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Refugees and Health

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More than one and a half million people seeking asylum have arrived in Europe since 2015 (Eurostat 2016), including a fourfold increase in one year of individuals risking their lives to enter by crossing the Mediterranean Sea. Such large numbers in a relatively short period have created a sense of crisis experienced beyond the continent. They are part of the largest global displacement since World War II, with an estimated 65.3 million people worldwide fleeing war, persecution, conflict, and human rights violations (UNHCR 2016). Most of the refugees are concentrated within the urban areas. According to the International Rescue Committee and the Humanitarian Policy Group more than half of all refugees live in large towns and cities (Crawford et al. 2015). Cities are being asked to provide services such as housing, education, and health care to an increasingly diverse group of newcomers and to maintain public safety, often without enough resources to accommodate these new demands. Thus the “refugee crisis” is also an “urban crisis.”

In Europe, the majority of new refugees come from Syria, Afghanistan, and Iraq, as well as other countries divided by conflict and violence (Eurostat 2016). Others are economic migrants who hope to build a better future for themselves and their families. This unprecedented and striking surge in migration to Europe has activated action by state, nongovernmental, and humanitarian agencies and revealed longstanding tensions between the priorities of each of these actors (Smith 2016) while also generating the mobilization of a new category of ad hoc grassroots organizations committed to providing emergency health relief and new approaches to welcoming new arrivals (Kitching et al. 2016).

Refugees arrive by foot, boat, train, and car across multiple border crossings. For many of them, their final destinations are cities in Germany and Sweden, because the governments of these countries have shown a willingness to accept them and their healthy economies are seen as promising job opportunities. Some of the refugees have family and friends who already reside in those places and can assist them in settling in.

Their journey is difficult, as they face countless obstacles in attempts to reach their destination. In 2015, as over 815,000 refugees and migrants crossed the borders of Serbia on their way to Hungary and Croatia, Hungary constructed a 175-kilometer-long barbed wire barricade along its border with Serbia and deployed határvadászok, or “border hunters,” to detain migrants (Haraszti 2015). More generally, competing national priorities and the complexity of migration patterns that place asylum seekers alongside economic migrants have made it difficult for the European Union to develop a collective response to recent arrivals, an effort further complicated by inconsistent examinations of asylum claims among the 28 member states (UNHCR 2010b). Refugees, therefore, became dependent
on the good will of the nation states and urban governments and their citizens to accept them and to provide them with the resources they needed to forge new lives in new lands.

In this chapter, we address one aspect of refugees’ experience in the cities: their health and well-being. We start by defining who is a refugee and what we mean by health. Then we assess the state of migrants’ health needs and examine resources available to migrants during their journey and once they arrive at their destination. We highlight the Serbian capital Belgrade as a transit location case. We conclude with some policy recommendations on how to better address refugees’ health care needs during and after their journey.

Toward Defining Refugees and Health

The term “refugee” reflects layers of international norms, statutes, treaties, and negotiations between nation states (Shacknove 1985). The most commonly accepted definition draws from the 1951 Convention on the Status of Refugees and its 1967 Protocol (UNHCR 2010a, p. 14), where a refugee is defined as a person who flees his or her country of nationality or residence with a “well-founded fear of being persecuted because of his or her race, religion, nationality, membership of a particular social group or political opinion.” Refugees are distinguished from asylum seekers in that their claim has been legally approved, but the United Nations considers migrants fleeing persecution or violence to be refugees even before they receive asylum (Park 2015).

Distinguishing between the separate pathways to migration and drivers of displacement has important implications for individuals’ refugee status and their admittance into the European Union and access to its services. Refugees can receive temporary admission status and expect to return to their country of origin when hostilities at home abate or a permanent resident status and stay in the new location. Other refugees are deemed inadmissible and are forced to return to their original countries or to find another location in which to settle. For the purpose of this chapter, we define refugees as those individuals who leave their country of origin to seek protection in another country. This definition emphasizes the common experience of forcible displacement, movement across borders, and the struggle to enter into a new society.

Charles Watters invokes the concept of “moral” economy of care to illuminate the process of distinguishing legitimate and illegitimate asylum seekers and refugees (Watters 2007). Legitimate refugees are those who are deemed “deserving of protection and care.” These “parameters of legitimacy” depend on several factors: the social attitudes toward refugees by residents of the receiving countries, media representations of refugees and their plight, and the political and legal apparatus of the receiving states (Watters 2007, pp. 395–396). Deserving refugees are those deemed to have legitimate claims to protection and residency in the host society. In Europe, there has been an attempt by the European Commission to create a common understanding of who are legitimate refugees and to define the minimum standards of health and welfare provisions they can access.

Political considerations can influence the environment refugees face and bring further confusion and uncertainty to the process of establishing their legal status and ultimately their ability to remain in the host society. Moreover, even once they are admitted, access to resources such as employment, housing, and health and welfare benefits can be contested or revoked. Legal and political considerations also create hierarchical differentiation among refugees. Conditions such as country of origin, religion of refugees, the mode of transportation used to enter a host country, the port of entry, the time of entry, age, sex, health status, and the number of refugees already admitted are all factors which may influence the reception that refugees are given within the host society. In Germany, chancellor Angela Merkel called in 2015 for an equitable distribution of refugees between EU member states. Yet, within Germany, researchers found that an uneven relocation strategy resulted in richer German states receiving disproportionately fewer vulnerable individuals, with little regard paid to refugees’ social networks of friends and family who had arrived before (Bozorgmehr et al. 2016).
Once in Europe, refugees’ access to health care and delivery of services varies greatly within the European Union, and, despite international calls to action, many European countries have struggled to implement health policies that appropriately meet the needs of immigrants and refugees (Illingworth and Parmet 2017). The study of European health policies found that only ten EU member states provided emergency health care for asylum applicants in 2004, and in 2010 only five member states gave unregistered migrants access to the same health services as citizens (Mladovsky et al. 2012). It is important to note that some but not all refugees are unregistered and thus legal impediments are not the only cause of the lack of adequate care. These policies often are at odds with definitions of health and well-being advanced by international and humanitarian organizations.

The World Health Organization defines health as “a state of complete physical, mental and social well-being” (WHO 1946). This definition stresses the importance of a holistic understanding of health that includes both preventive and curative care. Access to the highest attainable standard of health is promoted by the World Health Organization as a desirable goal for all individuals. The principles of equity, equality, and ethical treatment are seen as values that should guide the process of granting and receiving care. In this context, refugees are seen as people whose health needs are shaped by their special circumstances of displacement and exile and are deserving of humanitarian assistance as well as long-term care to deal with the consequences of their experiences with violence, destruction, and loss. For refugees in Europe, that may include a harrowing trip across the Mediterranean Sea, where thousands perished (Figure 20.1). In practice, the moral economy of care often places those who need protection outside the reach of care (Watters 2007). Mladovsky et al. (2012) highlights the need for health policies in the EU that put into practice the entitlements to health care for new arrivals and ensures a system that is responsive to their needs.

Most refugees settle in urban areas where, with other migrants, they are the major driver of population growth (McKinsey Global Institute 2016). In Europe, cities with a disproportional number of refugees are Berlin, Hamburg, and Munich in Germany, Stockholm, Malmo, and Gothenburg.
in Sweden, Paris, Lyon, and Marseille in France, and Athens, Thessaloniki, and Lesbos, in Greece. Refugees are also contributing to population growth in cities that lost population as a result of deindustrialization and the aging of the population. So far, reception of refugees is mixed. Countries that are already struggling financially like Greece have a harder time providing services to refugees than economically well-to-do countries. For example, a study by the International Monetary Fund shows that, in Sweden, the country with the biggest fiscal burden, the cost was estimated to rise from 0.3% of GDP in 2014 to 1.0% in 2016 (Aiyar et al. 2016).

The connection between social conditions and health has long been recognized among sociologists and social epidemiologists. Link and Phelan (1995) developed “the fundamental cause interpretation” approach in order to explain the association between socioeconomic status and health. Structural conditions, they argue, shape individuals’ exposure to psychosocial and environmental risk factors for health as well as available resources to address them. Effective health interventions, therefore, require careful attention to these social determinants of health (Illingworth and Parmet 2017). Similarly, a growing body of literature that examines refugees’ mental health conditions shows the interrelationship between clinical factors and the sociopolitical context in which they live (Sinnerbrink et al. 1997; Watters 2010). Thus the development of appropriate treatment strategies to deal with refugees’ health issues has to take those relationships into consideration as well (Ellis et al. 2010; Rousseau et al. 2013).

Assessing and Addressing Health Needs of Refugees in the Cities of Host Countries

As a continent, Europe has a long history of mass migration and forced displacement. The 20th century in Europe saw several waves of refugees fleeing persecution from within the continent, from death camps and pogroms, to large numbers of refugees arriving from the war-torn Balkans in the 1990s. Most recently, these prior waves of refugees were joined by a new surge of refugees coming from Sub-Saharan Africa, entering primarily through Spain, Greece, and Italy. Once they reached the European Union many dispersed to countries such as Germany, Sweden, France, and the UK. Scholars have noted that these recent historical examples provide important lessons in preparing for sudden large-scale immigration (Bundy 2016; Permanand et al. 2016). The migrant flows of 2015 originating from the Middle East further exacerbated conditions created by these previous waves.

Most research on refugees and health recognizes temporal aspects of health needs: before the journey begins, during the journey, and after arrival (Fazel and Stein 2002; Norredam et al. 2005; Zimmerman et al. 2011). Those needs are often interrelated, and there are no clear demarcations where one ends and another begins. Regardless of the conditions of their exile, once on the road they face multiple obstacles. Lack of material resources such as adequate food and drink, appropriate clothing, and safe transportation choices are just a few of such obstacles. The health needs of these new arrivals is closely linked to the accumulated physical and emotional trauma of their displacement and their journey, as well as the mode of transportation to their destination, such as boat or container (Zimmerman et al. 2011).

When discussing the health needs of refugees it is essential to consider the complex nature of forcible displacement as well as the diversity of resources, vulnerabilities, and experiences individuals bring with them. Refugees differ among themselves based on their socioeconomic characteristics, their experience in the countries they have left, their experiences of migration, and the experiences they have in the country of settlement. In addition, many refugees are unwilling or unable, owing to linguistic and culture barriers, to disclose their health problems to researchers. Nevertheless, the research on refugees shows them having more health related issues than the established residents in their recipient countries (Wangdahl et al. 2014).
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Refugees also face a backlash from their host locations. The presence of a large number of new, unfamiliar faces makes them seem dangerous, and this in turn may jeopardize their acceptance and safety. The securitization of refugees and the migration process often frames these new arrivals as needing to be contained and has led health care givers in host countries to focus on communicable disease threats at the expense of a more integrated health approach (Pugh 2004; Grove and Zwi 2005; Smith 2016).

The fear of disease, violence, and competition for jobs and services shapes local attitudes and may create hostile environments for the newcomers as well as for the others who arrived before them. Some of those concerns may be legitimate based on the location and characteristics of refugees. More often, such fears may be significantly exaggerated and be used as justification for violence committed against them. So refugees’ health and well-being are shaped by a broader sociopolitical and legal context that includes conditions of refugees’ experiences during their preflight and flight, but also during resettlement.

Migration Status, Social Determinates, and Health

Once they arrive at their final destinations, refugees are faced with a myriad of problems. Where will they live? How will they establish their legal status? What employment opportunities are available to them? Under the provision of the Dublin Regulation (Regulation No. 604/2013) that defines European Union member states’ asylum policy, refugees are required to register and apply for asylum at the first port of entry into the European Union. Even if they move to another location, they may be forced to return to their country of entrance.

The early 1990s saw an increase in readmission agreements allowing the European states to expel unauthorized immigrants or asylum seekers who had already passed through a “safe third country” along the way to applying for asylum (Coleman 2009). The policy was designed to prevent refugees from applying for asylum status in multiple locations. However, it has created an unnecessary burden for both refugees and the countries that originally received them. Spain, Italy, and Greece were particularly affected by these policies given their geographic location as entry points to the European Union.

Refugees’ health conditions may affect their acceptance as deserving immigrants and facilitate legalization of their status. Mental health conditions, pregnancy, and youth are three such factors. These are classes of people who are more likely to be seen as “deserving” of our care and compassion. Extensive research documents that war refugees suffer from higher rates of post-traumatic stress disorder, depression, and anxiety than other migrants (Burnett and Peel 2001; Steel et al. 2009; Bronstein and Montgomery 2011). These conditions are not surprising in that war refugees are more likely to be victims of torture (Goldfeld et al. 1988; Burnett and Peel 2001) and/or organized violence, which can adversely affect their mental health. More generally, refugee experiences such as long waits to legitimize their legal status (Laban et al. 2004) and conditions of exile (Sundquist and Johansson 1996) are also stressors that may lead to mental illness.

Minor children and youth represent one-fourth of all refugees in Europe (Bronstein and Montgomery 2011). Most of them are children traveling with their parents (Hebebrand et al. 2016). Some of their health needs are due to the physical stress of the migration process, which results in a high prevalence of infections and iron deficiency anemia (Hirani et al. 2016). Other medical issues arise from nutritional deficiencies (Hebebrand et al. 2016). In addition, refugee children are more likely than their peers to suffer from psychological problems caused by witnessing and experiencing violence and displacement (Fazel et al. 2012). Social isolation, arising from changes in their family composition and living conditions, may further adversely affect the health status of refugees (Porter and Haslam 2005). It is important to note that, just as it is for adults, adverse health conditions are...
exacerbated by the poverty, hostility, and racism that they often face in receiving countries as well as by stressors associated with their cultural adjustment (Fazel et al. 2012). Another problem that they face is difficulty in identifying their calendar age and subsequent suspicion about the legitimacy of their claims for residency.

Research shows the particular vulnerability of unaccompanied refugee minors. Nearly 25% of arrivals to Greece, Italy, and Spain in 2015 were children, many of them unaccompanied or separated from their families (UNHCR 2016). Most unaccompanied minors were young males, who often faced great physical and mental challenges during their journey and after their arrival. They suffered from exposure to violence and the loss of family members and had to endure their journey alone. Many of these individuals were victims of trafficking, forced labor, and sexual exploitation (Hebebrand et al. 2016). In addition, many minor refugees are placed into residential centers or foster care, where they may continue to face harsh and punitive environments (Human Rights Watch 2002). Not surprisingly, a study of refugees in the city of Malmo, Sweden, for example, found that minor male refugees were overrepresented in psychiatric inpatient care (Ramel et al. 2015). More generally, the victims of torture and sexual violence are also more likely to be seen as “deserving” of care and may qualify more easily for asylum status.

Research finds that the cumulative effect of stressors before, during, and after their journey can have major effects on the health condition of refugees and that their health is also influenced by social determinants such as being housed in barracks and camps on the outskirts of cities and lack of opportunities for integration into the mainstream society (Porter and Haslam 2005). In the worst position are unregistered migrants, who suffer from a wide range of physical, mental, and social health issues.

In addition to the health problems facing all refugees and migrants, their insecure living and working conditions represent additional stress factors (Biswas et al. 2011). The length of stay in detention centers is frequently associated with a worsening of mental disorders, in particular for those who have suffered exposure to trauma (Zimmerman et al. 2011). There are also reports of the increased prevalence of sexual and gender-based violence. Research in Belgium and the Netherlands among refugees, asylum seekers, and unregistered migrants found a higher incidence of gang and multiple rapes than found among the indigenous population (Keygnaert et al. 2012). Migrants in detention centers are at the risk of self-harm as well. Doctors working in the immigration detention center in Le Canet in the city of Marseille, France, for example, reported a rise in attempted suicide rates among the detainees: in 2007 there were 37 acts of self-harm recorded among 3,132 inmates (MDM 2009, p. 58).

Host Cities’ Responses to the Refugees’ Health Needs

Watters’s analytic model provides a good way to examine receiving countries’ responses to refugees’ health needs. The model incorporates three interrelated dimensions of care: political-legal, service, and clinical (Watters 2001). He refers to them as the institutional, service, and treatment levels. The institutional level of care dimension draws heavily on European Commission directives and guidelines on reception conditions and procedures that define minimum standards of refugee care (European Commission Council Directive 2003). Most countries have systems that differentiate between asylum seekers who are under consideration for refugee status and refugees who have already been granted the status (Langlois et al. 2016; Razum and Bozorgmehr 2016). Both groups receive some level of health care. The group who are left behind are refugees who are not able to make asylum claims. Individual countries make decisions about the access to care and the level of provision of services for all three groups.

Examination of entitlement to health care policies shows that restrictions depend on refugee status and on waiting time regulations (Bozorgmehr and Razum 2015). For example, Germany differentiates between refugees who are entitled to restricted services with access to limited emergency
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Medical care and refugees who qualify for regular services and have full access to care. Restricted access to services includes treatment for acute conditions, care during pregnancy and childbirth, and vaccinations. Refugees who are granted asylum status and long-term residence permits are entitled to regular access to services.

Even though all European countries have signed international legal instruments that guarantee the basic human right of health care to everyone regardless of their resident status, many refugees go without receiving it. A series of reports and studies have documented the barriers many refugees face in accessing medical care. A 2011 report by the European Union Agency for Fundamental Rights (2011) found that the costs of care, complex reimbursement procedures, lack of awareness by health providers and users about entitlements to health care, fear of detection by the police, and discretionary power of public and health care authorities are keeping vulnerable populations from receiving services that they need. Similarly, a report from the Doctors of the World documented the difficulties faced by refugees and asylum seekers as well as other vulnerable people in obtaining medical care. Based on interviews with 4,838 unregistered migrants, asylum seekers, and EU nationals who had lost their residency status in five European cities, the report shows how financial barriers to health care, acts of discrimination, police harassment, and fear of deportation prevent refugees from seeking and receiving necessary health services (MDM 2014). Finally, analyses of the health status of refugees and asylum seekers in the European region by Bradby and her colleagues (2015) found that demands for a high level of documentation to make a claim and difficulty in providing proper documentation (due to lack of literacy or language skills) were significant institutional barriers to accessing health care services. Other institutional barriers, including the inability to pay for services, confusing levels of entitlement, and the coupling of health services with immigration services, often limit access to mainstream services and force refugees to use specialist services instead. The location of refugees in reception or detention centers away from central cities where services are situated also makes it harder to access them physically (Bradby et al. 2015, p. 16).

The influx of refugees often creates public health related fears in host communities even though there is a low probability of an outbreak of infectious diseases that could affect the indigenous population (Gulland 2015). Refugees themselves are much more likely to be affected by such diseases. The poor living conditions during the migration process and in refugees’ centers as well as the physical and mental stress and deprivation may create conditions for infectious diseases to spread among the refugees, but such conditions are not present in most host communities (Scholz 2016). Additionally, the migration process may exacerbate non-communicable diseases such as cardiovascular disease, cancers, and respiratory diseases, which are not communicable.

The service level of care is the range of medical services available to refugees. It is influenced by the socioeconomic and political conditions of the receiving countries (Illingworth and Parmet 2017). Most detention centers provide some medical screening and act accordingly. Special attention is paid to infectious diseases, such as tuberculosis, when rapid care is paramount. Short-term care is available to deal with the most acute problems. Research has found that the most common types of health care refugees receive are maternity care and mental services (Hacker et al. 2015).

Doctors of the World operates free clinics in many urban locations in Europe. These clinics are essential places for receiving health care for many vulnerable people, including refugees. The survey conducted in clinics in Amsterdam, Brussels, London, Munich, and Nice in 2011 shows that the vast majority of patients, regardless of their legal status, did not have health insurance, hence the use of free clinics. Even though some may have been eligible for health care benefits, a lack of information about the coverage, knowledge about the rules of the system, and/or funds to cover copayments kept them from seeking them. In addition, a high percentage of users required an interpreter to receive adequate services. One-third of the respondents reported their health as being poor or very poor. Half of the health problems reported to doctors required essential treatment and were classified as urgent or fairly urgent, and only a small proportion of patients (13.7%) sought help for diseases
developed before their arrival to Europe. The study also found that most pregnant women coming to free clinics had no previous access to antenatal care and, in the case of clinics in Amsterdam and Nice, did not know where to go to get vaccinations (MDM 2012).

Importantly, medical services are becoming even harder for refugees to access. A 2013 study of health services provided by the Doctors of the World’s free clinics in 25 cities in eight European countries found a continuing need for the provision of antenatal care for pregnant women and vaccination for children. The study also found that a worsening of economic conditions in some of the refugee locations created an additional financial burden on them that in turn made it more difficult to meet their basic needs. The financial stress also negatively influenced the status of their health and well-being (MDM 2014).

**Responding to the Health Needs of Refugees in Transit Cities: The Belgrade Experience**

European countries received a relatively small proportion of the total refugees from the recent conflicts in the Middle East. The brunt of providing protection and accommodation for refugees was borne by Middle Eastern countries such as Turkey, which is host to 2.5 million refugees, along with Jordan and Lebanon (UNHCR 2016). One and a half million refugees came to Europe, where Germany and Sweden received the largest numbers of settled refugees (Eurostat 2016). Other countries, like Greece, Italy, Hungary, and Serbia, given their proximity to border crossings between the Middle East and the European Union, have served primarily as transit crossings to other locations in Europe. The sheer numbers of people arriving at their borders and cities often overwhelm these transit countries, so the priorities of transit nations have been to shelter the newcomers and provide them with food and drink. Also, they were more likely to deal with the short-term emergency health needs of refugees such as the consequences of dehydration, sunburn, blisters, and other acute physical ailments arising from difficult transits to Europe (Hebebrand et al. 2016). Given the high cost of transit, many refugees are traveling by foot (see Figure 20.2).

The big challenge for transit countries at the front line of the “refugee crisis” is the issue of capacity—whether they have the resources to provide adequate services for large groups of migrants in a short period of time (Spasić 2014)—and this affects many sectors of their society, including public safety, housing, health, education, and social services. The experiences of the cities in Greece, Italy, and Spain that have had to deal with the rapid growth of newcomers in a relatively short time have provided officials with certain guidelines on how to secure shelter, food, and health care for newcomers. In terms of meeting the health care needs of newly arrived refugees, the Healthcare Training Institute, for example, is helping European countries in estimation, training, and development of plans for unpredicted situations. Since December 2016, collaborative estimation missions have been held with the cooperation of the health ministries in Bulgaria, Greece, Italy, Portugal, Serbia, and Spain, and in Cyprus and Malta, to find a solution to the complex, multi-faceted, politically sensitive questions that require large allocations of resources to meet the health care needs of migrants (Jakab 2017).

Since May 2015, the Republic of Serbia has faced an enormous influx of refugees and migrants on their route from Greece towards Hungary or Croatia and ultimately to destination countries such as Germany and Sweden (see Figure 20.3). Serbia is located on the “Asian transversal,” which leads to Europe from the Far and Middle East across Turkey, which is used by migrants from the Arabian Peninsula, Ethiopia, and Somalia. It is because of this that Serbia is the country with the greatest number of refugees and internally displaced civilians in Europe. There were more than 815,000 refugees registered by the Serbian officials in 2015 alone passing through. Serbia has around 7 million inhabitants, and Belgrade, the capital, has 1.2 million people. In land mass it is the size of South Carolina (CIA).

The closing of the so-called Western Balkan migration route in March 2016 and an agreement between the EU and Turkey to keep refugees close to the border significantly reduced the number
of further entries into Serbia. However, the closing of the route also forced people in transit to remain in Serbia. Refugees were placed into 16 reception centers located in cities in the west and the north of the country. These refugees received permission to move freely and to apply for asylum in Serbia. Since the crisis began, the European Commission has granted 24.8 million euros for humanitarian aid to help ease the refugee and migrant situation in FYR Macedonia and Serbia (Delegation of European Union in Republic of Serbia 2017). From that amount, 20.1 million euros of aid was granted to Serbia. Initially, these funds provided immediate humanitarian assistance to refugees, including health services, temporary accommodation, warm clothes, food and water, specialized living spaces for children, and protection and security services. The help is now mostly focused on improving the living conditions of refugees at the official reception centers.

UNICEF and UNHCR, as UN agencies, are significant contributors to the activities of providing health care to the migrants. Apart from these agencies, international organizations such as CARE, the Ana and Vlade Divac Foundation, Catholic Relief Services, International Rescue Committee, Group 484, Polish Humanitarian Action, and Mercy Corps provide support for refugee health care
services. The Miksaliste facility in Gavrilo Princip Street is a good example of the type of support offered in Belgrade. NGOs use this facility in order to coordinate their programs and to provide a myriad of services such as the Corner for Mothers and Babies, Pre-School Children’s Corner, Women’s Corner, Activities Corner, and Youth Corner, as well as access to showers, doctors, and legal and psychological help. Mothers and children have priority in the Miksaliste programs because demand for health care services exceeds the program’s capacity of 300–400 people per day. At the beginning of their operation the Miksaliste programs also distributed food, but, since the Serbian government decided to force refugees into reception centers and stopped providing funds for food, the programs’ food distribution has stopped. Instead, Miksaliste programs only distribute non-food items for emergency cases.
The type of official, government sponsored care that refugees receive depends on their legal status. This is no different from the situation in other European countries. From the beginning, the Serbian government primarily addressed the needs of the registered migrants who were residing in refugee camps across Serbia or who asked for asylum. They were granted the same rights of access to health care as the citizens of Serbia. By doing this the government followed provisions contained in international laws and agreements as well as national legislation regulating Serbia’s migration regimes such as the Law on Asylum, Law on Health Care, Law on Social Care, and Law on Migrations Management. The refugee issues are handled under the jurisdictions of the Ministry of Health, Ministry of Labor, Employment, Veteran and Social Affairs, and Commissariat for Refugees and Migration. The National Health Insurance Fund provides the financial funds for providing health care to the migrants (Spasić 2014).

Every registered migrant in Serbia, when first registering, obtains an identification/registration number, which, in the case of a migrant who doesn’t have any personal documents, serves as the migrant’s health insurance number. Expenses incurred by providing health care are invoiced based on the migrant’s registration number directly to the account of the National Health Insurance Fund, which compensates the costs of services provided by health care providers. Most of these funds come from EU funds. However, when it comes to non-registered migrants residing in the city of Belgrade, the situation is different. They have neither a registration number nor personal documents, and reside in city parks and other temporary makeshift locations.

Belgrade has been affected the most by the influx of refugees. Thousands of refugees and migrants passed through the city on their way to Hungary or Croatia. At the beginning, the city authorities struggled with the difficult task of housing and feeding them. As a result, some of the health issues were generated by inadequate housing and also by hostility and violence coming from the host
society. Nevertheless, the shared view of NGO activists and volunteers from humanitarian organizations in the field is that, despite all the challenges and problems, the health care of the migrants in Belgrade functions better than the provision of social services and police protection.

The police in Belgrade do not have special and extraordinary authority regarding the informal migrants’ camps in the city center. They supervise and monitor the formation of the informal camps of the migrants. The police intervene in the case of fights, bullying, or serious disruptions of public order by migrants. The patrols from the police stations of Stari Grad and Savski Venac, within whose patrol jurisdiction migrants reside, visit the migrants’ temporary barracks and shelters from time to time and report to the City of Belgrade Police Directorate and to the Directorate for Foreigners, about any security problems.

Health Conditions of Non-Registered Refugees

Although Serbia has significantly improved its capacities to accommodate migrants, interviews with volunteers, NGO activists, and representatives of humanitarian organizations which provide help to the migrants in the city of Belgrade revealed harsh living conditions for migrants. One NGO activist described the situation by saying:

In the city itself the refugees are usually concentrated in the park around the Faculty of Economics. They sleep in the open parking, in the warehouses behind the bus station, and in abandoned wagons and railway depots . . . and they mostly survived the winter there. As a human being, I would say they were left to themselves. They lived in terrible conditions, on the edge of any human dignity.

Figure 20.5  Refugee in the park near the bus station in Belgrade.

Source: Asylum Protection Center, Belgrade.
These migrants are mostly young men who are not registered. Reasons for not registering vary. Some are stuck in Serbia because they are deemed inadmissible by the European Union’s standards to European Union countries because they came from places that are not recognized as legitimate refugee locations. Others do not want to be registered or to go to the camps because they believe that they would be able to find a way to move into the EU faster on their own. Some are also afraid of deportation from Serbia.

The cold weather during the winter of 2017 forced some of the migrants who lived in the open to use old furniture and tires as fuel to keep warm, cook food, and heat water. Even though the hygiene conditions are terrible, as one migrant explains there is not much they can do:

We have found refuge here, but we don’t have electricity. It’s cold; we’re scared. We’re afraid of infection, lice . . . We don’t intend to stay here; we all have different destinations as our goal. Some would go to London, some to Germany. I want to arrive in Switzerland. We are all in search of a better future.

At another location, a large room whose roof and walls are in utter decay, around 300 migrants, mostly from Afghanistan and Pakistan, are housed. The smoke from fires makes it difficult to breathe. The difficulties these migrants face is well summarized by this account:

I have been here a week and everything is becoming very hard! Serbs are nice, and we don’t want to cause problems to them, but we are hungry and don’t have clothes. We have no money left, but we don’t want to stay here, and they are not letting us across the border.

(VREME 2017)
Figure 20.7 An improvised place for the maintenance of personal hygiene of refugees near the railway station in Belgrade.
Source: Asylum Protection Center, Belgrade.

Figure 20.8 An improvised place for preparing meals in abandoned warehouses near the train station in Belgrade.
Source: Asylum Protection Center, Belgrade.
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The observation from one of the doctor volunteers (in direct personal communication) confirms these reports and draws attention to the connection between the living conditions and health needs of the refugees:

The migrants residing in the open in the center of Belgrade, or in improvised shelters, don’t have basic hygienic conditions: they don’t take a bath, don’t wash their personal belongings; they do not maintain personal hygiene, nor the hygiene of the space they are staying in. lice, scabies, body lice occurred. The women have problems with fungal and gynecological infections. Along with them, the babies are at risk—respiratory infections, high temperature, urinary infections are very frequent.

Even before the winter started, the NGO sector asked the government to help refugees living in the open. However, the government decided and recommended to all NGO organizations working with refugees in the city not to help the refugees living in the open in order to force them to go to the official reception centers. Only in February 2017 did some of them agree to go, because they could not stand the cold anymore. About 700 of these refugees were accommodated in the newly opened reception center in Obrenovac. In addition, there were about 300 unaccompanied minors housed in that facility.

![Figure 20.9](image-url)  
*Providing first aid to an injured refugee in an emergency center in Belgrade.*  
*Source: Asylum Protection Center, Belgrade.*
Because there were no official government sponsored programs to respond to the health needs of refugees living outside reception or asylum centers, NGOs stepped in. Similar to the situation in other cities across Europe, health care for migrants in Belgrade is provided by two international humanitarian organizations—Doctors without Borders (MSF) and Doctors of the World (MDM). Until recently doctors from MDM used Miksaliste to provide elementary medical services, mostly pain killers and antibiotics, as well as psychological help. MSF ran a mobile clinic in the park near the Faculty of Economics and provided first aid and basic medical services.

They also opened a new facility at Gavrilo Princip Street across from the Miksaliste. Doctors and psychologists provide medical care, including treatment for lice and scabies, and the Miksaliste facility offers services such as showers, disinfection of clothes, and new clothes. However, when it comes to serious health problems, severe health deterioration, and threats to the lives of migrants, they are admitted to the nearest health facilities or to the emergency health center.

Health Care for Registered Refugees

Registered refugees in Serbia also face a sobering set of health challenges, including the need for better services for acute conditions, for example wounds, burns, colds, and non-communicable diseases such as hypothermia, cardiovascular diseases, diabetes, hypertension, mental conditions, and simple physical exhaustion. Individuals with non-communicable conditions can also suffer greatly because they require continuous care, which is often interrupted as a result of their refugee status.

Women face a unique set of problems related to pregnancy and childbirth, sexual and reproductive health, and domestic violence. For women in a high-risk or advanced pregnancy, or with sexual and reproductive health issues, gynecological checks are provided in the clinical centers in Belgrade. Deliveries are regularly performed in the maternity hospitals. Children’s health care, for children residing with their families, is provided, when needed, in the University Children’s Hospital in Tirsova Street or in the Institute for Mother and Child Health Care in Novi Beograd. However, a big problem is the lack of funds for the transportation of migrants from the place where they reside to the clinics or hospitals. Because government funds cannot be used for paying expenses for their transportation such as taxis, NGOs, when possible, pay for it.

Another problem is a lack of interpreters, whose presence is necessary for services performed in health facilities or in specialist clinics. Translators can also help to establish a rapport with refugees, especially women and children. The following example from the medical provider (in direct personal communication) illustrates this point well:

We had one female migrant who was without her husband. The topics [related to her health condition] were inappropriate to be discussed in front of a translator, a male. I can see something is going on. Who brought her? The woman is dying, but she won’t reveal that bit of information [about her condition]. I don’t know how to ask her, and then I tried by using gestures. I tried everything. I suspected pregnancy, and I am constantly asking . . . Luckily, we were able to get that piece of information. She was extraterine [pregnancy outside the uterus]. The operation was done at the last minute. She could have died in half an hour.

The refugees and migrants in the reception centers face better conditions than the refugees in open spaces such as parks. Many of these centers are located outside of Belgrade in smaller cities. They offer shelter, food, and medical care as well as personal safety on a more permanent basis. The manager of one such place in Krnjaca near Belgrade (in direct personal communication) described the conditions by saying:
Refugees and Health

Everything is fine for now. We’re still learning. The Syrians are the biggest group. Last night, a Russian arrived from Ukraine. So far, we haven’t had any incidents. We are closing the barracks at half past eight, just in case. One room is rearranged into an infirmary, and medical teams started to arrive regularly. Representatives of non-governmental organizations also come; visits from UNHCR officials are scheduled. The police don’t come.

Typically, migrants are housed in barracks for about 50 people, with one bathroom, four shower cabins, and four toilets with four washbasins.

Refugees confront a broad range of problems that intersect with and exacerbate their health issues. In reception centers that accommodate migrant families, such as in the towns of Tutin and Sjenica, cases of domestic violence are reported, and local social and health services have become involved to take care of women and children victims. Also, case workers from Impuls, a nongovernmental human service organization in Tutin, reported cases of prostitution and sexual exploitation.

Uncertain futures and the long duration of traveling caused significant psychological problems among some migrants, leading them to use various pharmacological substances without supervision and control. Many of them use narcotics as well. Consequently, cases of organized narcotic trade have emerged in the refugee camps. At the same time, the danger of human trafficking is ever present. Traffickers regularly visit camps and offer transportation and transfer of entire families to the border, for a certain financial compensation. Muhammad had such an experience as an asylum applicant from Syria: “All the smugglers are also traffickers. I heard you pay a smuggler, and then he takes advantage of you and abuses you (Morača 2016).

Policy Recommendations: Toward Inclusion of Refugees in the Host Societies

The examination of services and treatments available to refugees shows several major problems. The first problem is generated by legal and policy mechanisms developed to restrict entry and stay in a country. These conditions make it harder for refugees to access health services as well as create additional stressors that further worsen their health status. It creates differentiation among refugees and pits one group of refugees against another. The second problem is based on lack of resources to provide consistent and long-term care. Most refugees receive some type of short-term care via official or charity channels. Lack of consistent access to care may lead to the worsening of their conditions and turn acute problems into chronic conditions. The third problem is caused by a lack of appropriate care. In some cases, in order to share the burden of caring for refugees, they are dispersed among multiple locations with an uneven level and quality of services. This is particularly the case for refugees who need mental health care that requires specialized, cultural-specific knowledge of refugees.

In order to address these problems, several evidence-based remedies are suggested in the literature. The first set of recommendations deals with creating more stable legal and political environments sympathetic to the needs of refugees. This includes the development of a clear path to legalizing their permanent status, the creation of more stable funding structures for health and social services, and a collaborative distribution of resources between government and nongovernmental organizations. These recommendations are based on the reality of refugees’ experiences as they become more permanent residents in host locations and thus need support to become economically self-sufficient.

The second set of recommendations addresses the cultural appropriateness and sensitivity of services. It addresses the design and delivery of education programs for professionals working with refugees. It encompasses the inclusion of refugees in development, planning, and execution of services provided to them. It also assumes the position that refugees and migrants represent potential resources that can revitalize both small and large cities by bringing entrepreneurship and improved services for all residents (Rabrenovic 2007).
The third set of recommendations deals with the coordination of services within countries and between countries. This includes the development of shared protocols for access to care, standardized assessment of health needs, coordination of services, and intra-agency cooperation. The 100 Resilient Cities initiative, supported initially by the Rockefeller Foundation, for example, provides opportunities for cities to increase their resilience by sharing best practices and by leveraging their resources to address shared problems. The health and well-being of refugees are influenced by conditions that facilitate their integration into the host society. They need fair and equitable access to housing, education, and employment. In some instances, they may need advocates to help them navigate the legal, political, and social environment that they face. In other instances, they may need moderators to facilitate conflict resolution between as well as within their families and communities. We already have examples of good practices that can be replicated, such as the Gateway Provider Model, which brings together the community support system and the health services system to address the needs of individuals (Ellis et al. 2010), or the model of “refugee economies,” which supports development of sustainable livelihood opportunities for refugees in the host societies (Betts et al. 2014). We only need a will in order to act.

References


