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On 16 November 2019, the CPME Board adopted the 'CPME Statement on the Medical Treatment of Refugees[1]' (CPME 2019/071 FINAL).

CPME Statement on the Medical Treatment of Refugees

The Standing Committee of European Doctors (CPME) represents national medical associations across Europe. We are committed to contributing the medical profession's point of view to EU institutions and European policy-making through pro-active cooperation on a wide range of health and healthcare related issues. [2]

Mass population movements brought on by war and other crises create significant humanitarian challenges for the international community. In Europe, the recent arrival of more than a million refugees fleeing conflict and persecution has raised questions about how to address healthcare and other needs of those seeking asylum. In some cases, public services have been stretched to their limits and otherwise stable healthcare systems have been tested. Health systems of Member States with 'hotspots' have been especially affected. The dangerous conditions in refugee camps in non-EU countries, such as Libya, further contribute to the poor health status of those refugees who transit such centres before arriving in the EU. This increases human suffering, and costs for EU health systems. The lack of effective EU action to tackle these known problems has allowed the situation to continue.

The World Medical Association (WMA) Resolution on Refugees and Migrants adopted by the 67th General Assembly in Taipei, Taiwan in October 2016 which reiterates the principles defined by the WMA Statement on Medical Care for Refugees originally adopted in Ottawa, Canada in 1998 outlines the responsibilities of physicians in medical care for refugees.

Physicians have a moral and ethical obligation to provide the same level of care to all patients, regardless of ethnicity, gender, sexual orientation, skin colour, political status or religion. But in some EU Member States, administrative and financial hurdles, including inconsistencies in benefit eligibility,

[1] CPME's policies on 'refugees' use the term as referring to all forcibly displaced persons regardless of legal status or reason for displacement. This includes migrants who have been granted legal status as refugee or asylum seeker and undocumented migrants. CPME policies use the term 'migrant' to refer to migration which is not driven by violent conflict, persecution or other emergencies. Examples are cross-border mobility between two EU Member States, economic or otherwise motivated migration from third countries to the EU. This statement is an update of the CPME Statement on the Medical Treatment of Refugees, adopted in November 2016.

[2] CPME is registered in the Transparency Register with the ID number 9276943405-41. More information about CPME's activities can be found on www.cpme.eu.

have impeded access to medical care for newly arrived refugees. As the number of arrivals peaked in 2015, volunteers played a key role in complementing the care provided through established channels. There is also an important role to play for National Medical Associations, in particular in advocating for refugee patients' rights and supporting refugee doctors.

Access to healthcare for different categories of refugees remains very varied across the EU. National legislation often differentiates between documented migrants in different stages of the asylum process, and undocumented migrants. While patients with an approved status as refugee or asylum seeker have free access to primary care in most countries, access to secondary care is restricted in many Member States, apart from in emergency situations. Undocumented migrants face far greater barriers to accessing healthcare, both at primary and secondary level, leaving only emergency care services available. Only few countries provide free access to healthcare services, such as Italy and Greece.

Providing medical care for refugees in Europe is feasible if the responsibility is shouldered by many. To ensure the sustainability of healthcare systems throughout Europe and to safeguard the status of medical care as a basic human right, CPME calls for consistent, humane and unbureaucratic solutions to avoid a complicated parallel system of care for refugees.

- **Defending medical ethics**

  The core ethical principles of the patient-physician relationship must be upheld in the case of refugee care. National Medical Associations and physicians should resist and speak out against any government efforts to restrict their professional autonomy and to deny refugees – whether they are recognised asylum-seekers or are living as undocumented migrants – the right to receive medical care. This includes maintaining physician-patient confidentiality and rejecting calls to administer treatments for which there is no medical indication (e. g., the use of genital examinations or X-rays to determine the age of refugees against their wishes or the administration of sedatives to facilitate deportation)[3]. The decision whether treatment is necessary should always be made by a qualified healthcare professional, not administrative staff. The right to receive medical care should be upheld both in reception centres, including those in hotspots, as well as closed centres.

- **Providing medical treatment**

  Fully integrating asylum seekers into established health systems could prevent unnecessary administrative costs and delay in medical treatment. Refugee care should involve prevention and include a comprehensive initial examination, as well as the administration of all essential vaccinations, in accordance with up-to-date recommendations, and subject to the patient's consent.

[3] Please also see WMA Statement on Medical Age Assessment of Unaccompanied Minor Asylum Seekers, adopted in October 2019.

- It should be noted that the integration of refugees has not resulted in an increase of infectious diseases in the general population. It is nonetheless important to review and align national vaccination recommendations for refugees. The differences between national approaches to vaccinations for refugees causes gaps in immunisation, in particular when refugees travel through several Member States before reaching a final destination. It is necessary to ensure access to vaccines for all age groups and regardless of legal status[4].
- There are a number of recurring health conditions among refugee patients including gastrointestinal disorders, malnutrition, dental problems, skin lesions and burns. Medical care should also include access to treatment for mental health problems, including post-traumatic stress disorder, brought on by the experiences of flight, torture, abuse, ill-treatment, displacement and deprivation.
- All efforts should be made to reduce communication barriers between patient and physician, such as ensuring funding for good quality independent interpreters. In addition, health promotion activities e.g. aimed at promoting vaccination and overcoming vaccine hesitancy should be mindful of refugees as one of the groups requiring communication tailored to socio-cultural needs.
- There should also be policy guidance on how to deal with the fragmentation of refugees' care and medical records, e.g. on vaccinations, caused by their frequent relocations. Resources such as the electronic Personal Health Record (e-PHR)[5] and Handbook for Health Professionals[6] developed jointly by the International Organisation for Migration and the European Commission could be considered as a possible solution.

- **Protecting vulnerable groups**

  Responding to refugee women's health needs requires particular attention and training for health professionals where necessary.

  Physical and psychological trauma due to the extreme stress, migration experiences involving danger or crime, and social isolation have impact upon women's physical, mental and sexual and reproductive health and rights. The circumstances of flight may also aggravate domestic violence in form of physical and emotional abuse. In addition, refugee women are also at a higher risk of poor pregnancy and perinatal outcomes. From a medical point of view, and given that ensuring sexual and reproductive health and rights is ensuring human rights and contributes to achieving the United Nations' Sustainable Development Goals (SDGs) e.g. SDG 3 on 'Good Health and Wellbeing', there is a need for targeted and coherent action[7].

  - Member States should ensure that maternity care and reproductive health care, including preventive measures, are accessible to all women without cost or eligibility barriers.

[4] See Giambia et al., 2019.
[5] See IOM, 2015a.
[6] See IOM, 2015b.
[7] See Keygnaert et al., 2019; WHO, 2018; PICUM, 2016.

- There may be a need for awareness raising and training of healthcare professionals and administrators on issues specifically related to sexual and reproductive health and rights in refugee communities, especially for midwives and gynaecologists, but also for paediatricians and GPs as they often play a crucial role in accessing other services. Depending on cultural background, for example, patients may be living with female genital mutilation (FGM). Health professionals should be equipped to provide the appropriate care for their specific health needs.
- To increase the participation rates of foreign-born women in healthcare programmes it has proven useful to utilize pre-existing bonds with women in the community[8]. This can be considered both for maternal health, as well as other services for instance mammography and cervical cancer screenings. With the help of these cultural mediators, religious, linguistic or personal needs, which may otherwise hinder refugee women from seeking care, can be adequately met.

An increasing number of refugees fall under the category of unaccompanied minors, defined as people under the age of 18 who have been separated from their families or who have fled their countries of origin without them. Physical examinations must be carried out by a qualified paediatric physician wherever necessary in accordance with the highest medical ethical standards. Medical age assessment is ethically problematic. In cases where medical age assessment is unavoidable, the health and safety of the young refugee must be the highest priority. Any examination should take into consideration possible traumatic experiences and cultural or religious sensitivities of each individual person. For age assessment, the use of ionising radiation or other potentially harmful investigation, such as genital examination, is unethical and should be avoided[9].

- **<u>Adapting health systems</u>**

  To create reliable and sustainable healthcare conditions, it is imperative that EU Member States devise and implement solutions which lower the threshold for medical care access for refugees, minimize red tape, expand human and financial resources in the relevant health sector, and untangle medical, administrative, financial and legal accountability among public authorities. This requires a consistent approach at all levels of government and transparency of funding – including at the European Union level.

- **<u>Enabling health and well-being</u>**

  Government authorities at all levels must be called upon to ensure access to adequate healthcare as well as safe and healthy living conditions for all, regardless of immigration status. Political leaders of EU Member States are urged to coordinate medical relief for refugees in a way that enables physicians to contribute their skills in a targeted manner. Action is also required

[8] See Operational Refugee and Migrant Maternal Approach (ORAMMA), 2019.
[9] Please also see WMA Statement on Medical Age Assessment of Unaccompanied Minor Asylum Seekers, adopted in October 2019.

beyond the healthcare sector to improve crucial determinants of health. These begin with the reception and asylum process. Living conditions in reception centres/camps, as well as housing conditions for settled refugees must be safe also for vulnerable groups such as women and children. There is a need for action to promote integration and combat racism. One important way to do this is to ensure better access to work and professional training for refugees. These factors require adequate and sustained funding as well as a robust infrastructure and qualified support. While cooperation between the government and NGOs is mostly systematic, it will be useful to further consolidate the involvement of different government structures and civil society.

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