accompanying family members, the presence of a supportive community in the destination centre, the outcomes of persons with similar medical needs, the availability of traditional and non-traditional assistance as well as the supports available to the entire family group. Do states assess the medical needs refugee in the greater context of the social capital available to the entire family group? What are some of the tools that may be useful to share with other states?

Could we collect and share information on integration outcomes for medical cases, including on the factors that promote successful integration and minimize costs?

b) Some non-resettlement countries receive refugees on a **temporary basis for medical care**. Is there value in pursuing formal or informal partnerships, whereby some refugees needing resettlement receive some medical treatment in a contributing non-resettlement country before arriving in the resettlement country?

4. Special rules/barriers for persons with HIV/AIDS

Refugees with HIV/AIDS face particular barriers to resettlement because a number of states have varying levels of bars against their admittance. These bars unfairly discriminate against those refugees whose vulnerability placed them at risk of HIV (such as women and children raped as an act of war or in flight). They may then be denied protection through resettlement, despite the fact that they face serious risk in the country of asylum, because not only of their health needs, but also social sanctions.

In the past decade, many countries have seen changing attitudes towards HIV/AIDS from both a medical and a social perspective. Many persons with HIV/AIDS, including refugees, have demonstrated that, with access to appropriate treatment and positive societal attitudes, it is possible to live full and productive lives with the condition. These developments have been achieved through active struggle against prejudices. In the case of refugees, it is necessary to tackle the xenophobia which heightens the hostility too often found directed against persons with HIV/AIDS.

How can states share experiences with a view to eliminating barriers to resettlement for refugees with HIV/AIDS?

5. Social factors in the resettlement countries

What factors are driving the reluctance to resettle refugees with medical needs? To what extent is it concern over integration challenges, social factors and/or costs? To what extent is the program and/or the receiving community focused on "success indicators" (such as achieving employment) that some refugees with medical needs may not be able to achieve? Are resettlement countries looking for 'easy' cases to resettle? How much of a factor is racism? Do fears of negative public opinion influence selection decisions?

How can such factors be addressed in such a way as to promote the resettlement of refugees with medical needs?

OUTLINE OF CHALLENGES: POST-ARRIVAL SERVICES

1. Lack of advance information to service providers

Those involved in the reception and integration of refugees often lack advance information about the medical needs of resettled refugees. The 'hiddenness' of medical conditions may produce poor settlement solutions, because relevant planning does not occur. This can lead to challenges relating to placement decisions (e.g. imbalance in distribution of refugees with medical needs, individual refugees resettled in areas where the best services are lacking). It can also mean that appropriate reception services are not immediately available (e.g. no wheelchair taken to the airport). Some states have an additional pre-departure medical screening to identify medical and health needs. The UNHCR already responded to these challenges by amending their procedures in 2007 so that refugees can now sign to give consent to share personal information on special needs with agencies who will be serving them.

Have these changes improved the flow of information? Are there separate barriers to communication of information within States? Could States assist each other in conducting pre-arrival assessments?

2. Refugees' understanding of their medical situation on arrival

Refugees sometimes arrive in the country of resettlement with a very incomplete understanding of their medical situation and any expectations that may be a condition of their acceptance. They may also be unfamiliar with the health care system in the resettlement country. Counselling is an important requirement. **Are there practical ways in which refugees can receive better counselling before departure as well as on arrival?**

At least one state has a specialized training on refugee needs for nurses who are designated focal points for refugees upon arrival. In other states the initial platform for referral is the General Practitioner, or the public health authorities. **Are there other good practices on assisting medical needs refugees and their families on arrival. Are there good practices that can be shared on how to ensure refugees are supported in coming to terms with their medical condition and the consequences?**

3. Privacy issues

Most states have legislation protecting the privacy of individuals and refugee-serving organizations are familiar with the need to protect refugees' privacy. In many cases, there is no need for service providers to know about the refugees' medical condition. On the other hand, given arriving refugees' isolation and frequent lack of information, refugees might in some cases welcome and benefit from an opportunity to share information with more people around them.

Are there good practices that can be shared on how to ensure refugees are able to control both their privacy and the sharing of information where they so choose?

4. Need for multi-disciplinary, refugee-sensitive services

Whatever their state of health, resettled refugees face many challenges as they adapt to their new life. Those with medical needs face an additional series of challenges, which necessarily affect their settlement. While some states have special training and accreditation opportunities for

specialists in refugee health, even this does not guarantee that every refugee benefits. Sometimes, those providing the medical services are unfamiliar with the realities of the refugee experience, and those providing the settlement services lack understanding of the implications of the medical condition. It is therefore important to adopt a coordinated, multi-disciplinary approach which takes into account the interplay of the various dimensions of the refugees' lives. This is well-illustrated in the report of a study conducted in Montreal of refugees from sub-Saharan Africa with HIV. The study reached encouraging findings about the benefits of a multidisciplinary approach and the positive outcomes for refugees when supported in this way.[1]

PARTICULAR ISSUES FOR MINORS WITH MEDICAL NEEDS

A key topic which does not appear on the current agenda is that of the particular needs of refugee children with medical needs, especially those unaccompanied refugee minors. These children have special considerations in where they will be resettled, depending on for example whether they are joining a family member. When planning for refugees who need resettlement because of their medical needs there must be a separate process for minors, since they have a different set of needs and concerns than adult refugees.

We recommend this special category for discussion be added as soon as possible and pursued in tandem with other discussions.

CONCLUSION AND SUGGESTED NEXT STEPS

This paper highlights a number of possible avenues for improving resettlement responses to refugees with medical needs. These are only some of the possible avenues. The tripartite process provides an excellent opportunity to work collaboratively to follow up on some of these avenues, combining the input of states, UNHCR and NGOs and sharing useful information and models between resettlement countries.

We recommend that we use the discussion time at the February 2008 Working Group on Resettlement meeting to identify **priority issues for follow up**. These could include:

- **Simple solutions** that would be relatively straightforward to implement.
- **Urgent issues** that need immediate attention.
- Issues that would particularly benefit from **collaborative attention** through the ATC process.
- Interesting possibilities that need **more consideration**.
- **Important and difficult issues** that must be on the agenda even though there is no immediate simple solution.

[1] McGill University Health Centre, Optimizing health outcomes for HIV-infected refugees from Sub-Saharan Africa, March 2007, http://www.muhc.ca/files/research/Optimizing_Health_Outcomes.pdf

To make the best progress on issues identified as priorities, we should agree on next steps in the process. These could include:

- Agreeing to explore further the issues at the 2008 ATC.
- Identifying information that could be usefully collected and shared in advance of the ATC.
- Establishing ad hoc groups to consider further specific issues and report back.
- Committing to having medical needs as a regular agenda item for the WGR/ATC.

We look forward to making the most of this opportunity to work together to ensure that refugees with medical needs can be quickly and effectively resettled, where that is the best solution for them.