

## High-level Meeting on maternal health and refugee women Malta, March 20-21



### High-level Panel Session

'A vision for maternal health for migrant and refugee women in Europe'

## Jose Carreira, Executive Director of the European Asylum Support Office (EASO)

### Background: Facts and figures

In 2016, 415.210 women<sup>1</sup> sought asylum in the EU+ territory (roughly 35% of all applicants for international protection), among which 164.705 were under 18 years old.

In some countries of origin, women would not be involved and informed about their husbands' affairs; or may not be used to sharing private information with strangers, especially of the opposite sex. In many situations they are not right-holders (they may be transferred from the father's protection to the husband's protection after marriage). In other words, refugee women often are not used to be heard.

In the specific asylum context, refugee women are confronted with the following issues:

- difficulties to present or substantiate their claim because of social or cultural reasons;
- furthermore, women may not know that the violation or discrimination against them can be relevant for the determination of their protection needs;
- women may face difficulties in discussing experiences of violence because of shame or trauma, fear of reprisals or shaming by the family;
- it is often assumed that female applicants' claims are dependant of male relatives' claims (husband or male relative is the householder);
- the experience of discrimination and/or denial of opportunities, services, obstructive legislative practice, and denial of education for girls or women;

In addition pregnant women or pregnant girls (below 18 years), are vulnerable on multiple accounts (as refugees- as women- as pregnant women-sometimes as underage pregnant women, and so on...) and particular consideration of their special needs must be given.

For example, asylum seeking women (and girls) may be giving birth earlier than the estimated date of delivery, and have more complications than the host female population, due to complications arising from experienced persecution/serious harm, the flight from the country of origin, or having undergone female genital mutilation (FGM).

<sup>1</sup> This data is available from Eurostat (<http://appsso.eurostat.ec.europa.eu/nui/submitViewTableAction.do>):

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Overall, asylum seeking women's physical and psychological health may be affected by:

- lack of knowledge about the country's health system
- languages difficulties
- a poor overall health status
- Underlying and possibly undiagnosed medical conditions
- psychological and medical effects of experienced persecution or serious harm
- psychological and medical effects of the flight from the country of origin
- fears about their immigration status and future.

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Response to these challenges

1. MS are obliged to identify, assess the special needs of the applicants and to respond to them in a timely manner. Therefore, authorities shall:

1. provide information to women on their rights as the right to health care,
2. empower them to express their needs, including medical issues, assist them to exercise these rights as right to medical and psychological support,
3. provide the services and support they are entitled to even if they do not express these needs or they do not demand them.

2. EASO shall continue assisting the authorities on the identification and provision of adequate support to persons with special needs.

EASO is committed to promote the highest standards in asylum and reception for women who find themselves in need of international protection.

This concern is translated by the mainstreaming gender issues reflected in all of its activities whether:

- when supporting national administrations in building capacity;
- or, when acting directly in the field together with frontline Member States where EASO provides support on the identification and protection of persons with special needs.

In supporting Member States in ensuring an adequate standard of living for all applicants for international protection, including those with special reception needs, EASO considers an appropriate health care provision of utmost importance.

In this sense, EASO Tools and training Modules refer to health care as encompassing:

- a) mental and physical health care
- b) counselling of applicants suffering from serious illnesses and
- c) necessary measures to promote the rehabilitation of victims of violence and torture.

In light of this, EASO has addressed healthcare provision in its activities, such as:

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- the development of an online practical tool for the identification of persons with special needs (IPSN):

It addresses in particular the special gender-related needs of female applicant, for example, referring the female applicant to any additional assistance that may be available for women such as medical services or child care or ensuring that she has the opportunity to lodge an independent application from her husband or male relatives.

- The development of operational standards and indicators on reception conditions:

Those standards include specific arrangements for applicants with special medical needs (pregnant women, single mothers with children, etc):

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Ensure provision of information on reception conditions, including health care;

This would include, for example, access to a paediatrician, gynaecologist or prenatal health care;

It would also include counselling provided to victims of trafficking and (gender-based) violence as well as victims of torture or other forms of psychological and physical violence.

The provision of relevant training to asylum and reception officials:

The EASO training curriculum includes inter alia modules on:

Interviewing vulnerable persons

Reception

Gender, gender identity and sexual orientation

- Deployment of experts to support MS under particular pressure to identify and better protect vulnerable applicants.

In general, EASO supports strengthening the reception capacity in the MS under particular pressure (Operating Plans to Italy, Greece, Cyprus or Bulgaria) to ensure that special procedural needs and special reception needs are appropriately addressed.

#### Conclusion:

As you can see, EASO is particularly committed and active in the protection of asylum seeking women and girls. However, the situation on the ground is a constant reminder that much more needs to be done together with national administrations and that we cannot rest on our laurels.

Since most of the services are provided by national health care system and regional or local services or intergovernmental organisations and NGOs, the ultimate responsibility and decisions fall under the competence of the national authorities.

As the Executive Director, I will continue highlighting this issue and collaborate with all stakeholders in order to support authorities to adapt the reception conditions and the asylum procedures to the special needs of refugee women and girls.

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### Ines Strenja, Doctor of Medicine and Chair of the Health and Social Policy Committee, Croatia

Dear Madam President, Ms. Marie-Louise Coleiro Preca,

Dear Ms. Silvana Koch-Mehrin, Founder of the Women in Parliaments Global Forum

Ladies and Gentlemen,

It is a great honor for me to speak about Croatian experiences in assessing medical care to refugee women going through hard times these days.

Introduction

Besides being on Eastern Mediterranean migrant-refugee route within the European Union, unfortunately Croatia has had its own experiences with its own nationals exiled during the Homeland War but also with a large number of refugees from neighboring Bosnia and Herzegovina.

For this reason, I thank Women in Parliaments for recognized Croatia's experience as a valuable contribution to the debate on improved health care system in the area of migrant and refugee women health. Even more so, since I myself, being a doctor, was the commander of the medical bataglion in Guardian brigade during the War.

Croatian experience during the actual migration crises

First time, after Second World War, number of forced displaced person worldwide exceeded 50 million as stated in the UNHCR Global trends in 2014.

Migration trends over approximately the past 15 years, mainly driven by conflicts in Africa and the Middle East, were primarily directed towards Western Europe via the Mediterranean Sea. Furthermore, it is said that more than 219,000 refugees and migrants in Europe crossed the Mediterranean Sea in 2014. The proportion of refugee girls and women has been gradually increasing, in 2011 it was 48%, in 2014 50%, which means one of every two refugees today is a female.

The uncertainty of travel through the Mediterranean Sea redirected the migration flow across the countries of South-Eastern Europe. Therefore, the migrant crisis of 2015/2016 was characterized by shifting the direction of migratory movement towards the Eastern Mediterranean migrant-refugee route so-called Balkan route. This shift had implications for the Republic of Croatia, which is located on the route of mixed migration flows<sup>2</sup> consisting of migrants<sup>3</sup> originating from unstable and war-affected areas of Asia and Africa, mostly from Syria, Afghanistan and Iraq.

The refugee/migrant crisis of 2015/2016 in Europe generated numerous issues at EU level and negatively affected the EU-Turkey relations, especially the relations between the countries along the Balkan route. The absence of a unified position on how the EU should respond to this situation has marked the relations among certain EU members themselves, whereby Eastern European states sharply criticized the approach adopted by Germany but also the whole conduct by Brussels in this extraordinary situation.

Due to its very modest experience as a migrant-receiving country, up until recently the Republic of Croatia has not paid any significant attention to the need of creating a long-term migration policy (and integration policy) or to security aspect of migrations exceeding usual declarations in strategic documents of the highest rank and the leading state officials' statements. Such self-perception of the state as an undesirable destination for migrants and as a transit area towards the rich countries of Western Europe, along with the

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sudden increase in the number of migrants that were provided with a fast and safe passage through the territory of the Republic of Croatia, presented favourable factors for perceiving the situation predominantly within the dichotomy between the security-based approach (statecentric) and humanitarian approach (human-centric).

The then government opted for the humanitarian approach. to be applied to this issue in spite of pressures from part of the general public and the then opposition to securitize it. The humanitarian approach implied organized reception, short-lasting accommodation and a safe transit towards the Hungarian and Slovenian borders, i.e. further ahead – mostly towards Austria and Germany. A well-organized reception and transportation of refugees as well as good conveyance of information to the public account for the fact that an anti-migration atmosphere did not take place in Croatia. Moreover, a significant number of citizens and part of non-government organizations participated in organizing humanitarian assistance, aimed at helping refugees. Due to this, securitization advocates did not have enough arguments to persuade the public about the need to undertake extraordinary measures protecting the Croatian border, including the military involvement and putting up a wire fence. This influenced the formation of the public that, unlike the public in some other European countries, is not currently showing a negative attitude towards refugees. his statement is supported by the absence of any public demonstrations directed against migrants.

A large influx of migrants over the Croatian border began on 17 September 2015, when over 11,000 migrants crossed the border in just one day. Since then until 15 April 2016, when the Eastern Mediterranean migrant-refugee route (so-called Balkan route) was officially closed, Croatia received over 600,000 migrants. Vast majority of them were only transiting through Croatia. All of them documented, photographed and registered. 17% were women, 30% minors, of which 40% girls and 59% boys. Statistics show that single males represent the most numerous group while women arriving alone or with their families and children represent particularly vulnerable group with need of special care.

In order to ensure adequate shelter, food, sanitation and health, Croatian Government established the Headquarters for the coordination of activities. All activities during the migrant crisis were based on several legal documents such as the Act on Protection of Population against Communicable Diseases, Regulation on the Content of Medical Examination of Asylum Seekers, Asylums, Foreigners under Temporary Protection and Foreigners under Subsidiary Protection, and the Act on International and Temporary Protection.

During the migrant crisis several reception centres (Kutina, Ježevo, Porin, Zagreb fair) and two transit refugee camps, camp Opatovac (September to November 2015, capacity app. 4,000 persons) and camp Slavonski Brod (November 2015 to April 2016, capacity app. 5,000 persons) were operational. A 24/7 emergency health care, free of charge, was provided to all migrants who were actively seeking medical help. 25,815 medical visits were carried out (primary health care (GP) 18,901, emergency health care 4,563, inpatient care within camp Sl. Brod 1,557, and hospital health care 794).

In order to prevent and control infectious diseases in such a specific environment, a number of public health activities were performed which also included regular epidemiological field team visits as well as availability of epidemiologists at the national level.

Unlike refugees, migrants transiting through Croatia are placed under mandatory 21-days health monitoring. Moreover, all of them undergo an initial medical examination by contracted GPs with the provision of a translator. During the medical examination medical history and vaccination status are obtained, physical examination is performed, and blood and stool samples are collected. All children should receive, free of

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charge, all vaccines appropriate for their age according to the Croatian mandatory immunization programme.

A large number of women are exposed to some kind of stress or are victims of torture, causing them mental difficulties and problems in adapting to the new environment. According to unofficial data, it can be concluded with great certainty that numerous women refugees are victims of sexual and other forms of violence, and many of them are victims of human trafficking, rape, other mental, physical and sexual violence, such as victims of female genital mutilation. In addition, these women come as pregnant women, nursing mothers and single mothers with small children.

Examples of issues at providing medical care to refugees – as a conclusion to the first part of my intervention

In 2015 during their stay in the Republic of Croatia 6 women gave birth but all of them (at their own insistence) left the maternity ward the day after and proceeded with their families towards their intended destinations.

There was also a case when a pregnant woman had strong contractions, but despite the suggestions and advice of doctors that she should give birth in Croatia, did not agree to that and went on her way, saying she would give birth in Austria or Germany.

We deem it important to mention that migrants and refugees present a very heterogeneous group with some subgroups which are more susceptible to diseases and illness, and therefore require a very specific type of medical health care and protection.

\*\*\* topics for discussion\*\*\*

I.

Primary health problems of young mothers and children

Experience shows that primary health problems of young mothers and children are

- Mental health conditioned by socioeconomic factors (poverty and housing) or stay in a new environment
- Children's health
- Mental health conditioned by trauma

Sporadic research in the field of female migrants' healthcare indicates that they generally suffer from stress-related illnesses (cardiovascular disorders, gastric and duodenal ulcers, rheumatoid arthritis, neuropathic diseases). (Poor) conditions on migrant routes and maladjustment to new climatic conditions are fertile ground for the development of "social diseases" such as tuberculosis, infectious and parasitic diseases, which the native (European) population has long fought off. All of these cause frequent pathological pregnancies and deliveries, and the lack of concern for the child's health and progress.

Migrant women during pregnancy have fewer check-ups and are not under continuous medical supervision, which according to some studies, results in a higher perinatal mortality, frequent pregnancy complications, premature births and births of children of low birth weight.

Using healthcare services in the host country is affected by a number of factors – lack of general and health education, weak contacts with neighbours and the local population in general, lack of information, and often

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language difficulties in communicating with health staff. Doctors' interaction with foreigners also has to be taken into account (it is often more superficial than their interaction with the local population).

Given the inadequate attention they devote to themselves and the insufficient care by the society for their state of health, it can be assumed that the prevention and early diagnosis of many diseases frequent today in the local population is neglected when it comes to migrants.

The psychosocial component of health can by no means be ignored.

II.

#### Financing health care of refugee women and children

Health services for migrants and refugees are financed from the State Budget.

Since the beginning of the migrant crisis on 16th September 2015, 1,100, 000, 00 euros were spent for medical services provided to migrants, leading to an average monthly value of 200 000, 00 euros for this purpose, with the register of total 24,628 patients, of which outpatient hospital emergency room 4452 patients, family medicine 18,204, infirmary reception center 1,268 and 704 hospital patients.

Medical documentation shows that we have provided most health services to women and children.

Medical records of providing health care to children show advanced pediatric services provided: pediatric trauma, dehydration, infection of wounds, fatigue, post-traumatic stress, pneumonia, hypothermia and frostbite.

#### CARE Project

Croatia is participating in the project "CARE – Common Approach for Refugees and other migrants' health", which received funding from the European Union's Health Programme (2014-2020). The aim of the project is to promote a better understanding of refugees and migrants' health condition as well as to support the adaptation of the appropriate clinical attitude towards refugees and migrants' health needs and in particular towards the health needs of vulnerable subgroups, such as minors, pregnant women and victims of violence. CARE project focuses on promoting and sustaining the good health of migrants and populations in Member States experiencing strong migration pressure.

Upon completion of the project, more appropriate health care deliveries, increased control of infectious disease risk in the early phase of migrant's care and better taking care of migrants' health over the European territory will have been obtained. Within the project all involved partners, including Croatia, have produced materials such as leaflets and booklets to improve health literacy of migrants, printed in several languages (Arabic, Farsi, English and Croatian), as well as posters and pocket calendars aimed at raising awareness among domicile population and reducing misconceptions related to migrants frequently present in our society.

Taking into account our own experiences in the recent migrant crisis in Croatia and the high degree of uncertainty about future developments, migrants and refugees are to be recognized as specifically vulnerable groups whose health, social and other needs are to be addressed with respect to human rights and equality principle.

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III.

Vision - Perspective, suggestions and recommendations

Health promotion is a process which seeks to encourage those habits and behaviours of individuals and communities that improve the health of individuals and groups. It aims to awaken an individual's sense of responsibility for his/her own health, the health of those around us as well as for the health of the environment in which we live and work.

Learning is an active process, and people of all ages are able to change their habits, behaviours and beliefs. Health promotion needs to take account of what people already know, think and feel about certain things. It is not enough just to explain to people the harmfulness of existing habits or benefit of the new ones. They should be encouraged to do something for their own health and the health of their environment.

Conversation is the main method used in health visitor services and counselling.

Speeches, lectures and radio-broadcast lectures are used to reach a bigger audience.

Discussion - several people speak about the same problem from a different point of view and this is followed by a discussion. Small groups have 10-15 members who have a common health problem. Large groups consist of 30 members or more and are less effective.

Presentation - showing a certain procedures (preparing food for infants, breast self-examination, exercises for recovery...)

The most common health-promotion resources are visual means (since through the senses of sight we receive more than 80% of the information), such as exhibitions, motion pictures (films), still images (film strips, paintings, drawings), printed (written) material. Spoken word is also used as tool. Means of mass communication such as the Internet (social networks), television, radio, newspapers and magazines are particularly popular.

Ministry of Interior, Ministry of Health and MDM Belgique (Medecins du Monde) signed a Memorandum of Understanding under which MDM's medical team is present in the reception centre in Zagreb every day from 16:00 to 20:00. The primary task of MDM is conducting initial medical examination.

Finally, I would like to stress the importance of a coordinated and coherent response to health care needs of migrants and refugees, which can only be achieved through the intersectoral, whole-of-government approach and health-in-all-policy, both at the national and the international level.

Vision

- facilitating the broadest possible access to health services for uninsured and/or unidentified persons;
- improving the provision of medical care in extremely difficult weather conditions (cold, snow, rain);
- more rigorous application of general hygiene and epidemiological measures, immediate notification to a higher-level service and application of control measures, as reception centres are environments conducive to the emergence of pathogens;
- organizing medical care for chronic patients along migration routes;
- analysing and reducing the large exposure of medical and other staff in the reception centre to health risks (so far the focus has been on the victims of the crisis, not the health needs of the staff in the services that help them);



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- more significant support from all EU institutions as well as financial support to ensure mobile modules for field work: a mobile surgical clinic, a fully mobile laboratory and a pharmacy (temporary medication storage).

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### Linda Lanzillotta, Vice President of the Italian Senate

Dear colleagues Members of Parliaments, dear friends, good morning and thank you to Women Political Leaders Global Forum and to Silvana for inviting me to take part to this important and interesting discussion on maternal health and mortality and thank you to Maltese Presidency for hosting me in such a beauty castle.

United Nations Millennium Goal no. 5 set the ambitious target of reducing maternal mortality by three quarters from its 1990 level. This is a very ambitious target, this is, true, but it is also a key goal for reducing substantially inequalities for women and more generally between different parts of our world.

This goal has still far to be achieved also if something has been done. In fact, between the early 1990s and 2015, maternal mortality has been reduced by 44% globally.

Africa remains the most critical area even if significant progress has been registered with a 45% reduction in deaths between 1990 and 2015, from 987 to 546 deaths per 100,000 live births. And Africa is also the crucial area from which wars and extremely poor conditions of life feed migration flows toward Mediterranean Sea and toward European countries.

We know and we can observe that women's social condition, together with wars and regional conflicts, are the most significant critical factors in maternal health. The most significant risk factors are poverty and situation of social exclusion in which some women live, exposing them to risks that, in the majority of cases, are the result of insufficient monitoring during pregnancy, precluding the chance of preparing for complications that may arise. Educating women and girls, particularly the most socially excluded, is therefore vital to ensure that they possess the knowledge they need to question traditional practices that endanger their own and their children's survival. That's why we can reduce maternal mortality only fighting against poverty and all its consequences with coherent policies to be adopted at all level of government-national, European as well global. Migration Compact is the strategy proposed by the Italian Government to the European Commission to tackle migration phenomenon and it is oriented exactly in this direction. We cannot anymore consider migration as a temporary problem but we have to be aware that it is one of the global, permanent, challenge of this new century. And this is true also for women conditions. We have to help migrant and refugee women when they arrive in Europe (and you know that Italy is doing a lot for this, very often without any European involvement as many time remembered) but we have also to look at a medium and long term perspective. From this point of view we are convinced that migration can be reduced fighting against wars but also supporting economic and social development of countries that migrants escape.

In health sector Italy has the capacity and is available to give its concrete contribution offering our experience and best practices and concrete help which has to be funded at European level. A single Country cannot face alone such an enormous task.

Italy's National Health Service is a European and global benchmark for safeguarding pregnancy and maternity, placing women at the centre of its focus without any distinctions whatsoever. In Italy, during

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pregnancy all women are guaranteed healthcare, regardless of whether or not they are EU citizens, or regular or irregular migrants. Healthcare is offered free of charge for those who are impoverished (irregular migrants are entitled to healthcare via an STP - Temporary Present Foreigner code which is valid nationwide across Italy). For us the focus of health policy and of the National Health System has to be human being whatever is nationality or legal condition. This is our constitutional principle.

Although it is rare for maternal deaths to occur in a socially-advanced nation like Italy, they are a public healthcare priority owing to the fact that they are unquestionably dramatic events, and because it has been documented that around 50% of such cases are avoidable.

Low as Italy's figure may be, it is particularly challenging to reduce it to zero. As we have seen, Italy's National Health Service provides complete pregnancy coverage and guarantees very high standards of care. As well as continuing to invest in advanced diagnostics in the future to improve current levels of performance, we must closely monitor the phenomenon of maternal mortality in order to meticulously identify the biggest causes of this phenomenon, however limited it may be.

For this purpose, in 2012, the Istituto Superiore di Sanità (ISS) launched ITOSS, the Italian Obstetric Surveillance System.

But, even if, as we have seen, Italy's National Health Service offers high standards of care for both pregnancy and childbirth. Moving on to pediatrics, here too healthcare is guaranteed for all, including the children of individuals who lack a valid residency permit.

In order to make an exhaustive assessment of neonatal and children's healthcare, we must take into consideration the circumstances on the ground in Europe over the last few years. Thousands of minors have arrived in Europe via the Balkan route or by crossing the Mediterranean. As a result of a lack of hygiene and the privations they suffer on their journeys, these extremely vulnerable children are exposed to infections, some of which can be acute.

As a consequence, maternal and children's health must be reconsidered from a transnational and European – if not to say global – viewpoint. In a globalized world characterized by the rapid and unending movement of people, healthcare is still run on a strictly national basis, resulting in sometimes huge differences between bordering nations. World Health Organization (WHO) guidelines offer a significant pathway, clearly identifying the critical nature of the objectives to be reached in the coming decades.

It is estimated that more than 60 million refugees in the world have permanently or temporarily had to leave their countries of origin as a consequence of conflict or natural disaster. Refugee status changes many things in these people's lives; it does not alter their right to healthcare or health. Every single one of these people, especially women and children, have health needs that vary depending upon where they come from, their ethnicity and age.

This is without even considering the extreme risk of attempting to cross the Mediterranean Sea: in the last three months, 1,354 migrants have died trying to reach the coast of Europe, one hundred and ninety of whom were children. Last year, over 700 children died at sea. Between January and September 2016, more than 664,500 children sought asylum in Europe. On the central Mediterranean route alone, 28,223 of the 181,436 migrants who set foot in Italy were children: 16% of the total.

Nine out of ten minors who arrived in Italy were unaccompanied.

It is clear that these experiences have deeply scarred these women and children, entailing significant psychological and social repercussions. The dramas of these people are inextricably bound up with the future

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of Europe: Europe can no longer turn its back on the vulnerable, women and children; they must be guaranteed protection from abuse and violence; they must be offered help and the opportunity of a better life.

As Europe's frontier on the Mediterranean, Italy has never shirked its key role in receiving migrants. This March, by a wide majority the Italian Senate, thanks to the fundamental contribution and support of my colleagues women Senate's members, voted in favor of a Law Bill to introduce measures that protect and safeguard unaccompanied foreign minors. For these children, the provisions ensure a ban on "push back", basic assistance and reception. The Bill places a special focus falls on two categories: victims of trafficking and minors who request international protection, including specialist psychosocial, healthcare and legal support, especially for the first category. The Law Bill ensures that the length of time minors spend in reception centres will be significantly reduced in favor of foster placement.

The pathway that Italy is mapping out for these minors is based on two factors: safeguarding the psychophysical health of these children as the weakest members of society, while at the same time setting them on a virtuous pathway towards social inclusion in Italy, saving them from a future of exclusion and difficulties that all too often can lead to crime and, as we have seen in recent years in Europe, fundamentalism and terrorism.

We have to think that migrants are a great resource for demographic declining countries as European countries are; so we have to consider these children as our compatriot in the future.