Lack of information for health providers and obstacles to ensuring continuity of care

The problem

Asylum-seekers often arrive in both transit and destination countries without any health records. Care providers, therefore, lack reliable information on the illness and treatment history of patients. For example, absence of information on the vaccination status of children is one problem that is systematically reported; no health records are available and, due to language barriers, it is impossible to obtain information from the parents. Patients often move from one country to another during their asylum-seeking process, and even when they are settling in a country, they may move from one place to another as countries may have policies to distribute refugees over their whole territory. In countries of transit, in particular, asylum-seekers may leave the hospital or interrupt treatment – against the care provider's advice – in order to continue their journey with their compatriots.

The high mobility of asylum seekers coupled with the fact that information is not exchanged between different levels of care services, as well as between countries/regions, make it impossible to ensure appropriate care and continuity of care. Furthermore, since many health professionals work in very poorly organized settings, they need to obtain information not only on the health situation of asylum seekers but also on services and resources available and administrative/legislative issues. Lack of coordination between multiple providers and health and social services, as well as the lack of specific training for all stakeholders worsen the situation and make it difficult to share information and to ensure continuity of care for asylum seekers and refugees.

Evidence of the barriers

A first important barrier is the absence of a coordinated unified database that would make it possible for health providers to access patients' medical records (Taylor, 2009). Health providers argue that ideally, information on patients (both personal documents and medical records) should "travel" with the patients, but this is not the case. Health care professionals participating in the focus groups reported that no adequate systems for the exchange of medical information between member states exist. They pointed out that there is no exchange of clinical data even within one country when patients move from one place to another, or between different health care settings (e.g. from a medical service in a refugee camp to a GP); this situation may exacerbate the loss of highly relevant information on the illness and treatment history of patients. Even in countries where computerized medical data systems do exist, different databases may not be connected and thus unavailable for consultation by care providers. Consequently care is often partial and fragmented.

Care providers working in reception centres and primary care need to gain information on the organization and access to specialised health care services such as mental health care, sexual and reproductive care, victims of violence care. They also stressed the importance of receiving specific training and guidelines on how to deal with particular vulnerable groups (e.g. persons with mental health problems, unaccompanied minors, victims of torture and sexual violence, women with genital mutilation, etc.).

They highlighted the need to be informed on available services and resources from other sectors (e.g.: housing, schooling, etc.) and to be involved in existing emergency plans to improve the health care response and access to health care for asylum seekers, including support for the implementation of a referral system for such patients. A tool for facilitating the collaboration between care providers would be the mapping of the different stakeholders acting in the field (international organizations, NGOs, national/regional health services, governmental agencies, etc.) and the creation of platforms for sharing the workload and expertise between and within countries.

It is also important that care providers have full knowledge of current legislation concerning refugees and asylum seekers, and the impact of different immigration status' on accessibility to healthcare services and the relevant administration processes (e.g. reimbursement/exemption of health care costs, etc.), as well as knowledge on laws concerning personal data protection, the universal right to health care and international treaties. Almost all interviewees and focus group participants highlighted the importance of training for health professionals, managers and administrative staff. The implementation of training courses on cultural competence is urgently needed in particular in those countries mostly affected by massive arrivals (e.g.: Greece) and those countries that are relatively new to immigration influxes, e.g.: Hungary, Slovenia.

The need to improve care providers competence is also highlighted in the literature review. A study (Ross, Harding, Seal, & Duncan, 2016) investigating healthcare professionals' views regarding improvements that could be made with migrants found that although most respondents reported that they were confident with immigration terminology, not all of them were aware that refugees have the right to full access to health care. According to WHO, care providers lack of knowledge on migrants related-health problems reflects an inability to manage the different health issues, including: communicable diseases, inherited conditions, chronic diseases, nutritional deficiencies, and the effects of displacement, trauma, torture, or sexual abuse (Odunukan et al., 2015). Furthermore health professionals need to be trained to improve their cultural competence in providing care to very diverse populations. For these reasons further education on care providers is needed to overcome these barriers to health care.

Measures to address the barriers

In order to effectively provide care for refugees and asylum seekers care providers need to access relevant information. To this purpose the establishment of an information system has been envisaged, that would be able to monitor migrants entering in the health care system. Participants in the focus groups suggested that some kind of European or national cohesive IT system should be created to enable the storage of relevant medical information about asylum seeker and refugees. Migrants transit rapidly through countries and for files to be transferred with them may take many months. Therefore participants suggested a sort of passport or digital ID card that can be used to easily access medical information.

One study (joels, 2008) reported that in UK the problem of poor communication between port health control units and local health authorities during assessments on point of entry in the country was addressed by introducing patient-held records for people seeking asylum. The study showed that the introduction of patient-held records helped to improve continuity of services and to standardise assessment. However, it seems that Patient-Held-Records is not necessarily the panacea to improve continuity of care. The results of a more recent study (Schoevers, 2011) conducted in The Netherlands show that the use of the Patient-Held Records was low, because it was not felt to be a solution by undocumented women and general practitioners.

Results from the literature highlight the need for coordination among service providers in order to reduce the complexity and overload of information and enable a more targeted exchange of information, thus ensuring continuity of care (Qayyum, Thompson, Kennan, & Lloyd, 2014). Coordination of care (Joshi et al., 2013) should involve: i) care planning, ii) informal communication between workers or services, iii) team meetings, case conferences, interagency meetings, iv) shared assessments and records v) coordination with non-health services including language services (interpreters, translated health information) formal settlement services, torture and trauma services and vi) referral pathways and inter-service agreements (Joshi et al., 2013).

Implementing additional support and training regarding refugee health needs on health-care workers could increase knowledge and confidence, reducing barriers to health care and improving quality of care. The

improvement of staff skills could be achieved by increasing education on refugee and asylum seeker groups through training, education sessions and production of practical materials outlining available services and support (Ross et al., 2016). This is in line with the WHO report (Bradby, Humphris, Newman, & Phillimore, 2015), the main goal being to implement actions focused on staff expertise: the provision of interpreters; enhanced cultural competency training and enhanced inter-sectoral working.

Training and continuing education should be available to all health professionals and others who interact with migrants, including reception staff, managers, social workers, border guards, and detention facility staff. Specific trainings, during the course of undergraduate health professions education as well as in post-degree continuing education – as for instance cultural competence training programme for medical students - is emerging as a critical component to ensure migrant needs (Odunukan et al., 2015). The cultural competence (Nazzal, Forghany, Charis Geevarughese, Mahmoodi, & Wong, 2014) of care providers encompass' skills, development of knowledge, attitudes. Improving cultural competence would, on the one hand, enable providers to work in multi-cultural situations, while, on the other, increasing the continuum of care with migrants' services utilization and reducing the number of migrants dropping out of care.

In providing cultural competency training it is important to take into account the limits of this approach if its implementation is to be based on the assumption that culture can be reduced to a technical skill in which health staff can be trained in order to develop the relevant expertise. Research and experience in health care (Chiarenza, 2012) show that simplistic representations of culture and the mere description of cultural differences are by definition stereotypical and may not reflect the uniqueness of the individual. Therefore, no simple knowledge-based training in which providers are taught the customs and values of particular ethnic minority groups can prepare professionals to adequately respond to refugees' needs. There is no "one way" to treat any migrant, given the enormous intra-group diversity within these broad classifications.

In conclusion, the exchange of best practices, with concrete examples of successful strategies in European contexts on how to address problems/barriers to access health services or to gain financial support for migrant healthcare in different countries is recommended as an effective measure to improve the situation.

Successful example

SH-CAPAC WP5 Training activities to develop refugee/migrant-sensitive health services by training health managers and health professionals
Granada, Spain

Service/department in charge of the measure
Escuela Andaluza de Salud Pública, Granada

Description of the measure
Online training course, that is part of the SH-CAPAC project "Supporting Health Coordination, Assessments, Planning, Access To Health Care And Capacity Building In Member States Under Particular Migratory Pressure" funded by the European Union's Health Programme (2014-2020).
The training contents have been selected and compiled in three tracks to meet the needs of the different participant profiles: *health Managers:* 15 units; *health Professionals:* 18 units; *administrative Staff:* 12 units. The training is delivered in an online format in English. Each unit has a balanced mix of theoretical and practical contents, focusing on theoretical presentations; problem based learning (case studies); experiential and analytic self-reflection.
Interactive online activities and group exercises complement the information provided. Additionally, participatory discussion sessions will be organised. During the course, trainees can post a message on the specific forum available for each Unit/Module and will receive feedback or answers to the questions from tutors.

Expected outcomes:
Carry out comprehensive public health and health systems assessments of the impact of the migratory pressures and identify the response needed by the national health systems.
Implement tools for addressing the health needs of refugees, asylum seekers and other migrants,
Recognise available resources to improve access to health care and public health interventions for refugees, asylum seekers and other migrants in their territories and health systems, and
Increase competences to provide migrant sensitive health care.

Resources needed for implementation:
Access to internet.

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