Report on the health status of newly arrived migrants and refugees in EU/EEA

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March – 2020

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Report on the health status of newly arrived migrants and refugees in EU/EEA

Consumers, Health, Agriculture and Food Executive Agency
Third EU Health Programme
2020
EN

This report was produced under the EU Third Health Programme [2014-2020] in the frame of a service contract with the Consumers, Health, Agriculture and Food Executive Agency (Chafea) acting under the mandate from the European Commission. The content of this report represents the views of the contractor and is its sole responsibility; it can in no way be taken to reflect the views of the European Commission and/or Chafea or any other body of the European Union. The European Commission and/or Chafea do not guarantee the accuracy of the data included in this report, nor do they accept responsibility for any use made by third parties thereof.

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GLOSSARY

Organisational definitions

- **Directorate-General Health and Food Safety (DG SANTE):** DG SANTE is the Commission department responsible for European Union (EU) policy on food safety and health and for monitoring the implementation of related laws.
- **European Centre for Disease Prevention and Control (ECDC):** ECDC is an EU agency aimed at strengthening Europe's defences against infectious diseases. The core functions cover a wide spectrum of activities: surveillance, epidemic intelligence, response, scientific advice, microbiology, preparedness, public health training, international relations, health communication, and the scientific journal Eurosurveillance.[1] ECDC also issues the "Handbook on implementing syndromic surveillance in migrant reception/detention centres and other refugee settings", which is aimed at enhancing early detection of single cases or outbreaks that require an assessment to trigger and guide appropriate public health measures.[2]
- **International organisation**: An institution drawing membership from at least three states, having activities in several states, and whose members are held together by a formal agreement.[3] Examples include the International Organization of Migration (IOM), which also operates a data portal on migration, or the World Health Organisation (WHO).
- **Non-governmental organisation (NGO):** An organisation that tries to achieve social or political aims but is not controlled by a government.[4]
- **Public authority:** Any government or other public administration, including public advisory bodies, at national, regional or local level.[5] In this study, it primarily refers to authorities in the health or migration sector (such as a Ministry responsible for one of the respective sectors).
- **The Consumers, Health, Agriculture and Food Executive Agency (CHAFEA):** CHAFEA is an Executive Agency set up by the European Commission to manage the European Union's Health Programme, Consumer Programme, the Better Training for Safer Food Initiative and the Promotion of Agricultural Products Programme.

Individual-related definitions

- **Asylum seeker:** A third country nationals that submitted an application for refugee status. In the scope of the study this related to asylum seekers in the EU or Health Programme participating country and which are awaiting the decision of refugee status
- **Irregular migrant:** Third country nationals that are staying in the EU or Health Programme participating country irregularly.
- **Migrant in the EU**: Any third country national -without an EU/EEA passport- arriving in the EU or Health Programme participating country since 2015 (first year of arrival).
- **Newly-arrived migrant**: In the context of this study, a newly-arrived migrant is defined as any third country national without an EU passport arriving in the EU since 2015, including asylum seekers, refugees, migrants in irregular situations, migrants arriving to the EU through family reunification, as well as regular migrants, for example arriving on a study permit.
- **Refugee in the EU**: An asylum seeker who has been granted refugee status or subsidiary protection status in an EU Member State or Health Programme participating country.

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[1] https://www.ecdc.europa.eu/en/about-ecdc

[2] https://ecdc.europa.eu/sites/portal/files/media/en/publications/Publications/syndromic-surveillance-migrant-centres-handbook.pdf

[3] https://www.britannica.com/topic/international-organization

[4] https://dictionary.cambridge.org/dictionary/english/ngo

[5] https://inspire.ec.europa.eu/glossary/PublicAuthority

- **Stakeholder**: A person such as an employee, customer, or citizen who is involved with an organisation, society, etc. and therefore has responsibilities towards it and an interest in its success.[6] In this study, stakeholders are primarily considered as organisations that might collect or hold data on migrants' health.

Migration-related definitions

- **Arrival country**: A country in which a person has first entered an EU member state or a country included in the scope of a study, irrespective of whether they migrate regularly or irregularly.
- **Destination country:** A country that is the destination for a person or a group of persons, irrespective of whether they migrate regularly or irregularly.[7]
- **Migrant Integration Policy Index (MIPEX):** A tool which measures policies to integrate migrants in all EU Member States, Australia, Canada, Iceland, Japan, South Korea, New Zealand, Norway, Switzerland, Turkey and the USA according to 167 policy indicators. It includes a metric of 38 indicators on a country's policies regarding the health of migrants.
- **Transit country:** A country through which a person or a group of persons move, in order to reach a destination country, irrespective of whether they migrate regularly or irregularly.

Health-related definitions

- **Brief Pain Inventory (BPI):** The BPI is a measurement tool for assessing clinical pain, which allows patients to rate the severity of their pain and the degree to which their pain interferes with common dimensions of feeling and function.[8]
- **Cardio-vascular diseases (CVD):** A cardio-vascular disease is a general term for conditions affecting the heart or blood vessels.
- **Chronic diseases:** Chronic diseases are defined broadly, and depending on the respective definition, as conditions that last 1 year or more and require ongoing medical attention or limit activities of daily living or both.[9]
- **Communicable diseases:** An infectious disease transmissible (as from person to person) by direct contact with an affected individual or the individual's discharges or by indirect means (as by a vector).[10]
- **Dermatologic disorders:** Conditions related to the skin.
- **European Core Health Indicators (ECHI):** ECHI is a list of health and health-related indicators aimed at providing comparable health information and knowledge system to monitor health at EU level.[11]
- **Gastro-intestinal conditions:** Digestive diseases are disorders of the digestive tract, which is also called the gastrointestinal tract. The digestive tract is made up of the oesophagus (food tube), stomach, large and small intestines, liver, pancreas, and the gallbladder.[12]

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[6] https://dictionary.cambridge.org/dictionary/english/stakeholder

[7] https://www.iom.int/key-migration-terms

[8] https://www.mdanderson.org/documents/Departments-and-Divisions/Symptom-Research/BPI_UserGuide.pdf

[9] cdc.gov/chronicdisease/about/index.htm

[10] https://www.merriam-webster.com/medical/communicable%20disease

[11] https://ec.europa.eu/health/indicators_data/echi_en

[12] https://medlineplus.gov/ency/article/007447.htm

- **Gynaecological conditions:** A gynaecological disorder is a condition which affects the female reproduction organs, namely the breasts and organs in the abdominal and pelvic area including the womb (uterus), ovaries, fallopian tubes, vagina and vulva.[13]
- **Harvard Trauma Questionnaire (HTQ):** A measure that was developed to assess trauma symptoms across cultures.[14]
- **Hopkins Symptom Checklist (HSCL):** The HSCL is a symptom inventory which measures symptoms of anxiety and depression.[15]
- **International Statistical Classification of Diseases and Related Health Problems (ICD-10):** The ICD-10 is an international standard diagnostic classification systematic that permits systematic recording analysis, interpretation and comparison of mortality and morbidity data collected in different countries or areas and at different times.[16]
- **Mental health conditions or illnesses:** Mental illnesses are health conditions involving changes in emotion, thinking or behaviour (or a combination of these). Mental illnesses are associated with distress and/or problems functioning in social, work or family activities.[17]
- **Morbidity**: The incidence of disease or the rate of illness (as in a specified population or group).[18]
- **Musculoskeletal disorders:** Musculoskeletal disorders (MSD) are injuries or disorders of the muscles, nerves, tendons, joints, cartilage, and spinal discs.[19]
- **Neurological disorders**: Neurological disorders are diseases of the central and peripheral nervous system encompassing the brain, spinal cord, cranial nerves, peripheral nerves, nerve roots, autonomic nervous system, neuromuscular junction, and muscles.[20]
- **Non-communicable diseases (NCD):** A noncommunicable disease is a medical condition or disease that is by definition non-infectious and non-transmissible among people.[21]
- **Ophthalmic conditions:** Conditions relating to the eye.
- **Pre- (or ante-) and postnatal care:** Care provided to a woman and her child during and after pregnancy.
- **Public Health**: Public Health is defined as "the art and science of preventing disease, prolonging life and promoting health through the organized efforts of society".[22]
- **Psychosomatic disorders:** Psychosomatic disorders, also called Psychophysiological disorders, are conditions in which psychological stresses adversely affect physiological (somatic) functioning to the point of distress.[23]
- **Respiratory diseases:** A type of disease that affects the lungs and other parts of the respiratory system.[24]
- **Sexually transmittable diseases (STD):** Any of various diseases or infections that can be transmitted by direct sexual contact including some (such as syphilis, gonorrhoea, chlamydia, and genital herpes) chiefly spread by sexual means and others (such as hepatitis B and AIDS) often contracted by nonsexual means.[25]

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[13] https://www.omicsonline.org/scholarly/gynecological-disorders-journals-articles-ppts-list.php

[14] https://ruor.uottawa.ca/bitstream/10393/36082/1/Darzi_Chantal_2017_thesis.pdf

[15] http://hprt-cambridge.org/screening/hopkins-symptom-checklist/

[16] https://www.who.int/classifications/icd/ICD10Volume2_en_2010.pdf

[17] https://www.psychiatry.org/patients-families/what-is-mental-illness

[18] https://www.merriam-webster.com/dictionary/morbidity

[19] https://www.cdc.gov/workplacehealthpromotion/health-strategies/musculoskeletal-disorders/index.html

[20] https://www.who.int/features/qa/55/en/

[21] https://www.ncbi.nlm.nih.gov/pubmed/23946874

[22] http://www.euro.who.int/en/health-topics/Health-systems/public-health-services

[23] https://www.britannica.com/science/psychosomatic-disorder

[24] https://www.cancer.gov/publications/dictionaries/cancer-terms/def/respiratory-disease

[25] https://www.merriam-webster.com/dictionary/std

- **Urologic diseases:** Urologic diseases or conditions include urinary tract infections, kidney stones, bladder control problems, and prostate problems, among others.[26]
- **World Health Organisation Disability Assessment Schedule (WHODAS)**: The adult self-administered version of the World Health Organization Disability Assessment Schedule is a measure that assesses disability in adults age 18 years and older.[27]

Study-relevant definitions

- **Confidence interval (CI)**: A confidence interval is a range of values that's likely to include a population value with a certain degree of confidence.[28] It is often expressed a % whereby a population means lies between an upper and lower interval.
- **Country fiche**: A fact sheet, displaying relevant information about a country's situation regarding a certain issue.
- **European Economic Area (EEA):** The European Economic Area unites the EU Member States and the three EEA EFTA States (Iceland, Liechtenstein, and Norway) into an Internal Market governed by the same basic rules. These rules aim to enable goods, services, capital, and persons to move freely about the EEA in an open and competitive environment, a concept referred to as the four freedoms.[29]
- **EU Health Policy Platform:** An interactive tool established by the European Union for stakeholders to boost discussions about public health concerns, share knowledge and best practices.
- **EU Health Programme:** The EU Health Programme is a funding instrument to support cooperation among EU countries and underpin and develop EU health activities. The current funding period runs from 2014-2020 and has a volume of EUR 449.4 million of which EUR 14.8 million are dedicated to projects related to migrants and refugees. In addition, to the EU28 countries, Iceland, Norway, Serbia, Moldova and Bosnia & Herzegovina are participating in the programme and are thus included in the scope of this study.

ACRONYMS AND ABBREVIATIONS

Acronym	Definition
ASD	Acute Stress Disorder
ATHIS	Austrian Health Interview Survey
BCP	Border-crossing Point
BMI	Body Mass Index
BPI	Brief Pain Inventory
CA	Cancer
CHAFEA	Consumers, Health, Agriculture and Food Executive Agency
CDC	Centre of Disease Prevention and Control
CHART	Changing Health and health care needs Along the Syrian Refugees' Trajectories to Norway

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[26] https://www.niddk.nih.gov/health-information/urologic-diseases

[27] https://www.psychiatry.org/File%20Library/Psychiatrists/Practice/DSM/APA_DSM5_WHODAS-2-Self-Administered.pdf

[28] https://www.simplypsychology.org/confidence-interval.html

[29] https://www.efta.int/eea. Note that Liechtenstein is not participating in the Third Health Programme and is therefore not included in this study.

Acronym	Definition
CI	Confidence Interval
COPD	Chronic Obstructive Pulmonary Disease
CVD	Cardio-vascular Disease
CXR	Chest X-Rays
DG HOME	Directorate-General for Migration and Home Affairs
DG JUST	Directorate-General for Justice and Consumers
DG SANTE	Directorate-General for Health & Food Safety
EC	European Commission
ECDC	European Centre for Disease Prevention and Control
ECHI	European Core Health Indicators
ECRE	European Council on Refugees and Exiles
EEA	European Economic Area
EHIS	European Health Interview Survey
EMIS	Egton Medical Information Systems
EPHA	European Public Health Alliance
EU	European Union
EUPHA	European Public Health Association
Eurostat	European Statistics
FBC	Full Blood Count
FGM	Female Genital Mutilation
FRONTEX	European Border and Coast Guard Agency
FRA	European Union Agency for Fundamental Rights
G6PD	Glucose-6-Phosphate Dehydrogenase
GGD	Public health department in Groningen
GP	General Practitioner
HBsAg	Hepatitis B Virus Surface Antigen
HBV/HCV	Hepatitis B Virus/Hepatitis C Virus
HHP	Handbook for Health Professionals
HIV	Human Immunodeficiency Virus
HP	Health Programme
HSE	Health Services Executive
HSCL	Hopkins Symptom Checklist
HTQ	Harvard Trauma Questionnaire
ICD-10	International Classification of Diseases
ICMHD	International Center for Migration, Health and Development
ICPC	International Classification of Primary Care
IMIRA	Improving Health Monitoring in Migrant Populations
IOM	International Organization for Migration
JA	Joint Action
MIPEX	Migration Integration Policy Index

Acronym	Definition
MoH	Ministry of Health
MoI	Ministry of the Interior
MoJ	Ministry of Justice
MdM	Médecins du Monde/Doctors of the World
MEHO	Migrant and Ethnic Health Observatory
MMR	Measles Mumps Rubella
MSF	Médecins Sans Frontieres/Doctors Without Borders
MS	Member State(s)
NCD	Non-Communicable Diseases
NGO	Non-Government Organisation
OECD	Organisation for Economic Co-operation and Development
PHEA	Public Health Executive Agency
PHE	Public Health England
PHR	Public Health Record
PTSD	Post-Traumatic Stress Disorder
QA	Quality Assurance
QAM	Quality Assurance Manager
QP	Quality Plan
RA	Rheumatoid arthritis
ReHIS	Refugee Health and Integration Survey
RfS	Request for Services
RIVM	Dutch National Institute for Public Health and the Environment
RKS	Robert-Koch-Institute
SCP	Social and Cultural Planning/The Netherlands Institute for Social Research
STD	Sexually Transmitted Disease
TB	Tuberculosis
TERTTU	The Asylum Seekers Health and Wellbeing Survey
TESSy	The European Surveillance System
THL	National Institute for Health and Welfare
TL	Team Leader
TOR	Terms of Reference
UCL	University College London
UNHCR	United Nations Commissioner for Refugees
URTI	Upper respiratory tract infection
VA	Visual Acuity
VPD	Vaccine-Preventable Diseases
WHO	World Health Organisation
WHODAS	World Health Organisation Disability Assessment Schedule

ABSTRACT

Context

Funded by the Third EU Public Health Programme, Optimity Advisors, together with the European Public Health Alliance and the study experts Prof. Elisabetta De Vito and Dr Philipa Mladovsky, undertook this study on the health status of newly arrived migrants and refugees in the EU / EEA. The study had two main objectives: (i) to identify and evaluate the existing sources and data on the health conditions of newly arrived migrants and refugees to Europe since 2015; (ii) to assess the actual health status of the target population on the basis of selected sources of health information.

Methods

The study relied on an extensive desk-based research exercise at international, EU and national level, a large-scale stakeholder consultation through online questionnaires and interviews across the 33 study countries to identify relevant data sources, as well as a workshop with key stakeholders from different Member States, through which 47 sources for potential inclusion were identified. Of those, 16 were included in the assessment of the health status of migrants.

Results

The study revealed that little to no systematic data collection of the health status of newly arrived migrants in the EU/EEA since 2015 is conducted. A comparison of available data is very difficult, if not impossible. A coordinated data collection effort across the EU would be useful to overcome the fragmented data.

EXECUTIVE SUMMARY

Context

Funded by the Third EU Public Health Programme, Optimity Advisors, together with the European Public Health Alliance and the study experts Prof. Elisabetta De Vito and Dr Philipa Mladovsky, undertook this study on the health status of newly arrived migrants and refugees in the EU / EEA. The study had two main objectives: (i) to identify and evaluate the existing sources and data on the health conditions of newly arrived migrants and refugees to Europe since 2015; (ii) to assess the actual health status of the target population on the basis of selected sources of health information. While other studies tend to focus on a comparison of the health status of migrants and national citizens of a given country, this study's focus was on newly arrived migrants and refugees in the EU/EEA. In addition, the purpose of the study was not to look at other studies or to propose new specific information systems, but to identify existing sources of data on the health status of newly arrived migrants and refugees in the EU/EEA since 2015.

Methods

The study relied on an extensive desk-based research exercise at international, EU and national level, a large-scale stakeholder consultation through online questionnaires and interviews across the 33 study countries to identify relevant data sources. The study focus was the identification and interpretation of primary data sources. The study team put a lot of effort into contacting different organisations, resulting into 423 unique email requests being sent out. However, the study team experienced significant difficulties in identifying responses from the organisations contacted, and in identifying relevant data sources. Out of all email requests sent out, 223 contacts (53%) did not reply. In addition, while certain information was found and is available regarding the health status of the target population, this information largely did not meet the study objectives, namely the first year of arrival of migrants and refugees. In a next step, a workshop with key stakeholders from different Member States was organised as a collected intelligence exercise on what sources may be systematically collecting data in Europe, and to highlight studies in European Countries that may include some of the data requested for the study.

As a result, data sources from 47 organisations from 22 EU/EEA countries, two European institutions, one European NGO, two international non-governmental organisations and two international organisations were identified for potential inclusion. Of those, 16 data sources from 12 European countries were included for the assessment of the health status of migrants.

Results

The study revealed that little to no systematic data collection of the health status of newly arrived migrants in the EU/EEA since 2015 is conducted. Thus, there is little to no information or even communication on the first year of arrival of migrants and refugees. Only in a minority of cases is data on the health status of migrants and refugees publicly available, usually in partnership with academic institutions. A comparison of available data on the health status of newly arrived migrants in the EU/EEA is therefore very difficult, if not impossible.
In addition, collecting data on the health status of migrants and refugees is problematic in many countries due to ethical considerations.

As a consequence, this study looked at and analysed individual datasets independently, rather than trying to draw conclusions of the health status of refugees and migrants at European level. A coordinated data collection effort across the EU would be useful to overcome the fragmented data in order to provide a holistic and comprehensive overview on the health status of migrants and refugees.

1. INTRODUCTION

The present document is the (Draft) Final Report (D4) of the analysis "The health status of newly arrived migrants and refugees in EU/EEA" (Chafea Service Contract No. 20177111) commissioned by Chafea to Optimity Advisors and overseen by DG SANTE.

The report is structured as follows:

Section 2 provides the context and objectives of the study, as well as information on the research methodology and an overview of the study findings.

Section 3 provides an overview of the available data sources.

Section 4 provides an assessment of the health status of migrants, provided by example of individual sources.

Section 5 includes the output documents achieved by the study in the form of annexes:

- Annex 1: Deliverable 1 (D1) – Compendium of health information sources identified in the study. Due to the strict data usage protocol, only a summary is provided in this document.
- Annex 2: Deliverable 2 (D2) – Report on the discussions and conclusions of the workshop.
- Annex 3: Deliverable 3 (D3) – A review on the health status of migrants and refugees to Europe since 2015 (Country fiches). Due to the strict data usage protocol, only a summary is provided in this document.
- Annex 4: Deliverable 4 (D4) – Final Report of the analysis.
- Annex 5 includes:
    - Annex 5.1: the migrants pathways developed to identify potentially relevant sources of data;
    - Annex 5.2: the guidelines used for interviews with stakeholders;
    - Annex 5.3: the online questionnaire;
    - Annex 5.4: the data usage protocol.
- Annex 6 illustrates complementary data from existing data sources.

2. CONTEXT AND OBJECTIVES OF THE STUDY AND METHODOLOGY

2.1. Study context

Since the start of the 2015 migrants' crisis, the European Commission (EC) has mobilised substantial economic resources to help Member States to address the challenges to local health systems posed by the increased flow of newly arrived migrants in Europe. The Health Programme provides funding for several projects in relation to migrants' health issues.[30] The Health Programme has dedicated EUR 14.7 million of the EUR 17 million assigned to horizontal issues, to projects related to migrants and refugees.[31] Using these resources efficiently to improve access to healthcare, address ill-health, and reduce health inequalities, is of great importance. A thorough assessment of the health status of migrants would help identifying unmet needs and adapt the health systems to deal with the specific health conditions of migrants and refugees arriving in Europe.

The dramatic increase in the migration flows to Europe in recent years has presented challenges in relation to assessing the additional health needs of newly arrived migrants. National health systems need evidence about the impact (or not) of migration flows and the health status of migrants themselves. A pan-European analysis is important to inform national and EU actions in this area.

However, data that distinguishes the health status of migrants from the general population is not systematically collected across the EU Member States and other Health Programme participating countries (Norway, Iceland, Serbia, Bosnia-Herzegovina and Moldova). Generally, organisations identify the specific health needs of migrants and refugees on an ad-hoc basis. Moreover, this information is generally not publicly available. Information that is published usually covers only specific cases or sub-populations rather than all migrants and refugees. Existing studies on the health of migrants have tended to focus on issues of access to healthcare and inequalities in health outcomes, while information on the health status of migrants and refugees is currently fragmented or entirely missing. As a result, a comprehensive and accurate picture of the situation across Europe is missing. Attempts to assess the health status of migrants and refugees in Europe, like the WHO "Report on the health of refugees and migrants in the WHO European Region"[32] to be published in December 2019, have relied on an extensive bibliographic review, rather than an analysis of existing data sets.

This study attempts to bring together the fragmented data, which will provide an important first step towards generating a holistic and comprehensive analysis on the health status of refugees and other migrants. This will contribute to the overall knowledge of the state of health in the EU and allow for a better adaptation of the national health systems to real needs. Understanding better the current health needs of this population is also a pre-condition for preventing future health inequalities and facilitating greater social cohesion and inclusion.

2.2. Study purpose and objective

The purpose of this study was to identify primary sources of routine, systematic and, if possible, at scale data collection at national level on the health status of migrants and refugees in the EU, EEA (Norway, Iceland) and Health Programme participating countries (Bosnia-Herzegovina, Serbia and Moldova) arriving since 2015 and in the first year of arrival. Too often, assessments of the health status of migrants are based on bibliographic reviews and ad-hoc data collection. Therefore, mapping the available data, systematically collected, across Europe would provide a most robust assessment.

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[30] Eurohealthnet. Policy Precis "Making the link: migration, refugees and health needs". Available from: https://eurohealthnet.eu/sites/eurohealthnet.eu/files/publications/PP_Migration_and_Health%20-%20Final.pdf

[31] https://ec.europa.eu/migrant-integration/feature/migrant-health-across-europe

[32] WHO (2018), Report on the health of refugees and migrants in the WHO European Region. No Public Health without refugee and migrant health. Available from: https://apps.who.int/iris/bitstream/handle/10665/311347/9789289053846-eng.pdf?sequence=1&isAllowed=y

The study aimed to:

- Provide the EC with the evidence needed to provide better knowledge on the health status of migrants.
- Provide the EC with a better understanding of the needs of Member States' health services to adapt to the new situation, and provide answers to the following questions:
    - Do the health and social services in the EU Member States available to migrants need to be adapted, considering this extra population: does the EU need extra or different services?
    - Are the communicable diseases changing or are new types of diseases prevalent among migrants entering the EU?

Therefore, the objectives of the assignment were as follows:

- **Study objective 1**: to identify and evaluate the existing sources and data on the health conditions of newly arrived migrants and refugees to Europe since 2015 (within first year of arrival).
- **Study objective 2**: to assess the actual health status of the target population on the basis of selected sources of health information.

2.3. Study scope

2.3.1. Material scope

The material scope of the study covers health information and analysis of the health status of migrants and refugees within their first year of arrival to Europe. It is important to clarify how these terms are understood for the purpose of this study:

Firstly, the term "**health status"** is understood to include:

- **Physical health** (communicable and non-communicable diseases) and;
- **Mental health**, including PTSD (post-traumatic stress syndrome).

Topics related to rights of access to healthcare, integration of migrants and refugees into healthcare and other systems, and health inequalities also fall outside the scope of the current assignment. The terms "**migrant"** and **"refugee**" are understood as follows:

- **Refugee in the EU**: An asylum seeker who has been granted **refugee status or subsidiary protection** status in an EU Member State or Health Programme participating country;
- **Migrant in the EU**: Any third country national -without an EU/EEA passport- arriving in the EU or Health Programme participating country since 2015 (first year of arrival). This can encompass the following types of people/legal situations:
    i. Third country nationals that are **residing in the EU** or Health Programme participating country **in a regular manner** (e.g. through a study or work visa);
    ii. Third-country nationals arriving through **family reunification** under the Dublin Regulation or Family Reunification Directive;
    iii. **Asylum seekers:** i.e. third country nationals that submitted an application for refugee status in the EU or Health Programme participating country and which are awaiting the decision;
    iv. **Rejected asylum seekers:** i.e. third country nationals that applied for asylum in the EU or Health Programme participating country, but were rejected and are awaiting to be returned;

v. **Detected irregular migrant:** Third country nationals that are apprehended for entering, staying or residing in the EU or Health Programme participating country irregularly, and are awaiting to be returned (often whilst being detained);

vi. **Undetected irregular migrant:** Third country nationals that are staying in the EU or Health Programme participating country irregularly;

The service was not envisaged as a bibliographical/literature review, but rather to focus on data from administrative data sources, international organisations and NGOs, believed to have potentially the capacity to collect primary data related to the health status of newly arrived migrants routinely and systematically. The service did not include the collection of new data, but was conceived to build upon already existing data, in particular datasets that provide systematic collection for an organisation or system, as well as surveys that provide data to health authorities systematically. Therefore, the analysis is based only on existing health data. Where information is being collected but not yet processed and analysed, it has been referenced in the study. This includes surveys, as long as the survey is focussed on migrants.

Moreover, this assignment did not intend to propose a new specific information system tailored to migrants and refugees.

2.3.2. Geographical Scope

The geographical scope of the study covers a total of **33 countries**, namely:

- The 28 EU Member States;
- EEA countries participating in the Third Health Programme, namely Norway and Iceland; and
- Other countries eligible to participate in the Third Health Programme, namely Serbia, Bosnia-Herzegovina and Moldova.

2.3.3. Temporal scope

The study covers health information collected **within the first year of arrival** of **refugees and migrants that arrived in the EU and Health Programme participating country since January 2015**. "Within their first year of arrival" means the 12-month period after:

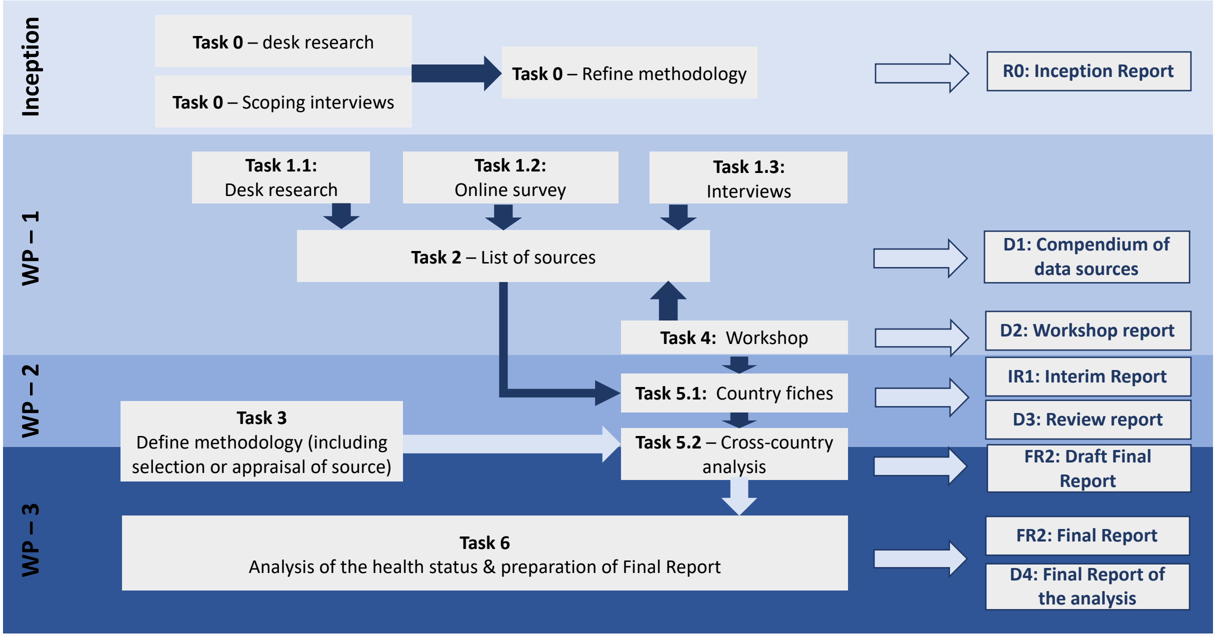
- the date that the migrant was registered by the national authorities for the purpose of launching the asylum application (for refugees, asylum seekers and rejected asylum seekers);
- the date of apprehension (for detected irregular migrants);
- the date of arrival into the Member State/country of residence, if the date of arrival into the EU is not recorded (for third country nationals arriving through family reunification or visa).

The study will exclude information on the health status beyond the first year or health conditions developed after the first year of arrival.

2.4. Methodological approach

The methodological approach has been structured along three Work Packages and three phases, broken down in six Tasks.

Figure 1 :Study design



Source: Optimity Advisors

The objective of **Work Package 1** (WP - 1) was to compile a list of sources of health information and the data held by organisations in the 33 relevant countries within the scope of this study, on the basis of which the analysis of the health status of newly arrived migrants and refugees since 2015 would be conducted in Work Package 2.

In the execution of the tasks, the study design was amended based on issues encountered in the delivery of the interim phase of the study. The main changes to the study design included:

- To produce a Compendium or Repository of sources of data across Europe. The repository contains information on all sources contacted, with a description of the data collected by those who have responded to the request for information.
- Task 3 was postponed until after the submission of the Interim Report as new sources were identified during the stakeholder workshop, and the study team had initiated a new round of consultations with organisations that had not responded to the request of information.
- The outputs of Task 5 were compiled in in the form of Country Fiches, and fed into the (Draft) Final Report.

In addition:

Work Package 1 was split into the following tasks:

- **Task 1:** Identification of data sources (organisations collecting health information on migrants and refugees) in the 33 study countries, through:
    - **Task 1.1:** Desk research;
        - Consultation of stakeholders to identify the relevant data sources:
    - **Task 1.2:** Online questionnaire with data holders;
    - **Task 1.3:** Interviews with data holders and other key stakeholders;
- **Task 4:** Workshop with key stakeholders.[33]

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[33] Task 4, the stakeholder workshop, was originally planned to be carried out as part of WP2 in order to validate the selection of sources identified and the planned methodology. During the execution of the contract, the

- **Task 2:** Compendium/Repository of sources of information consulted.

The objective of **Work Package 2** (WP-2) was to produce a review on the health status of refugees and other migrants arriving in Europe since 2015 (Country fiches) and conduct the analysis of the health status of refugees and other migrants on the basis of the sources of health information identified under WP1:

- **Task 3:** Define the methodology to be used for the analysis of the health status of the target group.
- **Task 5:** Conduct the analysis.
- The aim of **Work Package 3** (WP - 3)/**Task 6** was the preparation and presentation of the final report (FR2/D4).

2.4.1. Methodological Overview

Desk research

Through a **desk-based research exercise**, consisting of an intensive online search and review of the websites of relevant organisations at international and EU level, a preliminary list of potential sources of health information was developed. The desk research sought to identify all potentially relevant sources of health information in the 33 countries within the study scope.

The types of sources at **international and EU level** contacted included:

- International organisations focussing on health (such as the WHO) or migration (such as the IOM);
- EU institutions and agencies focussing on health (such as ECDC), or border management, migration or asylum (e.g. EASO and Frontex), including EU funded projects;
- International and European NGOs and networks that support migrants (e.g. Médecins du Monde; Médecins Sans Frontieres, Save the Children);
- **Other organisations** referred to during the stakeholder consultation.

The types of sources contacted at **national level** included:

- **Relevant public authorities and organisations:** including relevant Ministries (e.g. Ministry of Health or Ministry of Interior), national institutes of health, national institutes of disease control, national statistical offices, national health services, social security, national health insurance bodies;
- **Relevant NGOs** at the national level focussing on (mental) health care or focussing on migrants and refugees;
- **Other organisations or academic institutions** referred to during the stakeholder consultation**.**

As represented in the Figure below, the identification of sources was approached from two directions, namely from the international/EU dimension, as well as through organisations operating at the national/regional and local levels.

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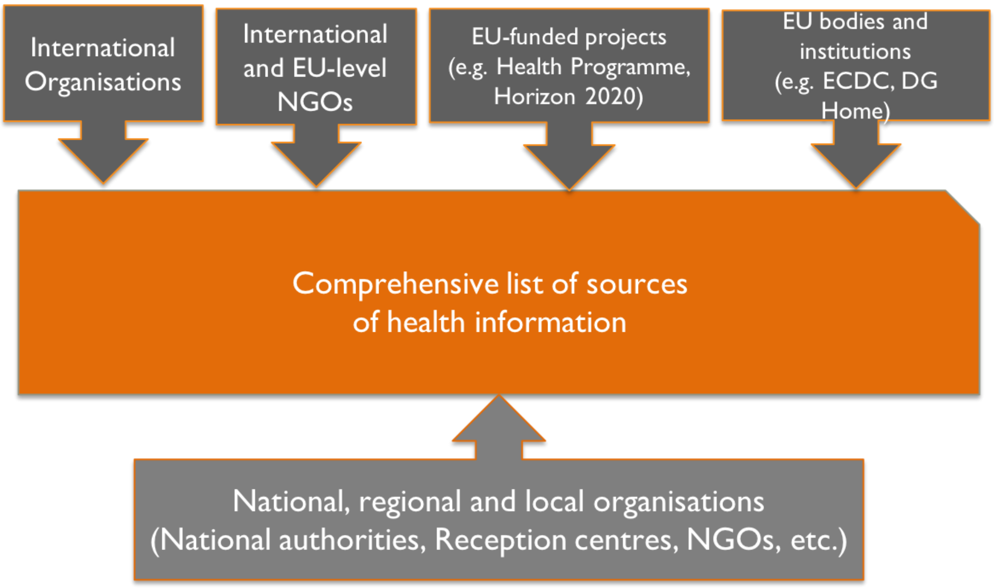
stakeholder workshop was carried out as part of the stakeholder consultation to bring together experts from across Europe to inform the study team on potential sources, and issues related to data collection.

Figure 2 :Two-directional approach to compiling a list of sources of health information



Source: Optimity Advisors

To map a comprehensive list of organisations at national level that could potentially hold relevant data for the study, the study team developed a series of pathways for newly arrived migrants and their possible contacts with organisations and institutions carrying out an assessment of their health status. In addition, the following typology of migrants was developed:

- **Group 1:** Legally Residing Residents;
- **Group 2:** Asylum Seekers and Refugees;
- **Group 3:** Detected Irregular Migrants;
- **Group 4:** Undetected Irregular Migrants.

The migrants' journeys that have been developed are presented in Annex 4.1.

The organisations approached for the study are similar to the potential data sources on migration and health listed by the IOM in their Global Migration Data Portal:[34]

- **World Health Organization (WHO)**: although the WHO provides a list of sources of health data, these are not specific to migration and health. The most recent WHO report on the topic, published in December 2018,[35] provides an assessment of the health status of migrants based on bibliographic sources rather than traditional or routine data sources at the national level as the ones presented below.
- **Traditional or routine data sources at the national level**:
    - **Civil registration, vital statistics and population censuses**: this type of administrative sources can, according to the IOM Data Portal, provide information on the births and deaths (and cause of deaths) of people, as well as length of

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[34] At the end of April 2019, a dedicated section on migration in Europe prepared by the European Commission's Knowledge Centre on Migration and Demography was released on IOM's Global Migration Data Portal/. See: https://migrationdataportal.org/themes/migration-and-health#data-sources

[35] WHO (2018). Report on the health of refugees and migrants in the WHO European Region. No Public Health without refugee and migrant health. Available from: https://apps.who.int/iris/bitstream/handle/10665/311347/9789289053846-eng.pdf?sequence=1&isAllowed=y

stay/date of entry into a country, citizenship status and country of birth. The data would identify migrants and could be used to analyse health outcomes based on these variables. This type of data sources, however, are not viable for the assessment of the health status of newly arrived migrants for the purposes of the present study. The information on health status based on cause of death of those migrants who have arrived in Europe after 2015 and died within the first year of arrival does not provide enough information on, and cannot be translated to, the health status of those who are still alive.

  - **Household surveys:** the IOM Data Portal refers to the Demographic and Health Surveys (DHSs) and the Living Standards Measurement Study (LSMS). These surveys do not collect data that is relevant for the study. DHS does not cover European countries.[36]
  - **Health Institution-based records and disease registers:** national hospital data and national epidemiological disease surveillance systems collect information on diseases, conditions and outbreaks that may affect public health. Similar to the findings of the present study, the IOM points out that most providers and insurers do not routinely collect data by legal status or on the national origin of the cases registered. The IOM Data Portal suggests that name-based algorithms have been used as an aetiological tool to "data-mine" such registries, for example in cancer registries. However, such an approach would not be appropriate for this study.
  - **Vertical disease control programmes:** vertical programmes are "so called because they are directed, supervised, and executed, either wholly or to a great extent, by a specialized service using dedicated health workers" for a given health problem.[37] According to the IOM Data Portal, national disease control programmes for Tuberculosis, HIV and Malaria are collecting data on migrant and mobile population groups. Many countries have mandatory Tuberculosis screenings for migrants and asylum seekers in place.[38] In the eastern part of the WHO European Region many states have sanitary-epidemiological systems, while the public health services in the Netherlands operate as a vertical column with limited involvement of primary health care services.[39] In Europe, the European Centre for Disease Prevention and Control (ECDC) carries out studies specifically targeted to assess the prevalence of STDs across the migrant population. On the national level, in Finland a study has been carried out specifically targeted at identifying the prevalence of immunity again vaccine-preventable diseases among adult asylum seekers.
  - **Foreign employment bureaus and migrant worker welfare agencies:** these sources may capture data on health insurance claims of migrant workers (indicating morbidities), mortality (in case of migrant worker deaths) and data on deportations based on medical grounds. These sources have been contacted when referred by national sources (Ministry of Health or Ministry of Interior).

- **Non-traditional or agency-based sources:**
  - The **Migration Integration Policy Index (MIPEX) Health Strand** is an example of a metric (38 indicators) that aggregates multiple indices defined by a broad expert group (over 100 experts involved in the development, piloting and implementation), for 48 countries as bench mark for measuring the equitability of a country's policies relating to the health of migrants, and including policies related

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[36] See country coverage following this link: https://dhsprogram.com/What-We-Do/survey-search.cfm?pgtype=main&SrvyTp=country

[37] See https://www.who.int/management/district/services/WhenDoVerticalProgrammesPlaceHealthSystems.pdf. P. 3.

[38] See e.g. https://erj.ersjournals.com/content/27/4/801

[39] See https://www.who.int/management/district/services/WhenDoVerticalProgrammesPlaceHealthSystems.pdf

to data collection and research. Representatives of the MIPEX Health strand have been consulted for the study and results of which are presented in Section 2.2.

  - **Research studies and reviews on the health of migrants at national level** are excluded from the study, although they have been screened for locating potentially relevant data sources and ad-hoc data collection related to the health status of migrants.
  - **IOMs own sources,** referenced in the Migration Data Portal, have been consulted as part of the study.

In addition to potential data sources listed above, additional sources have been consulted as part of the study, such as EU-level sources (ECDC, Eurostat), as well as potential sources in the national administration across all 33 countries, in particular ministries of health and interior, public health agencies, and national statistical offices.

Email consultation with key sources and stakeholders

The first contact with stakeholder institutions was primarily established via email. The email included a detailed introduction to the study, as well as data usage protocol. In addition, the second wave of mails included a link to the online questionnaire.

In total, 423 unique contacts were made via email. Of those, 223 contacts did not reply, while 200 contacts reacted: 41 contacts completed the survey, 10 contacts were interviewed, and 149 contacts preferred to respond via mail. A majority of data sources (153) stated that they do not collect relevant data or that their data would not fulfil the requirements/inclusion criteria (timeframe, migration status, time of arrival to the EU/EEA) specified for the study.

Online questionnaire to identify further sources and request health data

To reach as many organisations as possible, especially at the national level, sources identified during the initial desk-based research have been invited to either reply directly or fill in an **online questionnaire**. Through this online consultation or "request for data", both EU and national-level organisations from all countries within the scope of the study were targeted. The online consultation was "live" between 26th January until 26th August 2019.

The online questionnaire was deployed with the primary purpose of contacting identified sources to gain understanding of the health information that they may have and its availability for use in this study. The list of questions included in the online questionnaire is presented in Annex 4.3.

In addition, the online questionnaire was used to ask respondents to name or forward the link to the questionnaire to other organisations or partners active in the field of health assessment of migrants and refugees (**snowball technique** or chain referral). In total, **41 organisations responded to the survey** (excluding duplicates and empty submission).

Interviews and initial contacts with key sources and stakeholders

In addition to identifying sources through desk research and subsequently contacting them through emails and inviting them to respond to the online consultation, telephone interviews were held with selected stakeholders, including:

- **Potential data holders**: in order to gain better understanding of the issues surrounding data collection on migrant health, and more specifically to (1) better understand the type of information that is collected and recorded by them and (2) to request whether this data can be shared / whether access to the data can be obtained for the purpose of this assignment.

- Key **stakeholders who do not hold relevant data themselves**, but who have knowledge of the different organisations that record and collect data on the health status of migrants at EU or national level. The **purpose** of these contacts was to validate identified sources and to obtain directions for identifying further sources.

The main objective of the interviews was to i) achieve a better understanding of the respective data availability of the organisations regarding migrant health data and ii) get directed towards the most relevant potential data and information sources in the field. The interviews were based on an ad-hoc developed questionnaire (see Annex 5.3) and were semi-structured to keep a certain degree of flexibility to fit the respective interview partners. In total, **10 stakeholder interviews** were conducted with organisations that had been identified to have undertaken extensive pieces of research in the field of migrants' health in the past. Two European Union institutions, one international NGO, one international research group, four national research institutions as well two national public authorities have been interviewed. The purpose of the interviews was primarily to discuss ongoing and past research projects and data collections, and secondarily to seek guidance towards valuable potential data sources.

Workshop with key stakeholders

Based on the preliminary results of the identification of data sources, and after carefully reviewing the most relevant sources, the study team, DG SANTE and Chafea selected 59 stakeholders of the most relevant sources to participate in the expert workshop. The workshop with key stakeholders had originally the objective to verify the selection of health information under Work Package 1 and to review and contribute to refining the methodology for the analysis under Work Package 2. However, as the study team experienced significant difficulties in identifying relevant data sources and receiving responses from the organisations contacted, the focus of the workshop discussion was changed into a collective intelligence exercise on what sources may be systematically collecting data in Europe, and to highlight studies in several Member States that may include some of the data requested for the study.

The workshop was organised in Brussels on 28 March 2019 to present to the stakeholders the initial results of the identification of sources, to assess the current approach and to receive advice regarding further strategies and the verification of findings with experts in the field.

The **specific objectives of the workshop** were defined as:

- Verifying existing and available primary data sources and identify routinely data collection at EU country level which enables the health status assessment of migrants upon arrival in Europe.
- Seeking expert and stakeholder consensus on implementation aspects related to systematic data collection and analysis.
- Seeking expert and stakeholder advice on whether the assessment of the health status of newly arrived migrants and refugees is feasible with the available data.

The workshop was attended by participants from 19 organisations, representing international organisations, NGOs, national health and migration authorities and academics from a diverse and varied range of Member States and additional countries within the scope of the study. These included Belgium, the Czech Republic, Denmark, France, Finland, Germany, Greece, Italy, the Netherlands, Norway, Portugal, Spain, Sweden and the UK.

The questions discussed at the workshop were as follows:

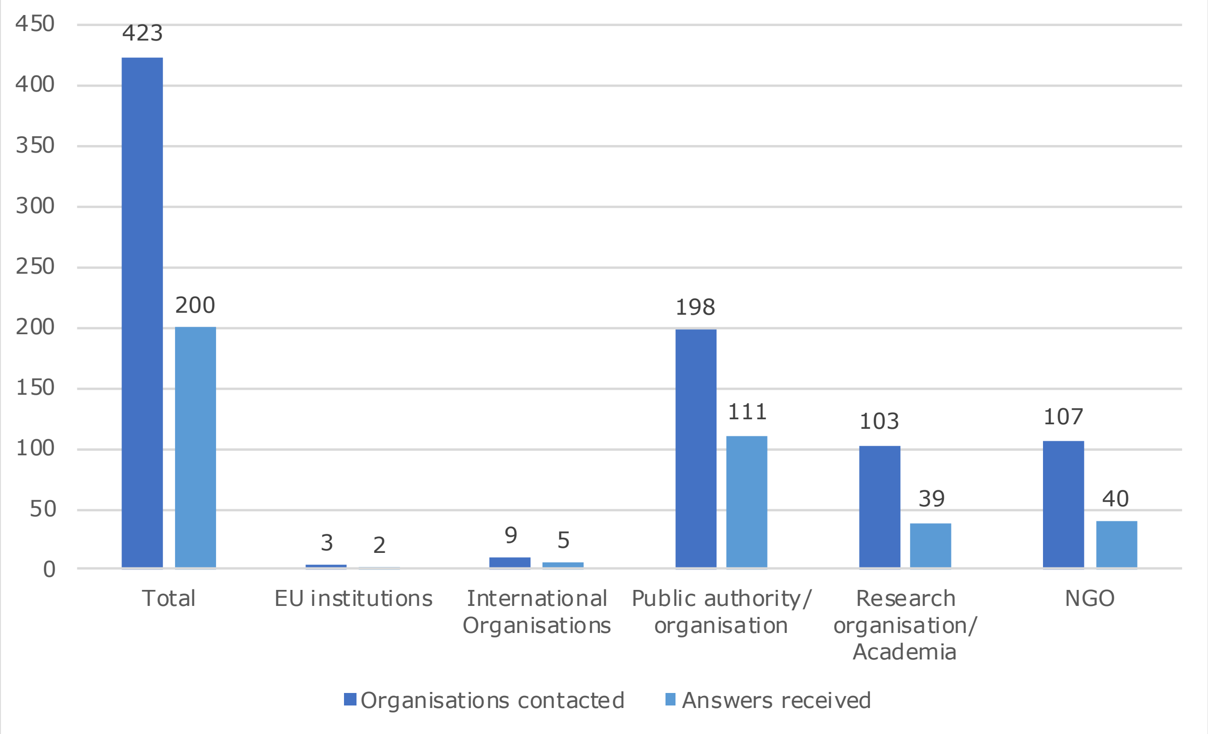
Table 1:Overview of questions discussed at stakeholder workshop

Session 1 – Mapping of sources across Europe	**Session 2 – Implementation of systematic data collection**	**Session 3 – Methodology for assessing health status of migrants**
• Have we identified all potential sources? • What other sources may be systematically collecting data in Europe? • Where should we focus our efforts over the next weeks to have a comprehensive list of data sources?	• What health indicators should be monitored? • What are the current barriers and facilitators to data collection?	• How can we use the available data to assess the health status of migrants and refugees?

Summary of the extent of the stakeholder consultation

Broken down by stakeholder group, the figure below summarises the extent of the stakeholder consultation. The number of responses refers to the number of responses received through email, survey or online conversation. The responses contained information on whether the respective organisation collected data or not, whether they could refer the study team to a potential data holder, or whether they could provide the study team with relevant data.

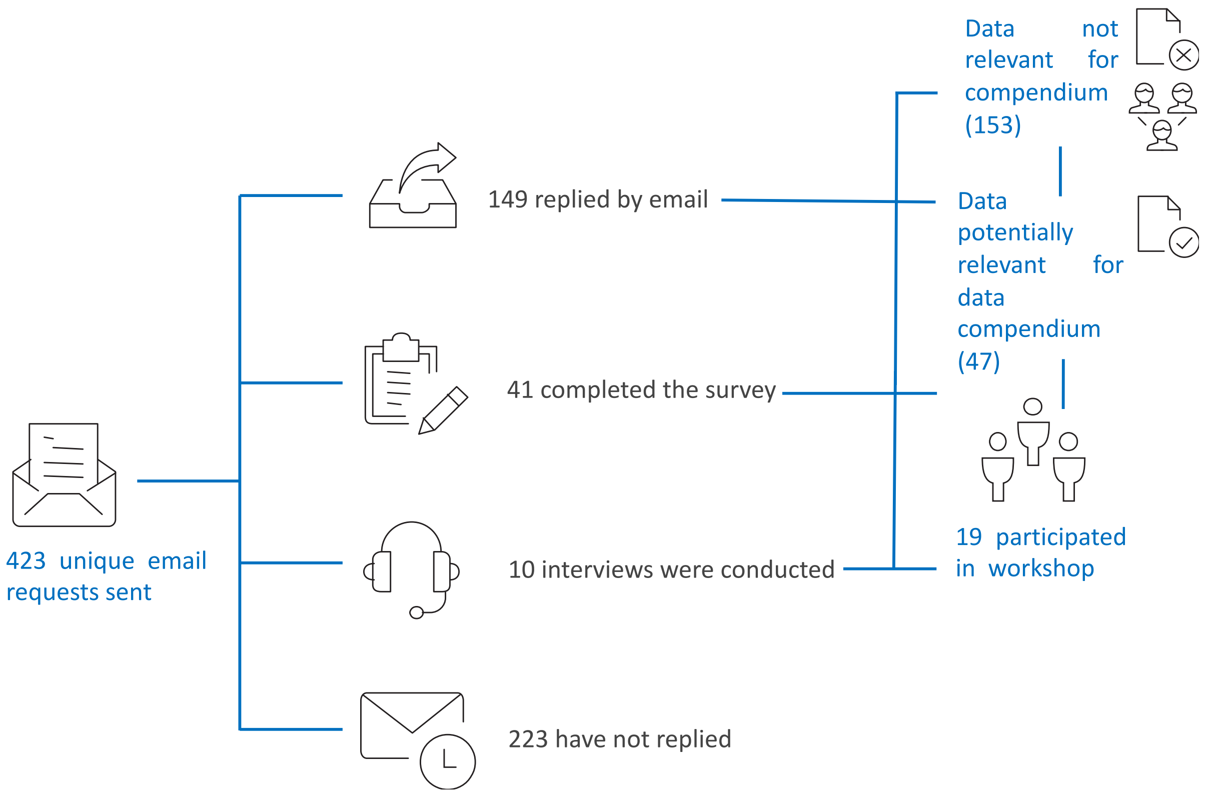
Figure 3: Number of requests sent and responses received by stakeholder group



Source: Optimity Advisors

Broken down into further detail, through the methods described above, the study team has made the following requests and received the following responses:

Figure 4: Breakdown of stakeholder engagement activities



Source: Optimity Advisors

The results of the stakeholder consultation, in particular the most promising data sources and data sets to conduct an assessment of the health status of migrants, are presented in the following sections. For each of the sources consulted, information provided has been collated in an Excel file and presented in the Data Compendium (D1).

The information collated for each potential source include: name and location of the organisation, the type of entity (i.e. whether public authority, international organisation, NGO, etc.), the level of operation (local, regional, national, or international), as well as the country of operation. In addition, for those sources relevant for inclusion in the study, the Data Compendium also outlines the characteristics of the data, the source through which the data source was identified, and whether it was included in the study for further analysis.

3. OVERVIEW OF AVAILABLE DATA SOURCES

This section provides an overview of the findings of the different data collection approaches. It also provides a summary of the information acquired through the email, interview and online consultations, and presents a list of sources selected and screened for data analysis in accordance with the requirements for inclusion in this study, as discussed earlier. Finally, this section discusses the findings of data collected for final data analysis.

3.1. Information gathered through the different consultations

Interviews were conducted with ten stakeholder organisations who had been identified to have undertaken extensive pieces of research in the field of migrants' health in the past. Two European Union institutions, one international NGO, one international research group, four national research institutions as well two national public authorities have been interviewed. The purpose of the interviews was primarily to discuss ongoing and past research projects and data collections, and secondarily to seek guidance towards valuable potential data sources.

Summary of stakeholder interviews

All interviewees pointed out that they were not aware of any systematic data sources on the health status of migrants at EU or national level, in particular in relation to the definition of migrant for this study (i.e. any person residing in Europe that does not hold an EU/EEA passport) and data pertaining to the first year of arrival. It was mentioned that it may take up to two years for data collected to be cleaned and analysed, even if it has been routinely collected, meaning that the most recent available data may be from 2017. One of the interviewees also mentioned that in Nordic countries (e.g. Norway), even when relevant data about migration status and health information is collected by administrative sources (i.e. municipalities), these data are not analysed routinely by the source. They are made available to academic institutions upon request.

The **European Centre of Disease Prevention and Control's (ECDC)** representative referred to previous work on epidemiology of HIV among migrants, which makes up ca. 40 percent of all new infections. Since 2016/17, the ECDC has created a migrant health task force. The interview partner recommended to look at the ECDC's systematic reviews assessing the burden of diseases among migrants looking at the TESSy database. The best data availability exists for HIV prevalence, which is mandatory to be reported to the national Centres of Disease Prevention and Control's (CDCs). Data up to 2017 may become available in the near future. In addition to data on HIV, the ECDC collects data on other communicable diseases, such as other STDs, TB, etc. The ECDC recommends and advocates the use of the country of birth as the most valid and uncomplicated identifier for the migration status to be able to assess the health status of migrants in the EU/EEA. However, the ECDC does not collect the time of arrival to the destination countries in a systematic way.

A representative from **Eurostat** explained that the statistical office of the European Union mainly collects information on health care administrative data, including hospital resources, hospital activities, morbidity and causes of death. The migration status is not collected directly. The only information Eurostat collects regarding the origin of patients is the place of residency of a patient, with no information about where the respective person is from originally. It is therefore difficult to draw conclusions on migrants' health from Eurostat data. Including new variables in data collection at EU level is possible but the implementation is complex: comparable data need to be available across Member States and usually the inclusion of new variables means other variables are excluded to keep the collation of data manageable. According to the interviewee, the most important variables to look at in the future would be the vaccination status, diagnosis-based morbidity and self-perceived health.

Other interviewees highlighted the lack of aligned data collection in the European Union. One of the interview partners based in Norway mentioned that in particular in countries with relatively low rates of immigration, the interest in collecting data on migrant health is relatively low. It was recommended to look at Nordic countries, which have well developed systems for collection of health-related data, in particular patient registries and systematic data collection at municipal level. Germany and Greece were also mentioned as countries that may be collecting relevant data in a systematic manner.[40] The interview partner pointed to relevant organisations to be contacted for data collection, including the national branches of Médicins du Monde as well as the WHO and the UCL-Lancet Commission, which have issued significant reports on the topic of migrant health.

A representative from the **UCL-Lancet Commission** was present at the stakeholder workshop and was interviewed in order to get a better understanding of the work of the Commission. Their very recent report titled "The UCL–Lancet Commission on Migration and Health: the health of a world on the move" is a synthesis of existing evidence found in several research databases. The report is thus mainly written by applying meta-analysis with a few case studies to highlight important aspects of migrant health. During the interview, barriers such as the lack of disaggregation of migration data or the insufficient differentiation of forms of migration, e.g. between students, migrant workers or asylum seekers, was discussed. In addition, the interview partner emphasised that refugee health checks are regularly conducted in the United Kingdom, but not always followed up with subsequent healthcare provisions. In addition, the insufficiency of chest rays to identify Tuberculosis accurately was mentioned. The potential introduction of separate and vertical health systems for specific populations was discussed as a suboptimal and expensive solution, while the importance to tend to the special needs of certain groups of migrants was raised. In addition, trust-building efforts were highlighted as positive measures to reduce the fear of undocumented migrants to access services and increase the level of information on migrant health.

Médicins du Monde (MdM), also present at the stakeholder workshop, mentioned in a follow-up conversation that they would be willing to provide data relevant to the study collected by the organisation, some of which has been published in the 2017 European Observatory Report "Falling through the cracks: The Failure of Universal Healthcare Coverage in Europe", produced by the European Network to Reduce Vulnerabilities in Health.[41] The report is based on testimonies and data collected from 43,286 people attending programmes run by MdM and partner NGOs across Europe: Belgium, France, Germany, Greece, Ireland, Luxembourg, Netherlands, Norway, Romania, Slovenia, Spain, Sweden, and United Kingdom. Switzerland is also included in the Observatory Report, although it is excluded from the present study. The local branches of MdM gave their consent to share part of the data and information relevant to the present study in a meeting in Spain. MdM agreed to share aggregated data recorded at their centres of operation from 2015 to 2018. The data includes information on communicable diseases such as Hepatitis B, MMR, Whooping cough/Pertussis and Tetanus as well as on non-communicable diseases such as Cancer, Diabetes, COPD, Asthma, Dementia, Cardiovascular Diseases and on psychological pathologies. Data for other countries of operation has not been received at the date of submission of the report (August 2019).

At national level, one of the organisations contacted in **Germany**, the Robert-Koch-Institute (RKI), collects data on migrants' country of birth, time of arrival in Germany and indicators on some diseases and the general health status perception in their national health survey. However, only a small number of newly arrived migrants and refugees is collected in the last iteration, ending in 2017. More relevant data was collected within the IMIRA-project in 2017, which sampled individuals of Syrian nationality to conduct a survey according to the European Health Interview Survey (EHIS) framework in addition to complementing health and disease prevalence questions.[42] At the end of 2019, data will be available to be shared. The interview partner also directed the study team towards the work of Oliver Razum and Kayvan Bozorgmehr of the University of Heidelberg and the University of Bielefeld[43]. Oliver Razum and Kayvan Bozorgmehr have recently worked on a project on the "improvement of the data on the health and primary medical care of

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[40] In a conversation with the Robert-Koch-Institute, the study team was pointed towards concrete research projects that have been and are currently conducted in Germany, e.g. the IAB-SOEP migration sample. In Greece, Médecins Sans Frontières collects raw data on refugee health, which can partly be shared.

[41] Report accessible from: https://mdmeuroblog.files.wordpress.com/2014/01/observatory-report-2017-web-version.pdf

[42] https://www.rki.de/DE/Content/Gesundheitsmonitoring/Themen/Migration/IMIRA/IMIRA_node.html (German)

[43] At the time of submission of this report, the study team has pursued to schedule an interview with both researchers to learn more about the availability of migrant health data in Germany, but so far were not successful in getting a response to the requests.

asylum seekers in initial reception centres in Germany".[44] In addition, they did a systematic mapping of empirical studies on migrant health in Germany, but only up to 2014 (outside the scope of this study).[45] The RKI also plans a survey with 7,500 individuals coming from Turkey, Poland, Croatia, Romania and Syria (the biggest migrant groups in Germany).

In an interview with a representative from the National Institute for Health and Welfare (THL) in **Finland**, two studies were discussed in more detail: The Asylum Seekers Health and Wellbeing Survey (TERTTU-Survey) as well as the Immunity Against Vaccine Preventable Diseases (VPD) Study. For the TERTTU-survey, 1087 participants were surveyed, with a 76 percent response rate, which is considered a good yield. The response rate of unaccompanied minors was considerably lower, situated only at 30 percent. The interview partner recommended a separate study for this group since particular ethical considerations as well as other specific requirements, such as recruiting issues, apply. Especially logistics, privacy considerations and data input were described as time-consuming exercises during the conduct of the study. The interview partner therefore described such an effort as only feasible with the appropriate infrastructure in a country. The Immunity Against VPD Study was conducted in parallel and used the same network of individuals. The study will continue over the summer of 2019, while facing challenges such as different logistical systems in place in each reception centre and difficulties in the recruitment of participants. General learnings from both studies were: to take time into account for planning and implementation of the study; to use networks; to bring experience in conducting population-based surveys among migrants; and to provide a multi-lingual study team.

To get a better understanding about the situation of migration and health in **Norway**, the study team spoke with an expert in migrant health at the Norwegian Institute of Public Health. The respondent reported about the decentralised situation of accommodation for asylum seekers in Norway and the effort to distribute asylum seekers across the country rather than in metropolitan areas such as Oslo. According to the interview partner, 2/3 of the healthcare costs are borne by the state, while patients have to cover 1/3 of the payments. However, above a certain threshold cap, additional costs do not have to be covered by the patients anymore. Similar to the UK, Tuberculosis tests are mandatory in Norway. Referrals to specialists are done by GPs and waiting times for certain specialists, such as psychiatrists, could be very long. The interview partner reported that the most robust data was collected for communicable diseases, although the collected data would not allow for a further differentiation other than the immigration status. The respondent therefore advised the study team to contact the statistical department of Norway.

In another interview with two researchers in **Norway,** the study team was informed about the Changing Health and health care needs Along the Syrian Refugees' Trajectories to Norway (CHART) study, which investigates the health situation of Syrian refugees with a longitudinal approach. Concretely, it looks at the self-reported health situation before departure from Lebanon (their first transit country) and within the first year of arrival in Norway. In addition, it looks at psychological trauma and long-lasting pain among refugees. The aim is to "contribute to a better foundation of evidence for development of high quality, equitable health care services – that also benefits newly arrived refugees."[46]

In **Spain**, a representative from the Ministry of Health pointed out that the health care statistics collected by the organisation with regard to morbidity may include whether the data pertains to Spanish nationals or foreign-born citizens. However, this information does not reflect whether the foreign born comes from another EU country or a third country, nor provides their legal status. In the data set there is no date of arrival in Spain, and it cannot be filtered to take account of the time scope of this present study (from 2015 onwards). The Ministry of Health received information from the Ministry of the Interior with regard to the number of refugees who hold a health card, but this information does not provide information about their health status. Therefore, the official health statistics managed by the Ministry do not have criteria on the migration status / date of arrival / state of health. The representative suggested to approach NGOs working in the field of health and refugees (e.g. Médecins du Monde, Red Cross), the Ministry for Labour Relations, or

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[44] See http://www.rki.de/DE/Content/Gesundheitsmonitoring/Gesundheitsberichterstattung/GBEDownloadsJ/JoHM_2017_01_gesundheitliche_lage1b.pdf?__blob=publicationFile (German)

[45] See https://link.springer.com/article/10.1007/s00103-016-2336-5 (German)

[46] See https://www.uib.no/en/generalpractice/chart

regional Ministries of Health. A representative from the Ministry of Labour relations also indicated that their General Directorate of Migration does not collect data relevant for the study.

In the UK, Public Health England (PHE) holds some relevant data as a public health agency, but does not collect data on migrants as per the study definition. The focus has generally been on ethnicity data rather than data based on migration status. The main data PHE collects that is of relevance for the present study is data on the around 5,000 refugees per year that are granted asylum in the UK as part of the resettlement scheme. In recent years, most of the refugees come from Syria, but not exclusively. The scheme is led by the Home Office (equivalent to the Ministry of Interior). The Home Office has commissioned the IOM to deliver the refugees' health assessment since 2013, and the IOM provides the data to PHE. It is important to note that the health assessment is conducted prior to the arrival in the UK, so it is not conducted on newly arrived migrants. The health assessment is comprehensive. It follows the IOM/European Commission's "Handbook for Health Professionals on the Health assessment of refugees and migrants in the EU/EEA"[47] and includes infectious and non-communicable diseases, mental health, mobility. Based on the assessment, infectious diseases are treated in the country of origin prior to the arrival, as well as the provision of vaccinations. The health assessment is also used to select and condition homes for refugees if, for example, they have mobility issues. The Home Office does some follow up of refugees once they have arrived in the UK, but usually more than a year after resettlement. Devolved responsibilities after arrival have been allocated to local authorities. PHE does not hold data after the arrival of refugees into the UK. Any data collected after arrival may be held by the Home Office. PHE occasionally looks at the data to inform changes to the protocol due to operational needs and meeting the health needs of the target population. The data is not routinely assessed but used as a resource as needed. A publication on the analysis of a cohort of refugees (n = 18,418) who underwent the comprehensive pre-entry health assessment between March 2013 and August 2017 is available.[48]

PHE has also a very good surveillance systems for TB in England[49] and HIV in the UK[50]. The TB data collected ask about place of birth, but information on when migrants have moved to the UK in not available. According to the data, more than 70 percent of newly diagnosed TB cases and more than 60 percent of HIV are on people born abroad. Annual reports are produced and publicly published with associated data tables. Visa applicants are screened for TB and the data may be managed by the Home Office.

PHE has also informed the study team of a pilot study using the ehealth record EMIS system. The system has a function to track those who are newly registered with a GP practice and are born in another country. Alerts for TB screening and vaccines are being piloted currently in some general practices and have the potential of being rolled out in the future if successful.

Summary of online consultation

The online consultation presented an opportunity to gather information on the extent to which the responding organisations collect data on the health status of migrants and refugees in a systematic manner. The online consultation also provided the study team with qualitative information about the quality of the described data and further sources to contact. In addition, it made certain comparisons (e.g. about variables collected in different datasets) feasible, which is particularly

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[47] Available from: https://ec.europa.eu/health/sites/health/files/migrants/docs/handbook_healthprofessionals_en.pdf

[48] Crawshaw AF, Pareek M, Were J, Schillinger S, Gorbacheva O, Wickramage KP, et al. Infectious disease testing of UK-bound refugees: a population-based, cross-sectional study. BMC Medicine. 2018 Aug 28;16(1):143. Available from: https://doi.org/10.1186/s12916-018-1125-4

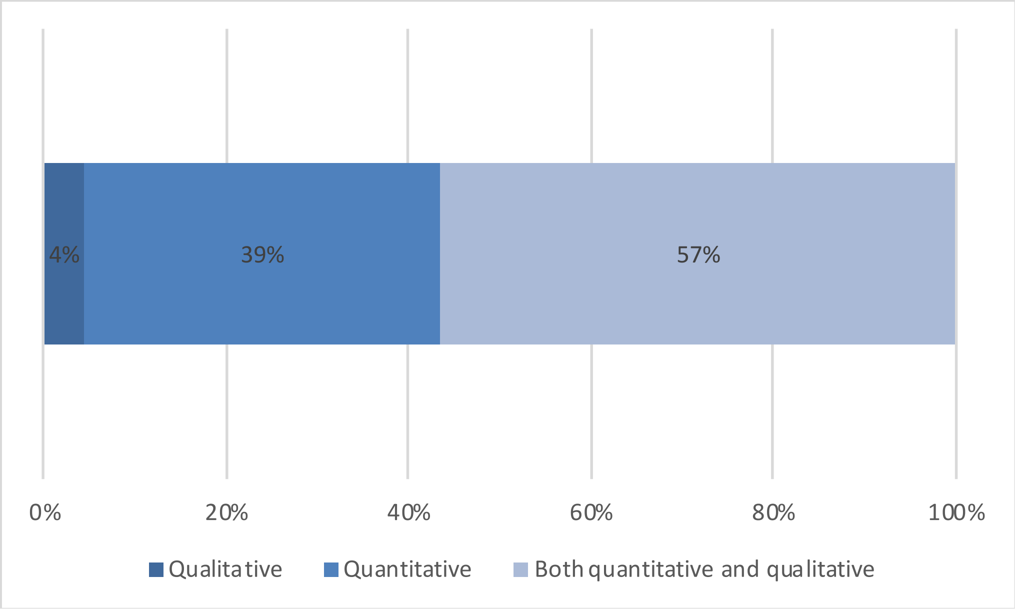
[49] Tuberculosis (TB) in England: surveillance data: https://www.gov.uk/government/publications/tuberculosis-tb-in-england-surveillance-data

[50] HIV: annual data tables: https://www.gov.uk/government/statistics/hiv-annual-data-tables

helpful given the dispersed data availability on the health status of migrants and refugees in Europe.

The online consultation illustrated that over a third of the responding organisations currently do collect or have collected data on migrants' health as part of their operations (in 15 cases out of 40 total responses to the specific question). Twelve of 40 responding organisations do so for the purpose of a specific piece of research, while three of the 40 responding organisations record data to measure their own performance. Thirteen of the 40 organisations have answered that they never collected data on migrants' health. Ten of 26 organisations who answered the specific question stated that they could share analysed/synthesised data with the study team or the European Commission. Six of the responding organisations were not able to share data at all. One organisation stated it only collects qualitative data, nine organisations stated they record only quantitative data, while 13 organisations collect both qualitative and quantitative data (based on 23 valid answers to the question). Almost two-thirds of the organisations that responded to the online consultation collect the data employed for their analysis themselves (17 cases out of 24 valid responses to the specific question), while the remaining seven organisations rely on other sources.

Figure 5: Nature of health information the datasets/studies collected (23 responses)



Source: Findings from online consultation

According to the survey, 12 out of 24 institutions responding to the specific question collect data that cover the years preceding 2015. Seventeen organisations stated they would hold information from the year 2015, while 16 organisations stated that health information would be available for the years of 2016 and 2017 respectively. Finally, 18 of the 24 responding organisations hold data from the year 2018. The majority of the data are focused on asylum seekers and refugees (16 as well as 14 valid responses to the specific question respectively). Little data are collected on migrants coming to the EU for work or on study visas (8 out of 24 valid responses to the specific question). Recording of data is mainly done through interviews / surveys being conducted as part of a piece of research (8 out of 23 valid responses to the specific question) as well as through general health assessments in reception facilities and healthcare facilities for asylum seekers and refugees (9 as well as 5 out of 24 valid responses to the specific question).[51]

The available datasets appear to generally contain a comprehensive range of common demographic information, although the date of arrival of the individual in the EU is information that is less commonly available than information regarding gender/sex, date of birth, country of origin, nationality (note: the date of arrival in the EU has been collected in 6 cases out of 24 valid

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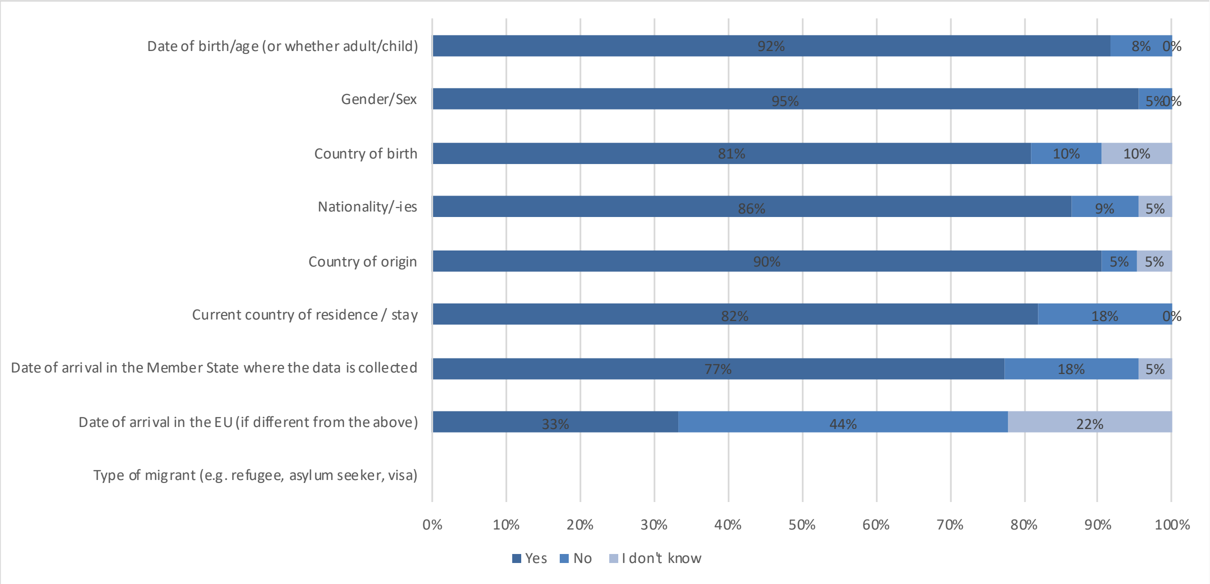
[51] Note that multiple answers were possible for this question.

responses to the specific question, while the arrival to the Member State was recorded in 17 out of 24 valid responses to the specific question).

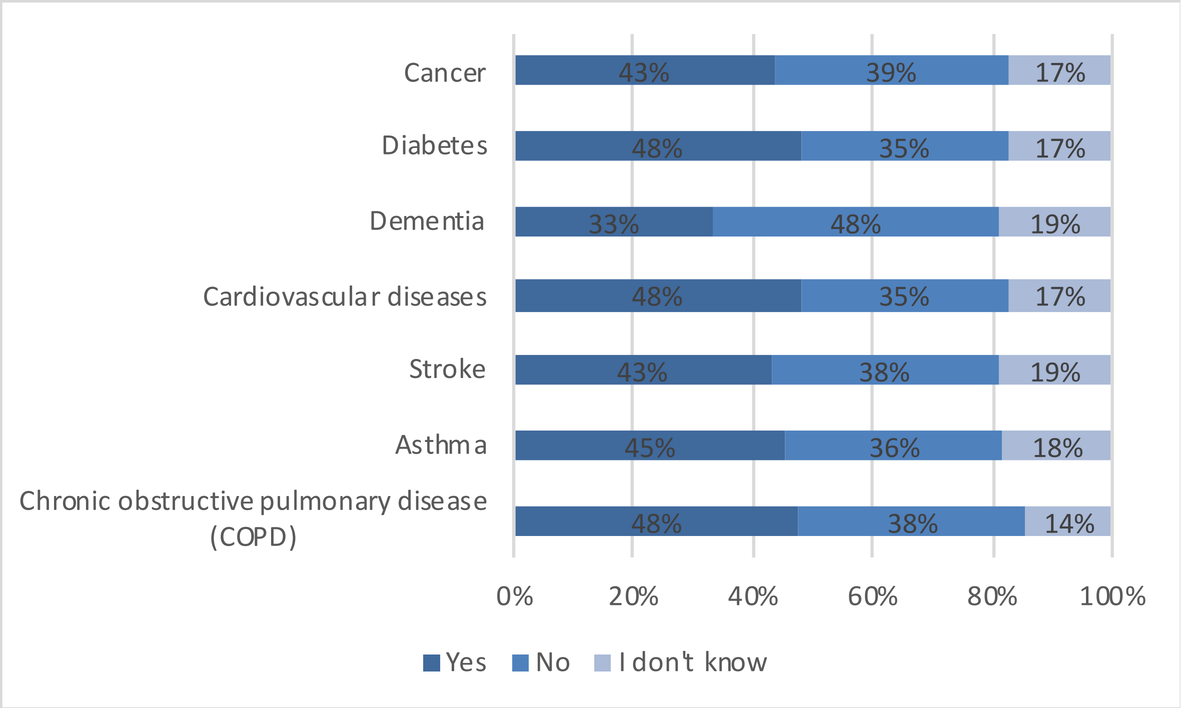
Figure 6: Number of datasets/studies collecting demographic information (24 responses)



Source: Findings from online consultation

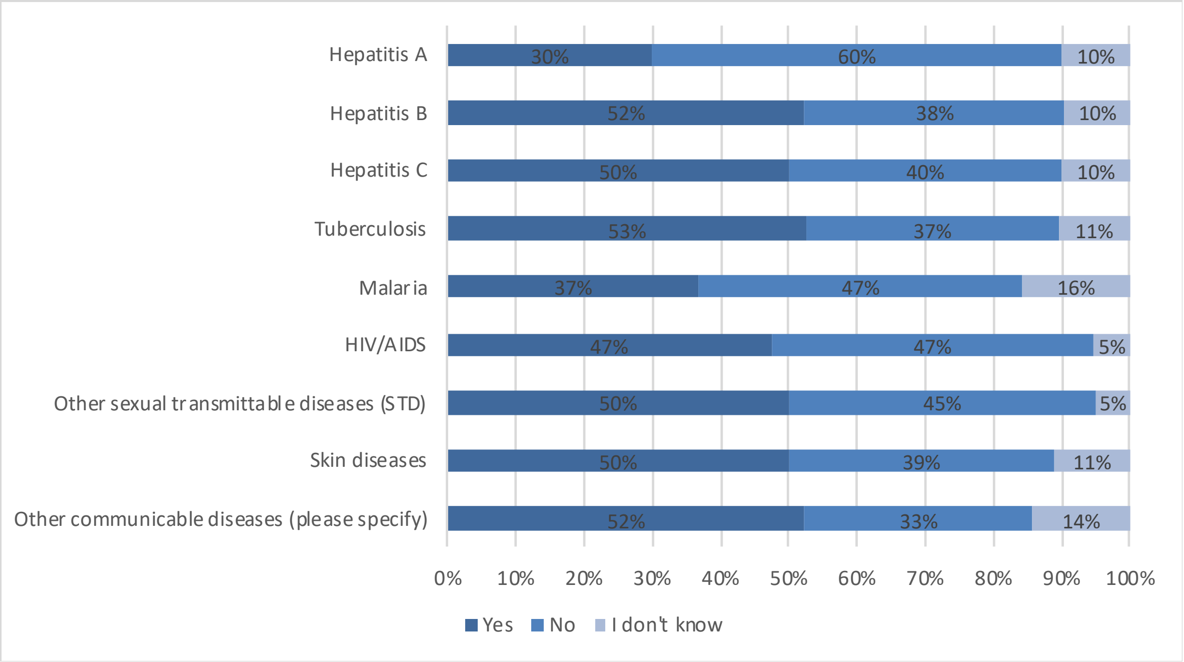
Overall, more organisations collect information regarding communicable diseases as opposed to non-communicable diseases. Mental health conditions, e.g. depression, PTSD, appear to be monitored amongst organisations at rates similar to common communicable diseases such as Hepatitis B and C (information on Hepatitis B and C are collected in 11 and 10 cases out of 23 valid responses respectively). More information on specific conditions can be found in the two Figures below.

Figure 7:Number of datasets/studies collecting information on specific non-communicable diseases (23 responses)



Source: Findings from online consultation

Figure 8: Number of datasets/studies collecting information on specific communicable diseases (23 responses)



Source: Findings from online consultation

Summary of stakeholder workshop

In the course of the stakeholder workshop, barriers that prevented a more conclusive data collection were discussed and potential remedying enablers were suggested. Notwithstanding the positive results of the workshop, presented in detail in Annex 2, the general consensus reached through the discussion was that **the availability of this highly specific data on the health status of migrants and refugees is limited and not aligned across borders.**

Although not central to the study, a theme that emerged at the workshop discussions involved the ethics and confidentiality of what data on the health status of migrants would be used for. The concept of a migrant-aware health system was also raised by participants at the workshop.

The main outputs of the workshop were:

- An initial validation of the organisations contacted across the 33 countries, at EU and at international level;
- Suggestions of several other potential data sources to be contacted by the study team; and more importantly,
- Agreement of participants to provide additional guidance to the study team beyond the workshop, by undertaking the following activities:
    - Share information on the data that their organisations collect and is relevant to the study;
    - Review again the organisations contacted in their country of residence to identify the right contact person in them;
    - Review and quality assure the country fiche for their country or residence or origin;
    - Utilise and leverage networks of participants.

In addition to the help in reviewing outputs of the study, the workshop helped in building trust with data-holding institutions to share information on the content of the data.

For the additional collaboration and support provided, the study team prepared and distributed among participants:

- The draft workshop report;
- The contact details of all participants after receiving their consent;
- A data usage protocol and research ethics guidance prepared by the study team (see Annex 4.4).

The workshop report is presented in Annex 2 and gives a concise summary of the most relevant themes and conclusions of the respective workshop sessions and an overview of potential data sources. The results of the workshop were collected in minutes and circulated among the participants after the event. The minutes are also presented in Annex 2.

After the workshop, the workshop summary was shared with all participants (on 24th April 2019). Participants were asked to send back any comments by 3rd May 2019, and to circulate the online questionnaire among national-level stakeholders in the country they were representing.

- At the time of the given deadline, only one participant had responded to the study team. Upon further contact, 4 participants were interviewed by the study team reading questions around data availability at national level.

3.2. Selected data sources for inclusion in the study

As outlined above, the study team experienced significant difficulties in identifying and selecting sources of health information to be used in the analysis of the health status of migrants and refugees. It was not the objective of the study to collect raw data or personal data of migrants and refugees. The study intended to identify existing datasets that contain processed and already analysed information on the health status of migrants. In addition, the study team was looking for data not yet processed or analysed in the context of a systemic collection in an establishment or system, as well as data from systematic health authorities' surveys. These principles were outlined by the study team in a data usage protocol (see Annex 4.4), as a result of the stakeholder workshop.

The results of the research conducted suggested that data on the status of migrants that would meet the requirements for inclusion in the study were not collected systematically by administrative sources. There is, however, some interesting, ad-hoc data collection, but access to those datasets is restricted. These restrictions are due to ethical considerations in certain countries, as often no special records on migrants and refugees can be created, or due to data protection issues. Further research confirmed these findings. For example, a DG JUST study from 2017 on the data collection in the field of ethnicity concluded that information is not collected on the grounds such as colour or racial origin across EU countries, and that data on ethnic origin and religion are collected on the basis of self-identification[52]. While such data are often essential to measure the level of implementation and monitor the impact of specific policies, these data collection measures (or lack thereof) regarding the situation of racial and ethnic minorities pose serious shortcomings.

As a consequence of the above, the stakeholder consultation focussed more on national-level sources. In addition, it was agreed that, as a minimum, the final report of the study would provide a "Compendium" of available data sources and studies with a summary of the main findings in relation to the health status of migrants that the data holders can infer from their data (where this is possible). The Compendium of data sources would contain a general description of the data that each source collects (if any) and an explanation of the data analysis and/or assessment of the health status of migrants as provided by the source.

In addition, the study team developed a set of selection criteria to apply to data sources to decide whether or not to include them in the analysis. The criteria developed for the selection of sources were adapted and tested to critically appraise the sources of information. The final criteria for appraising the health information sources in the Compendium are presented in the table below.

Table 2: Inclusion criteria

Inclusion criteria	Assessment
1. Does the dataset refer to the health status of migrants and refugees, defined at least as one of the following? a. Non-EU/EEA nationals: Regular migrants (e.g. travelling to EU with study visa or work permit; non-EU/EEA nationals who have received indefinite leave to remain or residence permit); b. Non-EU/EEA nationals: Asylum seekers c. Non-EU/EEA nationals: Refugees d. Non-EU/EEA nationals: Migrants arriving to the EU through family reunification	If YES, go to question 2 If NO, exclude

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[52] Farkas, Lilla (2017): Data collection in the field of ethnicity. European Commission, Directorate-General for Justice and Consumers, p. 4.

Inclusion criteria	Assessment
e. Non-EU/EEA nationals: Migrants held at the border or in detention centres (including rejected asylum seekers and detected "irregular" migrants); f. Non-EU/EEA nationals: Migrants staying in the EU in an "irregular" manner (e.g. overstaying visa).	
2. Has the data been collected after 2015?	If YES, go to question 3 If NO, exclude
3. Has the data been collected in the first year of arrival?	If YES, include in assessment If NO, exclude

The information collated for each potential source include: name and location of the organisation, the type of entity (i.e. whether public authority, international organisation, NGO, etc.), the level of operation (local, regional, national, or international), as well as the country of operation. In addition, for those sources relevant for inclusion in the study, the Data Compendium also outlines the characteristics of the data, the source through which the data source was identified, and whether it was included in the study for further analysis.

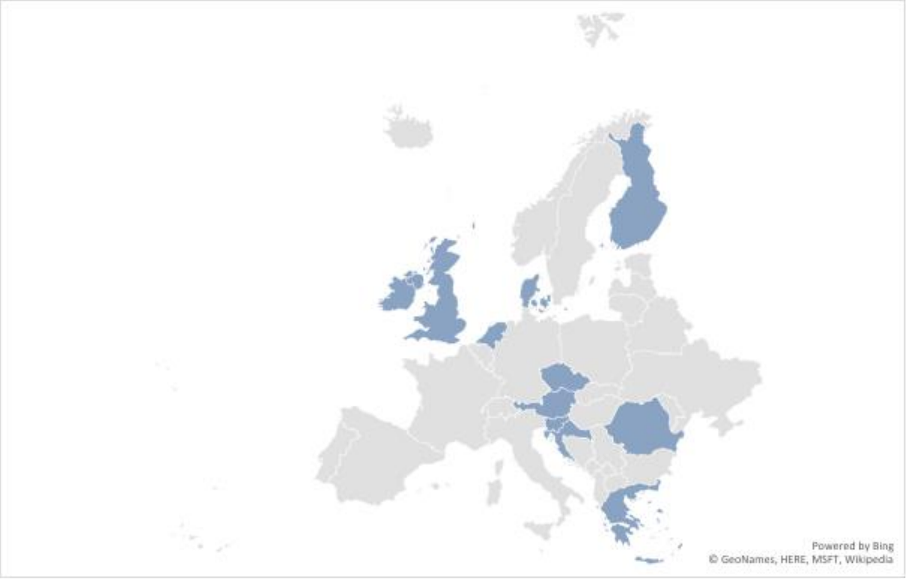
Selected data sources for inclusion in the study

The final list of data sources qualifying for inclusion in the study covers **47 organisations from 22 EU/EEA countries**, as well as from **two European institutions**, one **European NGO (umbrella organisation)**, **two international non-governmental organisations** and **two international organisations**.

The data sources presented in the Data Compendium have been screened for inclusion in the study against the criteria presented above. The sources that did not meet all the inclusion criteria and those that have not shared potentially relevant data with the study team, have been discarded from inclusion for further analysis. It is also important to note that some of the data identified that would meet the inclusion criteria, were not publicly available and could not be shared, despite the data usage protocol prepared by the study team (see Annex 5.4).

As a result, **16 data sources** from **12 European countries** were included in this report for the assessment of the health status of migrants and refugees. Countries from which the data sources included stem from are presented in the table below.

Figure 9: Countries for which data has been provided



Source: Optimity Advisors

Table 3: Data sources included in the assessment of the health status of migrants

Country	Organisation	Name/Description of data
Austria	Austrian Academy of Sciences and Vienna University of Business and Economics	• Refugee Health and Integration Survey (ReHIS)
Croatia	Médecins du Monde (MdM) Belgique office in Zagreb	• Anonymised data on health status of asylum seekers arriving or transiting through Croatia who have been provided with medical consultation by MdM
Czech Republic	Ministry of the Interior of the Czech Republic	• Summary of the epidemiological situation regarding the asylum seekers at the reception centres Praha – Ruzyně, Zastávka, the alien detention centres Bělá – Jezová, Vyšní Lhoty, Balková
Denmark	Dignity, a highly specialised NGO for the treatment of trauma-affected refugees	• Data from consultation with traumatised refugees collected by Dignity, an NGO for traumatised refugees

Country	Organisation	Name/Description of data
Finland	National Institute for Health and Welfare (THL)	• Asylum Seekers' Health and Wellbeing Survey (TERTTU) and Immunity Against Vaccine Preventable Diseases Study
Greece	Médecins Sans Frontieres (MSF) Greece	• Reports on activities on providing aid to migrants and asylum seekers in Greece in 2015, 2016, 2017 and 2018
Greece	Collective of researchers (Rojek, A.M., Gkolfinopoulou, K., Veizis, A. et al. (2018))	• "Clinical assessment is a neglected component of outbreak preparedness: evidence from refugee camps in Greece "
Greece	Collective of researchers (Ben Farhat et al. (2018))	• "Syrian refugees in Greece: experience with violence, mental health status, and access to information during the journey and while in Greece". Cross-sectional population-based quantitative survey combined with an explanatory qualitative study in eight sites in Greece during winter 2016/17.
Ireland	Health Services Executive (HSE)	• Data collected at Balseskin refugee reception centre in Ireland in the years 2016-2018
Ireland	Health Services Executive (HSE) /International Organisation for Migration (IOM)	• Medical examinations in Lebanon prior to travel to Ireland from 2015 to 2017
Malta	Ministry of Health (Malta)	• Data collected at reception centres in Malta
Netherlands	Social and Cultural Planning (SCP) and Research and Documentation Centre of the Ministry of Justice and Security	• Syrians in the Netherlands report
Netherlands	RIVM National Institute for Public and Environmental Health and GGD Groningen (Public health department in Groningen)	• TB entry screenings of migrants
Romania	Ministry of the Interior – General Directorate for Medical Emergency Management /	• Data on the number and predominant medical conditions of asylum seekers in Romania: Health assessment in

Country	Organisation	Name/Description of data
	General Inspectorate for Immigration	reception facility for asylum seekers/refugee camps
Slovenia	Government Office for the Support and Integration of Migrants	• Data from Medical examinations in 2018
United Kingdom	Public Health Wales	• Policy document on the basic health information on migrants in Wales

3.3. Synthesis of issues related to ad hoc data collection

One of the **main findings** of the extensive consultations was that, in general, **data on the health conditions of migrants and refugees is not recorded separately from the native population.** In some cases, datasets distinguish nationals from foreigners, but these latter usually include other EU citizens residing in the country. Distinguishing the records for migrants based on the date of arrival to focus only on newly arrived migrant is even more difficult, as this is information that is usually not recorded. This means that the majority of the data on newly arrived migrants focuses on health assessments of refugees applying for asylum (and this assessment is sometimes carried out prior to arrival in Europe) or migrants seen at reception centres. However, refugees and migrants seen in receptions centres are only a fraction of the newly arrived migrants in Europe as per the study definition.

Another key finding of the extensive consultation with the identified potential data sources is a **general absence of systematic data collection** of the health status of newly arrived migrants in the EU/EEA from 2015. Although data are collected by administrative sources about health status of the population, the identification of migrants as a sub-population group is not systematic. In addition, even where there is some identification of migrant status, the following common additional problems have been encountered:

- The definition of 'migrant' in identified datasets is different from the study definition of 'migrant', e.g. all foreign-born are considered migrants even if they are nationals of another EU Member State;
- Date of arrival is not recorded;
- Data on health status is collected through national surveys, not in a national database;
- Through disease registries it may be possible to monitor the health status of migrants in relation to some specific diseases (e.g. TB, HIV, cancer);
- Due to different variables in which datasets may capture the migration status (e.g. citizenship, country of birth, country of residency), comparability across countries is difficult.

The issues faced in the execution of this contract are not dissimilar to the issues encountered in previous attempts to assess the health status of migrants and refugees in Europe. In their Deliverable 9: recommendations for collecting migrant specific health data, the Migrant and Ethnic Health Observatory (MEHO) project reflects to what degree it has been possible to obtain migrant/ethnic specific health indicators and to what degree this was not feasible.[53] One of the objectives of the MEHO project was the development of indicators to monitor the health status of migrants in Europe by using existing health related databases and surveys. MEHO concluded that the "expectations of what could be possible were too large" and that, in reality, many problems occurred from the conception of an idea to the realisation, with the realisation being more moderate than expected. Issues faced include 1) problems related to definitions that made comparability of populations very challenging; 2) problems related to the unavailability of

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[53] See MEHO project Deliverable 9, available from: https://webgate.ec.europa.eu/chafea_pdb/assets/files/pdb/2005122/2005122_deliverable_9.pdf

migrant/ethnic specific health indicators in many countries because it is not allowed to register ethnicity or migrant status or because linkage of databases is not allowed; 3) obtaining an overview of existing data was a much larger effort than expected; 4) besides comparability of the study populations, difficulties were present when not registries but surveys were taken into consideration. In addition, and similarly to the present study, the MEHO project has observed that "country of birth" is the criterion mostly used to distinguish between migrant and native populations.

It is possible that within the organisations contacted many people responsible for the area of migrants' health and that, in the consultation, the right person or department in several organisations has not been contacted. This issue or risk has been mitigated as much as possible by following up with the organisations in several rounds of contacts, asking to be referred to the right contact or organisation if known, and through expert elicitation – asking again to be referred to the right contact and right organisation.

4. ASSESSMENT OF THE HEALTH STATUS OF MIGRANTS

The following section provides an analysis of the health status of migrants based on the individual data sources identified and provides detailed information on the collecting organisation and source of the data that has been identified to discuss the health status of migrants and refugees arriving in Europe after 2015. In addition, the section discusses information on the population under observation and investigates key findings of the specific datasets and studies identified. Finally, limitations of the respective data sources are outlined.

The data that is presented in this section has been provided by **16 organisations in 12 European countries**. Ten sources are official government sources, two from an international and one from a national NGO, and three sources are from research organisations / academia. Where data is presented in a table or graph format, the data source is stated below. Finally, the section presents a synthesis of the assessment. All data presented below have been sent back to the data providers for review and check for factual accuracy. The majority of data providers responded, indicated in footnotes for individual data sources, but in a minority of cases, no response was received.

Additional graphs and tables are included in Annex 6. These have been provided by the organisations listed below and have been determined to be of value to the study, but they are not crucial for the main data analysis presented in the following section.

4.1. Overview of selected data by country

Austria

Organisation: Austrian Academy of Sciences and Vienna University of Business and Economics [54]

Sources and Type of Source: Refugee Health and Integration Survey (ReHIS)[55]

Population under observation: Newly-arrived migrants from Syria, Iraq, Afghanistan and other countries in the year 2015. N=515 (73 females, 447 males).

Key Findings:

According to the survey, the study population was in a generally good health condition on a self-rated health scale from 1 ("very good") to 3-5 ("not good"). However, significant differences between men and women could be observed: While one in three women rated their health as "very good", 42 percent of the men did so. In contrast, 18 percent of the women rated their health as "not good", while only 14 percent of the men did so. In addition, men between 20-39 years were perceiving their health as better than men in the age group between 40-59 years. Refugees from Afghanistan and other countries less often perceived their health as being as good as Syrians. Educational attainment did not have a significant impact on self-perceived health. In comparison to the Austrian population, men of the age group of 20-39 displayed a slightly worse self-perceived health situation with 12 percent of the men reporting a health status that is "not good" in contrast to 7 percent of Austrian men. 17 percent of the migrant women in the same age group reported a health status that is "not good", while only 9 percent of Austrian women did so. Finally, 25 percent of the male refugees in the age group of 40-59 years reported a "not good" health status, in comparison to 21 percent of Austrian men.

Forty three percent of the women in the survey reported some form of depressive symptoms, while 32 percent of the men did so. 40 percent of the women reported symptoms of anxiety, in contrast to 29 percent of the men. The age comparison revealed that 53 percent of the 15-24 year olds

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[54] This analysis has been reviewed by the data providers of the Austrian Academy of Sciences.

[55] The ReHiS study uses the Austrian Health Interview Survey (ATHIS 2014) compare the health status of migrants to the general population.

displayed symptoms of depression or anxiety, while the age groups of 25-34 years (33 percent) and 35-44 years (35 percent) displayed far lower rates. Half the individuals in the age group of 45-60 years reported depression or anxiety symptoms.

Limitations*:* For this study, only refugees have been taken into account. Data can be accessed for scientific purposes at the Austrian Social Science Data Archive: doi:10.11587/7LX1BD. Self-rated health is highly subjective. Women are underrepresented in the sample.

Croatia

Organisation: Médecins du Monde (MdM) Belgique office in Zagreb[56]

Sources and Type of Source: Anonymised data on health status of asylum seekers arriving or transiting through Croatia who have been provided with medical consultation by MdM

Population under observation: Asylum seekers arriving or transiting through Croatia who have received medical attention by MdM; raw data; N=2249 (Men= 1667, Women=581, Not specified=1). Data is collected according to the International Classification of Primary Care (hereafter referred to as ICPC scheme). The data derived from the years 2016-2019.

Key findings:

Most of the individuals in the dataset are nationals of Afghanistan (565), Syria (487), Iraq (244) and Iran (237). A more detailed list of the distribution across nationalities can be found in the Figure below.

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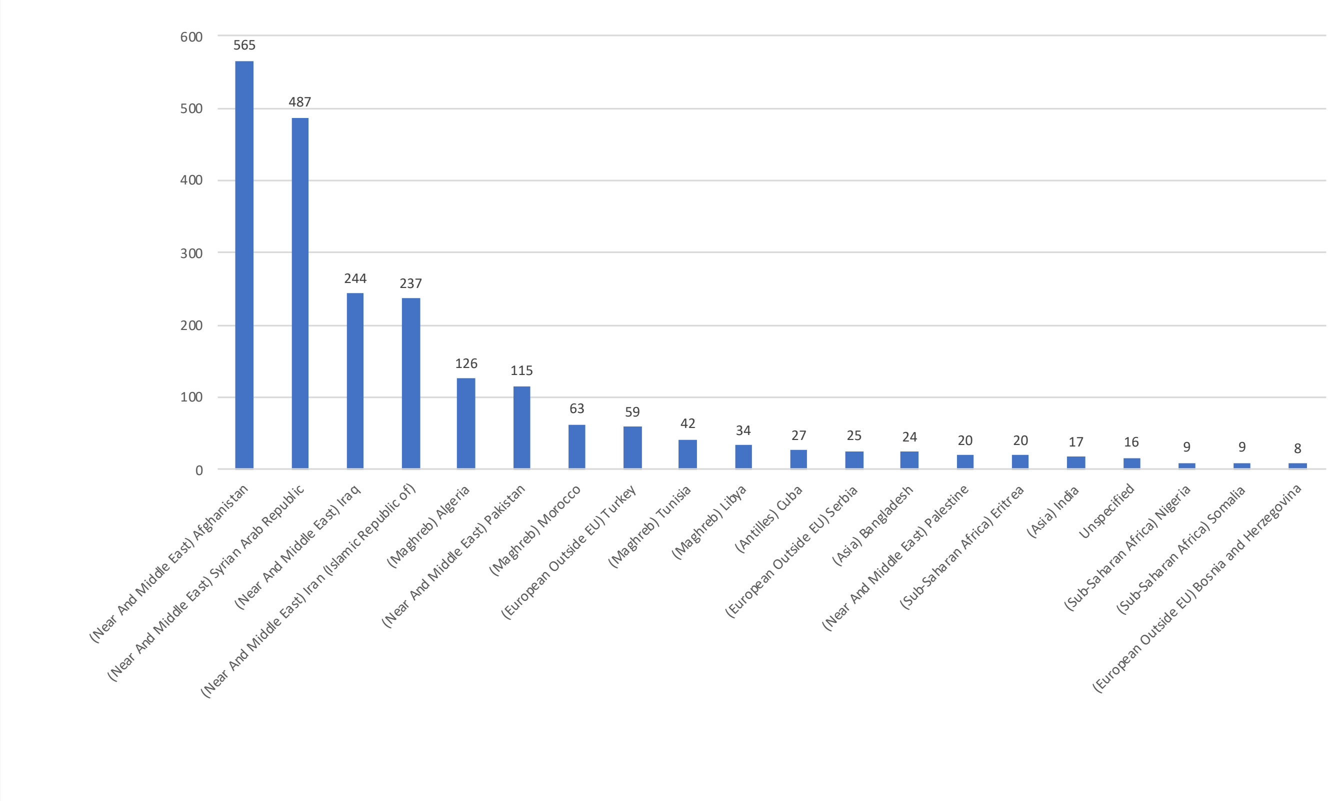
[56] The data analysis has been reviewed by the data providers of MdM.

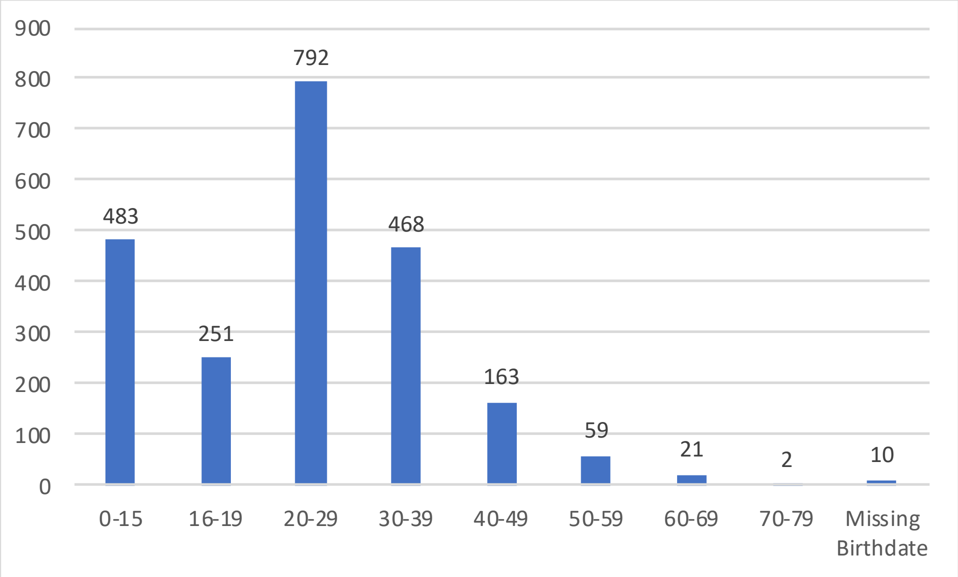
Figure 10: Graph displaying the number of asylum seekers having had medical consultations at MdM (Top 20 nationalities displayed)



Source: Own calculations of data on medical consultations provided by MdM Belgique – Croatia

As can be seen in Figure 11, individuals aged 20-29 years represented the biggest group of people (792), followed by underaged individuals between 0-15 years (483) as well as individuals aged 30-39 (468). Only 23 individuals were 60 or above years old upon their arrival to Croatia. This hints at a generally young population that received medical attention by MdM in Croatia.

Figure 11: Age groups of individuals seeking medical attention

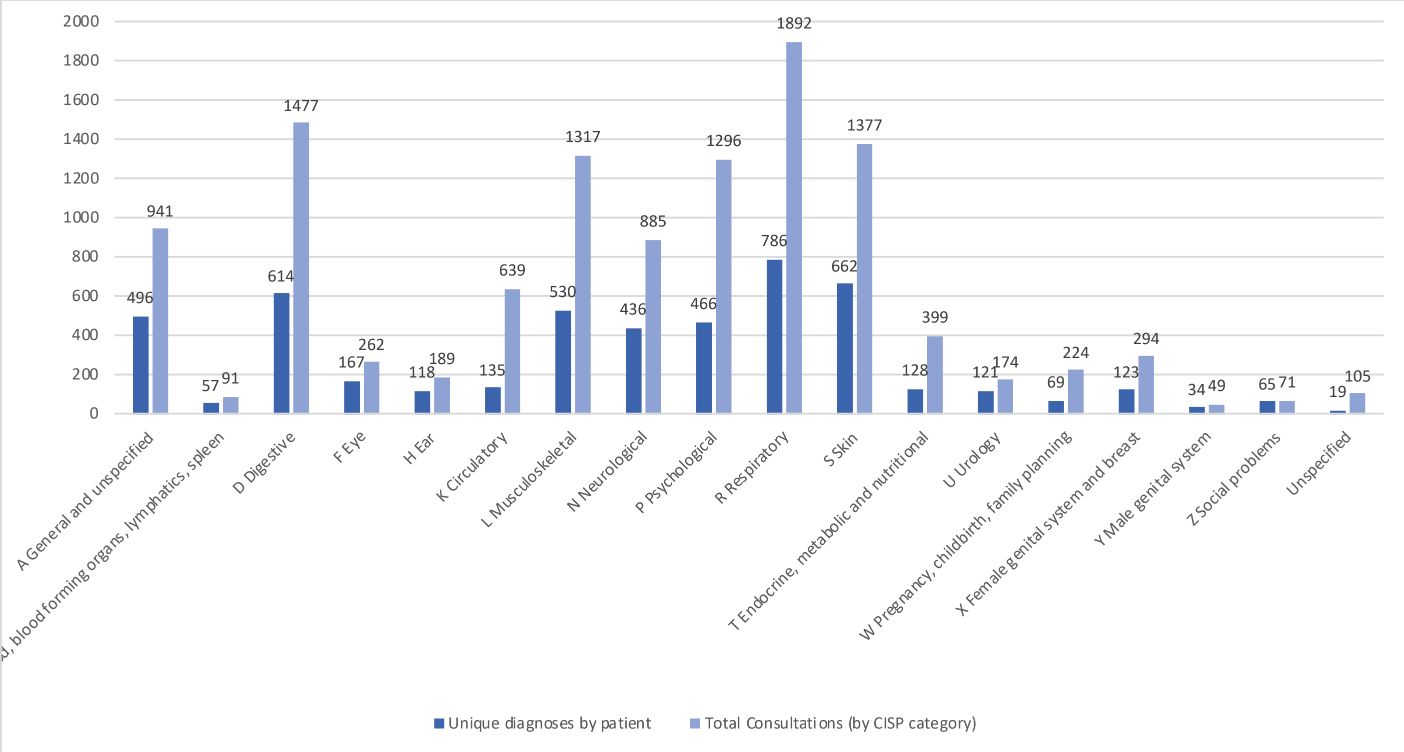


Source: Own calculations of data on medical consultations provided by MdM Belgique - Croatia

Figure 12 displays the most frequent conditions found among asylum seekers in MdM's dataset according to the ICPC. The dark blue bars display the number of cases by patient, while the light blue bars reveal the number of total consultations as per the respective conditions. The most frequent conditions found among asylum seekers in the dataset are respiratory conditions (786), followed by skin conditions (662) and digestive conditions (614). These are followed by musculoskeletal (530), general and unspecified (496), psychological (466) and neurological (436) conditions.

The conditions that accounted for the most total consultations have been respiratory (1892), digestive (1477), skin, musculoskeletal (1317) and psychological (1296) conditions. In total 11,682 examinations or treatments have been conducted in the time period between 18th August 2016 and 4th March 2019.

Figure 12: Number of medical conditions by ICPC found among asylum seekers in Croatia



Source: Own calculations of data on diagnostics provided by MdM Belgique – Croatia

Limitations: Data is not based on a representative sample, but derives from asylum seekers seeking medical attention.

Czech Republic

Organisation: Ministry of the Interior of the Czech Republic[57]

Sources and Type of Source: Summary of the epidemiological situation regarding the asylum seekers at the reception centres Praha – Ruzyně, Zastávka, and the alien detention centres Bělá – Jezová, Vyšní Lhoty, Balková.

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[57] The data analysis conducted by Optimity has been sent to the data providers, but no response had been received at the date of submission of the report.

Population under observation: Asylum seekers arriving in the Czech Republic in the years of 2015 to 2018.

Key findings:

In all four years of observation, syphilis was the most prevalent of all epidemiological conditions.

In 2015, 25 cases of syphilis, most commonly from Ukraine, Cuba, Azerbaijan, Pakistan, Iraq, Russia and China, were diagnosed among 3352 health screenings (see Table below). In addition, salmonella was diagnosed in 17 cases, mostly among individuals from Pakistan, Afghanistan and Syria. In addition, scabies was found in 12 cases among individuals mostly coming from Syria, Iran, Iraq, Pakistan and Afghanistan.

Table 4: Summary of most prevalent conditions in the reception centres in 2015 (from 3,352 entry health screenings)

Disease – diagnosis (ICPC scale)	Total number	Nationality
Syphilis (A 51 – A 53)	25	Ukraine, Cuba, Azerbaijan, Pakistan, Iraq, Russia, China
Salmonella – mostly typhimurium (A 02)	17	mostly Pakistan, Afghanistan, Syria
Scabies (B86)	12	Syria, Iran, Iraq, Pakistan, Afghanistan
Pediculosis (B 85)	9	Syria
Varicella (B01)	5	Somalia, Pakistan
HIV (B 20 – B 24)	5	Georgia, Pakistan, Nigeria, Cameroon, Ukraine
hepatitis B virus (B 16)	4	Cameroon, Ukraine, Syria
TB (A15)	3	Ukraine, China
Campylobacter jejuni (A 04)	2	Afghanistan, Ukraine
hepatitis C virus (B 17)	1	Georgia
Enterobiasis (B 80)	1	Syria
Neisseria gonorrhoeae (A 54)	1	Afghanistan

Source: "Health review of asylum seekers 2015" provided by the Czech Ministry of the Interior

In 2016, syphilis was found in 26 cases among 1741 health entry screenings, mostly among individuals from Ukraine, Mongolia, Cuba, Slovenia, Armenia, Georgia, Kyrgyzstan, Moldavia and Thailand (see Table below). Pediculosis, commonly known as infestation with lice, was diagnosed in 19 cases, mostly among individuals from Afghanistan and Iraq. In addition, scabies was diagnosed in 9 health screenings most prevalently among Ukrainians, Somalians and Syrians.

Table 5: Summary of most prevalent conditions in the reception centres in 2016 (among 1741 entry health screenings)

Disease – diagnosis (ICPC scale)	Total number	Nationality
Syphilis (A51 – A53)	26	Ukraine, Mongolia, Cuba, Slovenia, Armenia, Georgia, Kyrgyzstan, Moldavia, Thailand
Pediculosis (B85)	19	Afghanistan, Iraq
Scabies (B86)	9	Ukraine, Somalia, Syria
Campylobacter jejuni (A 04)	5	Algeria, Syria, Ukraine
Varicella (B01)	4	Syria, Ukraine, Afghanistan, Iran
hepatitis B virus (B 16)	1	Ukraine
hepatitis C virus (B 17)	1	Ukraine
Scarlet fever (A38)	1	Iraq
Salmonella (A02)	1	Iraq
TB (A15)	1	Ukraine

Source: "Health review of asylum seekers 2016" provided by the Czech Ministry of the Interior

As already pointed out above, syphilis was also the most prevalent condition among asylum seekers in 2017, with 14 cases among 1880 entry health screenings, most commonly from Ukraine, Cuba, Vietnam, Colombia, Moldavia, Georgia and Armenia (see the Table below). In addition, six cases of HIV were diagnosed, most prevalently among Ukrainians, Russians, Colombians and Cubans. Tuberculosis (TB) was diagnosed in 5 cases for individuals from Guinea Bissau, Ukraine, Georgia and Moldova.

Table 6: Summary of most prevalent conditions in the reception centres in 2017 (among 1880 entry health screenings)

Disease –diagnosis (ICPC scale)	Total number	Nationality
Syphilis (A51 – A53)	14	Ukraine, Cuba, Vietnam, Colombia, Moldavia, Georgia, Armenia
HIV (B20- B24)	6	Ukraine, Russia, Colombia, Cuba
TB (A15)	5	Guinea Bissau, Ukraine, Georgia, Moldavia

Disease –diagnosis (ICPC scale)	Total number	Nationality
hepatitis C virus (B 17)	4	Georgia, Tunisia, Ukraine
Salmonella (A02)	3	Chad, Syria, Iraq
Shigella spp. (A03)	3	Armenia, Colombia
Varicella (B01)	3	Turkey, Ukraine
Campylobacter j. (A04)	2	Ukraine
Scabies (B86)	2	Iraq, Georgia
Yersinia enterocolitica (A04.6)	1	Ukraine

Source: "Health review of asylum seekers 2017" provided by the Czech Ministry of the Interior

In the most recent year 2018, 17 cases of Syphilis have been recorded in 2093 entry health screenings, mostly among citizens of Ukraine, Cuba, Moldavia, Uganda, India, Mongolia and Armenia (see the Table below). Secondly, campylobacter jejuni, causing diarrhoea, fever, and abdominal cramps, have been found in 6 cases and mostly across individuals from Ukraine, Kazakhstan, Cuba and Moldavia.

Table 7: Summary of most prevalent conditions in the reception centres in 2017 (from 2,093 entry health screening)

Disease – diagnosis (ICPC scale)	Total number	Nationality
Syphilis (A51- A53)	17	Ukraine, Cuba, Moldavia, Uganda, India, Mongolia, Armenia
Campylobacter j. (A04)	6	Ukraine, Kazakhstan, Cuba, Moldavia
hepatitis B virus (B 16)	2	Bulgaria, Nigeria
HIV (B20-B24)	2	Nigeria
Scabies (B86)	2	Afghanistan
TB (A15)	1	Georgia
Escherichia Coli (B04.4)	1	Uzbekistan
Lyme disease (A69.2)	1	Ukraine

Source: "Health review of asylum seekers 2018" provided by the Czech Ministry of the Interior

Limitations*:* Only asylum seekers were covered. Data resulted from medical examinations at health reception centres and might therefore not be representative for the whole asylum seeker population. Only epidemiological data was collected. The data providers were asked for confirmation of the analysis, but had not responded at the date of submission of this final report (30 October 2019).

Denmark

Organisation: Dignity, a highly specialised NGO for the treatment of trauma-affected refugees[58]

Sources and Type of Source: Data from consultation with traumatised refugees collected by Dignity, an NGO for traumatised refugees.

Population under observation: Traumatised refugees from Syria, Eritrea, Iraq, Iran and Afghanistan in Denmark.

General remarks provided by Dignity:

> ***"****Based on our data collected for both the newly arrived sub-group (who have lived in Denmark for 0-5 years) and our target-group of patients more generally, we see some patterns emerge about the symptom levels for PTSD, anxiety and depression, as well as the patients' social functioning.*
>
> *For the newly arrived sub-group, we see an increase in the symptom-level for PTSD, anxiety, depression and social functioning, the longer patients have lived in Denmark before starting treatment. These measures are based on validated scales, including selections of the Harvard Trauma Questionnaire, the Hopkins' Symptom checklist and the WHO disability assessment schedule. This trend is also evident on a larger scale in our general target group.*
>
> *For our target group more generally, we see a worsening of the symptoms in about 50 percent of those patients awaiting treatment on our waiting list. Additionally, the largest improvement for our patients receiving treatment is seen among those, who receive treatment within 8 years of their arrival in Denmark. This trend appears to be related to a higher level of social functioning (measured by the WHO disability assessment schedule) among those patients, that arrived most recently in Denmark. Our preliminary conclusions point to a deterioration in social functioning over time, likely linked to untreated PTSD-symptoms. Our assessment of the target-group at large relies on data, not only from the DIGNITY rehabilitation clinic, but also from three other national rehabilitation clinics, that work with refugees with PTSD. The inclusion criteria for our-target group at large is thus that patients fulfil criteria for a PTSD diagnosis."*

Source: PowerPoint presentation on data collected by Dignity within their own operations.

Key Findings:

According to the data provided by Dignity, the average age of the 46 men and 25 women in the sample was situated at 36 years for men and 38 years for women (see Table 8). 80 percent of the individuals in the study population are Syrians, while the others came from Eritrea, Iraq, Iran and Afghanistan. Six percent of the individuals were in paid employment and 60 percent were married. 55 percent of the individuals had been in Denmark for three years or less, 34 percent had been there for three years and 11 percent for four to five years.

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[58] Data analysis has been approved by the data providers at Dignity.

Table 8: Demographic statistics about the individuals in the study

Demographic statistics	
Average age by gender	36 years (men) 38 years (women)
Sex	65 percent male (n=46), 35 percent female (n=25)
Nationality	Syrians (80 percent), Eritrea, Iraq, Iran and Afghanistan (in sum 20 percent)
In paid employment	6 percent
Married	60 percent
Years in Denmark	55 percent < 3 years; 34 percent = 3 years; 11 percent = 4-5 years

Source: PowerPoint presentation on data collected by Dignity within their own operations.

Of the 71 individuals in the study, 70 percent had experienced torture in their life, 61 percent had received beatings to their heads, 48 percent had been suffocated or strangled and 78 percent had nearly drowned (see Table 9).

Table 9: Trauma exposure according to HTQ3 scale

Experienced traumas	Share of individuals In the study population
Torture	70 percent
Beatings to the head	61 percent
Suffocation or strangulation	48 percent
Near drowning	78 percent

Source: PowerPoint presentation on data collected by Dignity within their own operations.

Mental health was assessed by using standardised methodologies, which are listed in Annex 6. To diagnose Post Traumatic Stress Disorders (hereafter referred to as PTSD), the Harvard Trauma Questionnaire (hereafter referred to as HTQ) was used. The HTQ assesses trauma history before, during and after migration and combines several items describing PTSD symptoms, using a four-point Likert scale rated from 1 (not at all) to 4 (extremely).[59]

The score for PTSD revealed that asylum seekers who had been in the country for more than five years displayed higher levels of PTSD, followed by individuals who had arrived very recently (see the Figure below). The self-perceived score was generally lower for individuals who had been in Denmark less than five years, while it was higher for individuals who had been in Denmark for five years.

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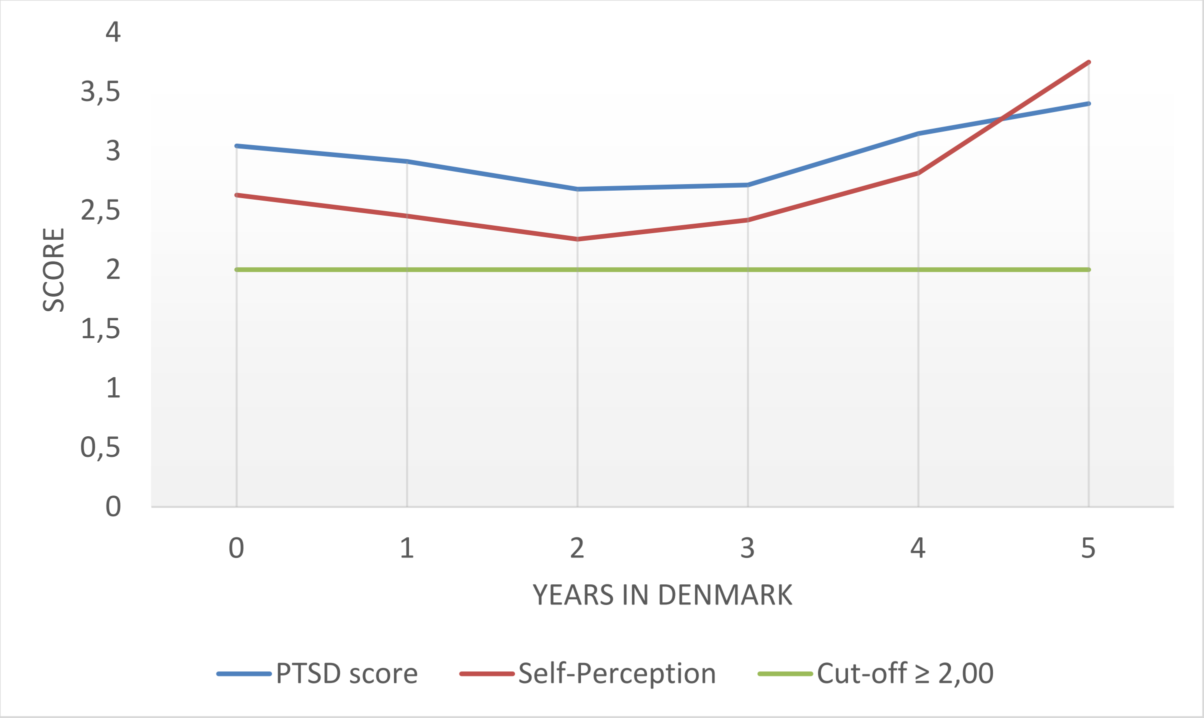
[59] Schwarz-Nielsen, Kathrine Hvid, and A. Elklitt. "An evaluation of the mental status of rejected asylum seekers in two Danish asylum centers." Torture 19.1 (2009): 51-59.

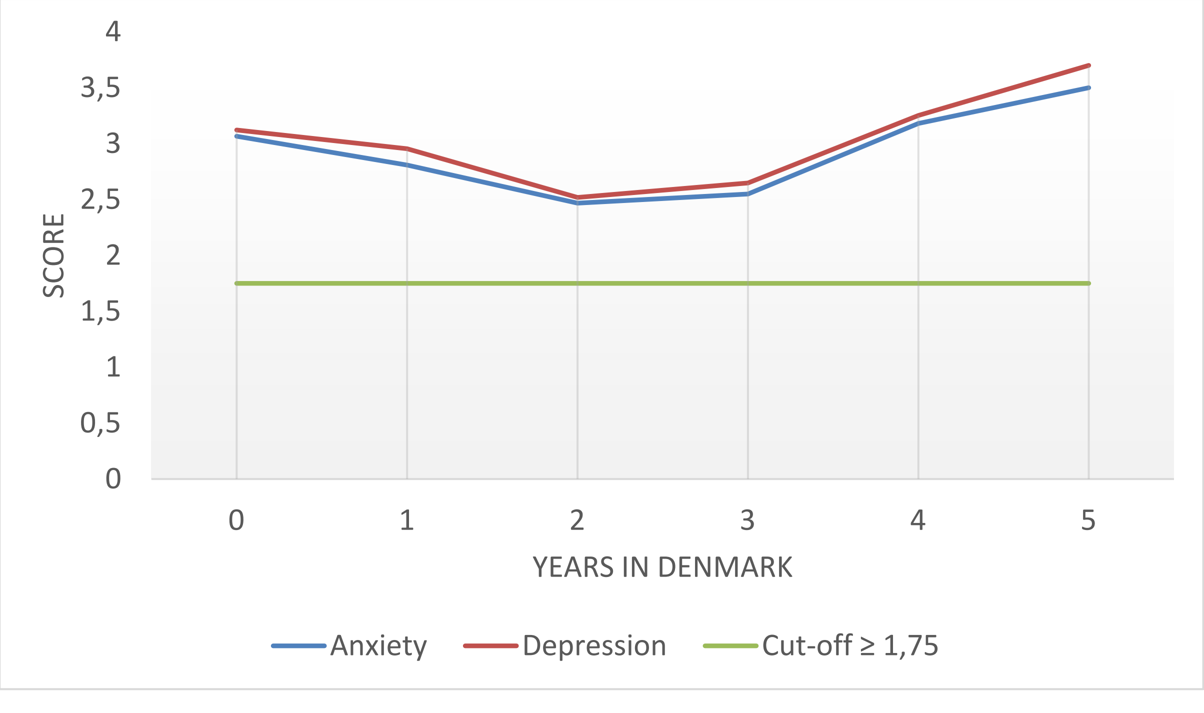
Figure 13: Occurrence of PTSD among newly arrived traumatised asylum seekers



Source: PowerPoint presentation on data collected by Dignity within their own operations.

For anxiety and depression, individuals who had lived in Denmark for four or five years displayed higher levels of anxiety and depression than individuals who had been in Denmark for fewer years (see the Figure below). Individuals who had spent 2 years in Denmark displayed the lowest value.

Figure 14: Anxiety and depression (HSCL-25) among the newly arrived, traumatised asylum seekers



Source: PowerPoint presentation on data collected by Dignity within their own operations.

Additional information can be found in Annex 6.

Limitations: Patients referred to the clinic operated by Dignity are not representative of all newly arrived refugees in Denmark. Inclusion criteria for the newly arrived migrants in this dataset is that they fulfil the criteria for Acute Stress Disorder (ASD).

Finland

Organisation: National Institute for Health and Welfare (THL)[60]

Sources and Type of Source: Asylum Seekers' Health and Wellbeing Survey (TERTTU) and Immunity Against Vaccine Preventable Diseases Study [61].

Population under observation: Asylum Seekers in their first year of arrival in Finland in 2018.

Summary of key findings:

Data was collected among 784 adult asylum seekers who participated in the survey who have arrived in 2018. One third of the surveyed refugees reported a poor or average health status and 42 percent reported a long-standing illness or health problem at the time of the interview. Among the most common conditions reported were cardiovascular, musculoskeletal and respiratory diseases. About half of the respondents reported a permanent injury due to an accident or violence. In addition, headaches, back pain and dental and oral problems were reported regularly.

83 percent of the respondents reported the experience of at least one potentially traumatic event endured during the journey or in the country of origin. Symptoms of severe depression and anxiety were found among 40 percent of the respondents. In general, women displayed poorer health and wellbeing than men. Women experienced difficulties of sexual and reproductive health and one in ten women was pregnant when arriving in Finland.

Among the 67 participating adolescents (13-17 years old), a fifth perceived their health as average or poor, while a quarter reported having a long-standing illness or health problem. Around a fifth of the questioned adolescents reported allergy symptoms, as well as headaches and a quarter reported a lack of appetite at least a few times a week. A third experienced sleep disturbances, and dental as well as oral problems were also often named. Half of the adolescents had difficulties in peer relationships and a quarter had behaviour problems. 87 percent had experienced a traumatic event before or during their journey.

96 primary school-aged children (7-12 years old) were included in the study by surveying their guardians. The general health status of those children was described as average or poor in a fifth of the cases. A quarter had a long-standing illness or health problem. About 10-15 percent of the children displayed a headache, loss of appetite, problems in urination and stomach problems several times a week. About a quarter of the children had sleep disturbances as well as difficulties in peer relationships. 73 percent of the children had experienced at least one potentially traumatic event.

Lastly, the study included health information on 140 under school-aged children (0- 6 years). One in ten children displayed poor or average health. In addition, about 10 percent of the children suffered from allergies and bed-wetting. Psychosocial symptoms were diagnosed in slightly less than a fifth of the children. A third had behavioural problems and a quarter had problems in peer

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[60] The data analysis has been approved by one of the study authors of the TERTTU survey.

[61] The full English abstract is available under the following link : http://www.julkari.fi/bitstream/handle/10024/138298/URN_ISBN_978-952-343-351-9.pdf?sequence=1&isAllowed=y

relationships. Half of the children had experienced one or more potentially traumatic event during their journey to Finland.

Detailed findings:

For the study, 1,433 individuals had been invited, of which 1,087 actually participated in the survey. The study consisted of a face-to-face interview conducted in the mother tongue of the participant and a standardised health examination. In most cases (79 %), the study was conducted within one month of registering an asylum application in Finland. Of those, 638 were male and 449 were female (see Table 10).[62] Among the participants, 784 were adults and 285 were minors arriving with family members, while 18 were unaccompanied minors. In terms of nationality, 487 of the participants were from the Middle-East and North Africa, 330 came from Russia and the former Soviet Union, 160 were from the rest of Africa and 110 from other regions.

Table 10: Description of the study sample and participation rate

	Sample (n=1,433)	Participation rate (n=1,087)	Participation rate in %[63]
Sex			
Men	840	638	76.0
Women	592	449	75.8
Other/not known	1		
Study group			
Adults	992	784	78.6
Unaccompanied minors	76	18	25.7
Minors arriving with family members	365	285	78.1
Regional group (based on nationality)			
Russia and the former Soviet Union	406	330	81.3
Middle-East and North Africa	656	487	74.2
Africa (excl. North Africa)	218	160	73.4
Other regions (excl. Asia, Latin America, nationality N/A)	153	110	71.9

Notes: excl.=excluding; nationality N/A=nationality data unavailable.
Source: TERTTU survey main findings summary provided to Optimity. More information can be found in the full report available via the following link:

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[62] More information can be found in the TERTTU survey study protocol published in BMJ, which can be found via the following link: https://bmjopen.bmj.com/content/9/4/e027917.share

[63] Participation rate out of the total sample

http://www.julkari.fi/bitstream/handle/10024/138298/URN_ISBN_978-952-343-351-9.pdf?sequence=1&isAllowed=y

Table 11 below reveals that the individuals with the highest self-rated health were from the Middle-East and North Africa (73.7 percent), while the rates for participants from Russia and the former Soviet Union displayed the lowest rate of self-rated health (57.2 percent). Additionally, the latter group displayed the highest share of individuals with a long-term health problem (56.1 percent) in contrast to individuals from other regions displaying a far lower share (32.1 percent). Cardiovascular conditions were most prevalent across Russians and individuals from the former Soviet Union (displayed by 33.6 percent), while only 10.2 percent of the Africans (excl. North Africa) suffered from them (total sample 19.1 percent). Musculoskeletal diseases were reported by 32.3 percent of the participants from Russia and the Soviet Union, while only 7.1 percent of Africans (excl. North Africans) did so (total sample 18.2 percent). With 17.5 percent of the individuals from Russia and former Soviet Union reporting respiratory diseases, they also displayed the highest prevalence in this category. Once again, the lowest rate was found among Africans (excl. North Africans) with 3.9 percent (total sample 9.9 percent).

The prevalence of Hepatitis B in the total sample was situated at 1.5 percent, while it amounted to 1.2 percent for Hepatitis C. For Syphilis, the prevalence was 0.7 percent, while it was 1.1 percent for Gonorrhoea and 2.1 percent for other types of communicable diseases. The prevalence for significant depressive and anxiety symptoms in the last seven days was situated at 39.1 percent in the total sample. The highest rate was found among Africans (excl. North Africans) with 61.3 percent while the lowest rate was found among Russians and individuals from the former Soviet Union (32.3 percent).

In addition, several indicators on traumatic and torture experiences are reported in Table 11, with a 40.3 percent prevalence of torture, a 36.6 prevalence of being tricked or forced into doing something against their will and 32.7 percent having experienced imprisonment or a kidnapping.

Table 11: Summary of the key findings of the TERTTU Survey by regional group among adults

	Russia and the former Soviet Union	**Middle-East and North Africa**	**Africa (excl. North Africa)**	**Other regions**	**Total**
Number of individuals and measurement	n=229 % (95 % CI[64])	n=340 % (95 % CI)	n=128 % (95 % CI)	n=84 % (95 % CI)	n=781 % (95 % CI)
Self-rated health good/rather good	57.2 (50.7–63.5)	73.7 (68.7–78.1)	58.3 (49.5–66.5)	69.9 (59.2–78.8)	65.9 (62.5–69.1)
Self-reported long-term illness/health problem[65]	56.1 (49.6–62.5)	36.8 (31.8–42.0)	36.7 (28.8–45.4)	32.1 (23.0–42.8)	41.9 (38.5–45.4)
Most common somatic diseases previously diagnosed by a physician					

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[64] Confidence level

[65] Self-reported long-term illness or health problem affecting one’s functional capacity (not necessarily diagnosed by a physician)

	Russia and the former Soviet Union	Middle-East and North Africa	Africa (excl. North Africa)	Other regions	Total
Cardiovascular disease (ICD-10 I00-I99)	33.6 (27.8–40.0)	11.8 (8.7–15.6)	10.2 (6.0–16.8)	22.6 (14.9–32.8)	19.1 (16.5–22.0)
Musculoskeletal disease (ICD-10 M00-M99)	32.3 (26.6–38.7)	15.3 (11.8–19.5)	7.1 (3.7–13.1)	8.3 (4.0–16.5)	18.2 (15.6–21.1)
Respiratory disease (ICD-10 J00–J99)	17.5 (13.1–22.9)	8.2 (5.7–11.7)	3.9 (1.6–9.1)	N/A	9.9 (8.0–12.2)
Most common communicable diseases previously diagnosed by a physician					
Hepatitis B	N/A	N/A	N/A	N/A	1.5 (0.8–2.6)
Hepatitis C	N/A	N/A	N/A	N/A	1.2 (0.6–2.3)
Syphilis	N/A	N/A	N/A	N/A	0.7 (0.3–1.6)
Gonorrhoea	N/A	N/A	N/A	N/A	1.1 (0.5–2.1)
Other type of communicable disease	N/A	N/A	N/A	N/A	2.1 (1.3–3.4)
Significant depressive and anxiety symptoms (past 7 days)[66]	32.3 (26.4–38.7)	36.6 (31.5–42.0)	61.3 (52.3–69.7)	34.9 (25.5–45.8)	39.1 (35.6–42.6)
Potentially traumatic experiences prior to arrival to Finland					
Imprisoned or kidnapped	30.6 (24.9–36.8)	27.2 (22.7–32.2)	53.2 (44.4–61.7)	29.8 (21.0–40.4)	32.7 (29.5–36.1)

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[66] Measured with the 25 item Hopkins Symptoms Check List (HSCL-25)

	Russia and the former Soviet Union	Middle-East and North Africa	Africa (excl. North Africa)	Other regions	Total
Tortured	30.8 (25.2–37.2)	38.5 (33.4–43.8)	60.3 (51.5–68.5)	42.9 (32.7–53.6)	40.3 (36.9–43.8)
Sexual abuse	9.6 (6.4–14.2)	11.1 (8.1–14.9)	34.1 (26.4–42.8)	10.7 (5.7–19.3)	14.4 (12.1–17.0)
Forced or tricked into something against own will	32.9 (27.1–39.3)	32.1 (27.3–37.3)	57.6 (48.8–66.0)	33.3 (24.1–44.1)	36.6 (33.3–40.1)
Permanent injury due to violence	28.3 (22.8–34.6)	16.7 (13.0–21.0)	54.3 (45.6–62.8)	28.6 (19.9–39.1)	27.6 (24.5–30.8)
Permanent injury due to an accident	23.9 (18.8–29.9)	20.2 (16.3–24.9)	20.5 (14.3–28.4)	29.8 (21.0–40.4)	22.4 (19.6–25.5)
Female genital mutilation (FGM)	N/A	10.3(6.1–17.0)	34.0 (22.3–48.1)	N/A	10.6 (7.5–14.8)

Notes: N/A=Estimates not possible because regional group consists n<30 or observation unit size is n<5.
Source: TERTTU survey main findings summary provided to Optimity. More information can be found in the full report available via the following link http://www.julkari.fi/bitstream/handle/10024/138298/URN_ISBN_978-952-343-351-9.pdf?sequence=1&isAllowed=y

Additional information can be found in Annex 6.

Limitations: The study only includes asylum seekers. Note that the findings in the tables above are unadjusted. The data is based on survey data and therefore relies on subjective health assessments.

Greece

Organisation: Médecins Sans Frontières (MSF) Greece[67]

Sources and Type of Source: Reports on activities in Greece in 2015, 2016, 2017 and 2018, focused on the provision of medical and humanitarian assistance to migrants and asylum seekers in Greece.[68]

Population under observation: Data collection from medical consultations provided to migrants and asylum seekers on Greek islands and on the mainland.

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[67] The data analysis has been reviewed by the data provider of MSF Greece.

[68] Note that information for 2015, 2017 and 2018 derive from dedicated reports from MSF Greece, while the information for 2016 derives from the Greek section of the international activities, as a dedicated report for 2016 has not been identified.

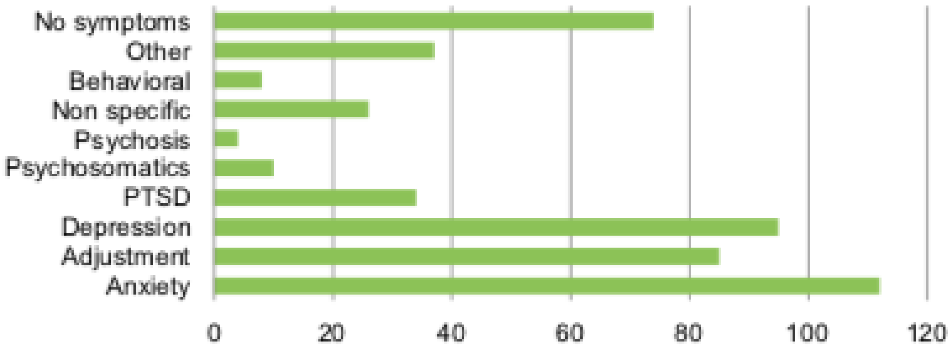
Key Findings:

***2015*:** From the beginning of their medical activities in March 2015 until December 2015, MSF conducted 44,053 medical consultations (33 percent women and 67 percent men). 17.6 percent individuals who have received medical attention have been considered vulnerable (that is individuals that are disabled, children under five years old, elderly, pregnant women, unaccompanied minors and single parents).

The patients came from Syria (42 percent), Afghanistan (29 percent), Iraq (10 percent) and Pakistan (8 percent) and other countries (incl. Iran, Bangladesh and Somalia). The most common illnesses MSF has treated were respiratory tract infections (35 percent), followed by traumatology (14 percent) and skin infections (11 percent), of which most were associated with living conditions during the journey. Gastro-intestinal illnesses accounted for 10 percent of the illnesses.

In the aforementioned period of time, 695 individual psychological sessions and 2,098 group psychological sessions were conducted. Many of those were related to traumas suffered before and during the journey. Most common conditions included anxiety, depression and adjustment (see the Figure below). Individuals who were treated because of mental health issues reported that they had experienced life-threatening events, physical violence by authorities and ill treatments by smugglers as well as authorities. The report on activities in Greece in 2015 also included summaries for activities on Greek islands individually.

Figure 15: Categories and number of cases of psychological symptoms



Source: Taken from Report on activities in Greece in 2015

***2016*:** In 2016, 54,200 outpatient consultations were conducted in the MSF's medical consultation centres. 8,100 individual mental health consultations and 650 group mental health sessions were carried out.

On the Greek island Lesbos alone, 12,830 basic healthcare consultations were carried out (for example in the mobile clinics in Moria and Kara Tepe). In the clinic in Victoria Square in Athens, 4,055 medical consultations were conducted, and 152 patients were treated in 574 individual mental health consultations.

***2017*:** According to the 2017 report, 4,500 arrivals were recorded on Greek islands in the months of September and October and were even higher in the summer months. In total 11,990 medical care consultations, 12,670 mental healthcare consultations and 7,420 sexual and reproductive healthcare consultations were conducted by MSF in Greece.

Challenges in mental health found in asylum seekers arriving to the Greek islands and the Greek mainland included PTSD, depression and anxiety. On the island Lesbos, PTSD (32%), depression (28%) and anxiety (20%) were frequently diagnosed in psychological consultations. In addition, many cases of sexual violence were recorded. On the mainland Victoria Square Urban Centre, 32 percent of the mental healthcare patients suffered from depressive symptoms, while 25 percent showed symptoms of anxiety. 63 percent of the patients had moderate symptoms, while 26 percent displayed severe psychopathologies.

In terms of physical illnesses, cardiovascular, musculoskeletal, gastrointestinal, genitourinary as well as skin conditions and asthma/chronic lung diseases, oral cavity conditions, neurological conditions as well as diabetes were among the more frequent diagnoses. On the island Lesbos in the first three months of 2017, common conditions were cardiovascular conditions (27%), asthma/chronic lung disease (16%), neurological conditions (15%) and diabetes (6%). In Victoria Square Urban Centre in Athens, 40 percent of patients were treated for infectious diseases, while 13 percent presented upper respiratory tract infections. Gastrointestinal, musculoskeletal and dermatological non-infectious conditions were among the more common diseases with 7 percent each respectively.

2018**:** In 2018, information on specific conditions was not as detailed as it was in the aforementioned reports of 2015 and 2017.[69] However, information about the most prevalent diseases in the different centres of operation was available. In the MSF Athens Day Care Centre, the most common mental health conditions that have been treated included depression, anxiety and symptoms related to past traumas were the main diagnoses. Patients in this clinic mainly came from Afghanistan, Iran and Iraq. The most common non-communicable diseases (NCD), were diabetes, hypertension, hypothyroidism, asthma and epilepsy.

On Evros, the most common morbidities included respiratory infections, orthopaedics/musculoskeletal/trauma-related conditions, as well as insect bites/skin rashes/dermatological issues. These conditions were collected in 2,967 primary healthcare consultations (which included some cases of travel medicine). On the island of Lesbos, MSF carried out 12,116 total consultations in the paediatric clinic in Moria. The conditions, often caused by poor hygiene conditions in the camps, primarily included upper and lower respiratory tract infections (43 percent), water diarrhoea (10 percent) and skin diseases, such as scabies, chickenpox and lice (14 percent). 2,358 consultation were carried out for clinical psychological support and 2,570 consultations for psychiatric and medical care in the centre in Mytilene.

In the Athens Day Care Centre (which was opened in September 2016 and is primarily focused on sexual violence and treatment for transmittable sexual diseases), has recorded 7,891 consultations on sexual and reproductive health. Those numbers included 2,343 gynaecological, 3,230 antenatal care, 353 postnatal and 169 sexual violence consultations. In addition, 163 requests for the termination of pregnancy were counted. Gynaecological consultations focused on the treatment of genital infections, menstrual disorders, constipation, haemorrhoids, STDs and urinary tract infections. In addition, 1,971 clinical psychological care consultations were carried out, of which 565 were psychological assessments and 1,406 were psychiatric care consultations. Finally, 2,005 consultations on non-communicable diseases were conducted, of which 90 percent were follow-up consultations. The five most common NCDs treated were diabetes, hypertension, hypothyroidism, asthma and epilepsy.

Limitations: Data has not been aggregated for 2017 and 2018 and therefore mainly includes examples of conditions found on Greek islands and in centres in Athens. Data from 2016 was extracted from the international activities report of 2016 and includes little information about specific conditions.

Organisation: Collective of researchers, from now on referred to as Rojek, A.M., Gkolfinopoulou, K., Veizis, A. et al. (2018)[70] [71]

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[69] As already mentioned in a footnote above, data for 2016 was not as detailed as it derives from a brief country section for Greece of the international report.

[70] Full reference: Rojek, A.M., Gkolfinopoulou, K., Veizis, A. et al. Clinical assessment is a neglected component of outbreak preparedness: evidence from refugee camps in Greece. BMC Med 16, 43 (2018) doi:10.1186/s12916-018-1015-9

[71] The data analysis has been reviewed by one of the study authors.

Sources and Type of Source: **"**Clinical assessment is a neglected component of outbreak preparedness: evidence from refugee camps in Greece ". Prospective Data from 13 refugee camps in Greece, deriving from the observation of consultations with patients.

Population under observation: 528 patient consultations in the timeframe of 3-7 July 2017. 306 male and 222 female patients

Key findings:

The most prevalent diseases found in Rojek, A.M., Gkolfinopoulou, K., Veizis, A. et al. (2018) were of respiratory nature (281), followed by skin conditions (131), gastro-intestinal conditions (88) and neurological conditions (51). The report also details the exposure of individuals to infectious diseases (due to recent international travel, close contact with unwell contacts or zoonotic exposure) and vulnerability to infectious diseases. However, the evidence on the latter two factors is very limited due to no assessment of risk factors in the consultations.

Limitations: The scope of this work was limited to patient presentations in official refugee camps in Greece. The representativeness of these findings for refugees treated in other health-care settings or other countries is therefore unknown.

Organisation: Collective of researchers, from now on referred to as Ben Farhat et al. (2018)[72] [73]

Sources and Type of Source: "Syrian refugees in Greece: experience with violence, mental health status, and access to information during the journey and while in Greece". Cross-sectional population-based quantitative survey combined with an explanatory qualitative study in eight sites in Greece during winter 2016/17.

Population under observation: 1,293 refugees were questioned, of which 728 held Syrian citizenship (41.3% female). Only Syrians were considered for the conduct of the study.

Key findings:

The study focussed on the experience of a traumatic event in the country of origin and during the journey to and the stay in Greece as well as mental health among refugees. The study also observed the links between traumatic experiences during the journey as well as living conditions in Greece on mental health among the individuals included in the study.

Data is presented by camp or location in which the survey has taken place. The median age reached from 12 (in the camp in Ritsona) to 23 in Athens. Most of the individuals were coming from Aleppo (between 19.2 and 35.5 percent), followed by Damascus (between 9.3 and 31.6 percent). Between 37 and 82.2 percent of the individuals in the sample were described as nuclear families, which can be defined as a "group of people who are united by ties of partnership and parenthood and consisting of a pair of adults and their socially recognized children."[74] Between 36.2 and 79.5 percent of the individuals were married, while 18.8 to 62.8 percent were single. Both these statistics hint on significant discrepancies in family and marital status across camps or locations. Finally, the education status also varied significantly across the sites. The rate of individuals that received no education was situated at 13 percent in one camp, while it was as low

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[72] Full reference: Ben Farhat, J., Blanchet, K., Juul Bjertrup, P. et al. Syrian refugees in Greece: experience with violence, mental health status, and access to information during the journey and while in Greece. BMC Med 16, 40 (2018) doi:10.1186/s12916-018-1028-4

[73] The data analysis has been reviewed by one of the study authors.

[74] See the definition of the Encyclopaedia Britannica via the following link: https://www.britannica.com/topic/nuclear-family

as 3.6 percent in another camp (note, however, that sample sizes were relatively low). The share of individuals with primary education varied from 10.8 percent to 44.4 percent, while the share of people with secondary education was situated between 27.8 and 54.6 percent. Finally, the number of individuals who have received tertiary education (such as a university degree) was situated between 14.8 and 32.3 percent.

Table 12: Population characteristics of Syrian refugees by settlement

Characteristics	Ritsona camp *N* = 286 *n* (%)	Katsikas camp *N* = 133 *n* (%)	Hotel Ioannina *N* = 117 *n* (%)	Samos hotspot *N* = 73 *n* (%)	Athens hotel *N* = 119 *n* (%)	Total *N* = 728 *n* (%)
Female	139 (50.2)	52 (39.7)	53 (45.7)	22 (30.1)	30 (25.2)	296 (41.3)
Median age, years [IQR]	12 [5–30]	21 [9–31]	13 [8–25]	20 [15–31]	23 [17–30]	18 [7–30]
City of origin						
Aleppo	99 (35.5)	39 (29.3)	58 (49.6)	14 (19.2)	35 (29.7)	245 (34.0)
Damascus	26 (9.3)	42 (31.6)	14 (12.0)	15 (20.6)	24 (20.3)	121 (16.8)
Al-Hasakah	61 (21.9)	13 (9.8)	11 (9.4)	18 (24.7)	9 (7.6)	112 (15.6)
Dar Ezor	21 (7.5)	5 (3.8)	11 (9.4)	1 (1.4)	12 (10.2)	50 (6.9)
Family status on site						
Nuclear family	221 (82.2)	92 (71.3)	40 (37.0)	30 (56.6)	27 (25.0)	410 (61.5)
Single parent	9 (3.4)	9 (7.0)	22 (20.4)	1 (1.9)	5 (4.6)	46 (6.9)
Child alone	2 (0.7)	1 (0.8)	–	5 (9.4)	2 (1.9)	10 (1.5)
Alone	10 (3.7)	24 (18.6)	4 (3.7)	16 (30.2)	62 (57.4)	116 (17.4)
Other	27 (10.0)	3 (2.3)	42 (38.9)	1 (1.9)	12 (11.1)	85 (12.7)
Among respondents ≥ 15 years						
Marital status						
Single	21 (18.8)	30 (39.5)	21 (39.6)	29 (53.7)	60 (62.8)	161 (41.4)
Married/union	89 (79.5)	45 (59.2)	32 (60.4)	24 (44.4)	34 (36.2)	224 (57.6)
Separated/divorced	1 (0.9)	–	–	–	–	1 (0.3)

Characteristics	Ritsona camp *N* = 286 *n* (%)	Katsikas camp *N* = 133 *n* (%)	Hotel Ioannina *N* = 117 *n* (%)	Samos hotspot *N* = 73 *n* (%)	Athens hotel *N* = 119 *n* (%)	Total *N* = 728 *n* (%)
Widowed	1 (0.9)	1 (1.3)	–	1 (1.9)	–	3 (0.8)
Unknown	14	2	4	2	1	23
Level of education						
None	15 (13.0)	5 (6.7)	2 (3.6)	3 (5.6)	7 (7.5)	32 (8.2)
Primary	51 (44.4)	11 (14.7)	13 (23.6)	9 (16.7)	10 (10.8)	94 (24.0)
Secondary	32 (27.8)	37 (49.3)	30 (54.6)	33 (61.1)	46 (49.5)	178 (45.4)
Tertiary	17 (14.8)	22 (29.3)	10 (18.2)	9 (16.7)	30 (32.3)	88 (22.5)
Unknown	11	3	2	2	2	20

Source: Ben Farhat et al. (2018) Syrian refugees in Greece: experience with violence, mental health status, and access to information during the journey and while in Greece. Available via the following link: https://bmcmedicine.biomedcentral.com/articles/10.1186/s12916-018-1028-4

Table 13 below reveals the prevalence of anxiety disorders across different demographics. In total, between 75 (in Hotel Ioannina) and 80 percent (Samos Hotspot) of the sample population suffered from anxiety disorder. The condition was more prevalent among women with numbers reaching from 82.1 percent to 100 percent in comparison to 65 percent to 76.5 percent among men. In the age group between 14-25, 69.6 to 95 percent of the sample population suffered from an anxiety disorder, while 73.2 to 88.9 percent did so among the over 25 year-olds. Numbers across marital status were situated between 66.7 and 90.5 percent among singles and 74.1 and 93.8 percent among individuals in a marriage or union. Numbers for separated/divorced or widowed individuals were too low for meaningful interpretation.

Regarding the correlation of the anxiety disorder and the family status, the share of individuals in a nuclear family reaches from 63.2 to 100 percent, while the number reached from 50[75] to 91.7 percent for individuals defined as single. Numbers for individuals with another family status were too low for meaningful interpretation. The share of individuals suffering from an anxiety disorder varied between 75.9 percent and 90.6 percent in case the person had dependents or family in Europe, while it reached from 66.6 to 83.3 percent for individuals with no family in Europe.[76] In case a violent event had been experienced in the recent past, the number of individuals displaying symptoms of anxiety varied from 72.4 percent to 90.9 percent, while the percentage was situated between 71.4 and 91.2 percent for individuals who have not endured a violent event. Individuals with a chronic disease displayed very high rates (up to 100 percent) of anxiety, but again the sample size makes a meaningful interpretation difficult, which is also valid for vulnerable individuals. Regarding individuals without a chronic disease, the share of individuals suffering from an anxiety condition was situated between 71.4 and 91.2 percent. For persons not considered vulnerable, the share of people suffering from anxiety disorder varied between 72.2 and 90.9 percent.

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[75] However, this only concerned one individual.

[76] Again, the latter category displayed a relatively low sample size.

The share of individuals who were enduring an anxiety disorder and who had been based in Greece for more than 9 months, was situated between 72 and 100[77] percent. For individuals who had spent fewer months in Greece, the share varied between 71.4 and 91.7 percent. Finally, the correlation of duration of travel (more than two in comparison to less than two months) was investigated. For individuals of the former category, the share of individuals displaying symptoms of an anxiety disorder was situated between 69.8 and 94.7 percent, while it varied between 62.1 and 82.9 percent for the latter category. The study emphasised that in Hotel Ionnina the length of the journey had a significant positive correlation to a higher anxiety disorder rate among the individuals in the study.

Table 13: Prevalence of anxiety disorder morbidity

Characteristics	**Ritsona camp *N* = 100 *n* (%)**	**Katsikas camp *N* = 67 *n* (%)**	**Hotel Ioannina *N* = 48 *n* (%)**	**Samos hotspot *N* = 38 *n* (%)**	**Athens hotel *N* = 79 *n* (%)**
Screened positive	80 (80.00)	50 (74.6)	36 (75.0)	35 (92.1)	60 (76.0)
Women	40 (83.3)	19 (82.6)	23 (82.1)	10 (100.0)	11 (91.7)
Men	39 (76.5)	30 (69.8)	13 (65.0)	25 (89.3)	49 (73.1)
Age group					
14–25	21 (77.8)	20 (76.9)	16 (69.6)	19 (95.0)	31 (75.6)
>25	59 (80.8)	30 (73.2)	20 (80.0)	16 (88.9)	29 (76.3)
Marital status					
Single	14 (70.0)	22 (73.3)	12 (66.7)	19 (90.5)	39 (76.5)
Married/union	59 (80.8)	26 (74.3)	21 (77.8)	15 (93.8)	20 (74.1)
Separated/divorced	1 (100.0)	1 (100.0)	–	1 (100.0)	–
Widowed	-	-	-	-	-
Family status at the site					
Nuclear family	56 (80.0)	25 (71.4)	12 (63.2)	7 (100.0)	8 (80.0)
Single parent	7 (100.0)	6 (100.0)	13 (86.7)	1 (100.0)	4 (80.0)
Child alone	2 (100.0)	1 (100.0)	–	4 (100.0)	1 (100.0)
Alone	7 (77.8)	16 (72.7)	1 (50.0)	11 (91.7)	42 (76.4)
Family in Europe					
Yes	70 (79.6)	44 (75.9)	32 (76.2)	29 (90.6)	55 (78.6)
No	10 (83.3)	6 (66.7)	3 (60.0)	6 (100.0)	5 (55.6)

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[77] Note that the observed number was situated at only 2 individuals.

Characteristics	Ritsona camp *N* = 100 *n* (%)	Katsikas camp *N* = 67 *n* (%)	Hotel Ioannina *N* = 48 *n* (%)	Samos hotspot *N* = 38 *n* (%)	Athens hotel *N* = 79 *n* (%)
Experienced at least one violent event					
Yes	25 (83.3)	21 (72.4)	9 (75.0)	20 (90.9)	18 (75.0)
No	55 (78.6)	29 (76.3)	27 (75.0)	15 (93.8)	42 (76.4)
Chronic disease					
Yes	8 (100.0)	3 (100.0)	6 (100.0)	4 (100.0)	7 (70.0)
No	72 (78.3)	47 (73.4)	30 (71.4)	31 (91.2)	53 (76.8)
Vulnerable					
Yes	16 (94.2)	8 (100.0)	13 (76.5)	5 (100.0)	5 (71.4)
No	64 (77.1)	42 (72.2)	23 (74.2)	30 (90.9)	55 (76.4)
Length of stay in Greece					
>9 months	22 (88.0)	18 (72.0)	30 (75.0)	2 (100.0)	55 (76.4)
≤9 months	56 (76.7)	32 (76.2)	6 (75.0)	33 (91.7)	5 (71.4)
Duration of travel					
>2 months	46 (85.2)	24 (75.0)	18 (94.7)	13 (92.9)	30 (69.8)
≤2 months	30 (73.2)	26 (74.3)	18 (62.1)	22 (91.7)	29 (82.9)

Source: Ben Farhat et al. (2018) Syrian refugees in Greece: experience with violence, mental health status, and access to information during the journey and while in Greece. Available via the following link: https://bmcmedicine.biomedcentral.com/articles/10.1186/s12916-018-1028-4

In conclusion, Ben Farhat et al. (2018) found "extremely high levels of violence experienced by Syrian refugees during their journeys and when seeking protection in Greece, including violence perpetrated by some state authorities" and "high levels of anxiety and distress in this population, compounded by lack of information on legal procedures and uncertainty about the future."[78]

Limitations: A limitation mentioned in the report is the "difficulty of documenting individual histories, including the complexity of reporting sexual violence."[79] In addition, the study only covers refugees (in contrast to the whole migrant population). As mentioned above, the case numbers for the respective demographics were low for some entries.

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[78] Ben Farhat, J., Blanchet, K., Juul Bjertrup, P. et al. Syrian refugees in Greece: experience with violence, mental health status, and access to information during the journey and while in Greece. BMC Med 16, 40 (2018) doi:10.1186/s12916-018-1028-4, P. 10-11

[79] Ben Farhat et al. (2018) P. 10

Ireland

Organisation: Health Services Executive (HSE)[80]

Sources and Type of Source: Data collected at Balseskin refugee reception centre in Ireland in the years 2016-2018.

Population under observation: Data collection from medical consultations at the Balseskin refugee reception centres in Ireland.

Key Findings:

2016: In 2016, Ireland HSE saw 1377 new persons (from 1682 who were offered screening) and 2029 emergency attendances were conducted (see Table below). TB was tested in 1,377 persons via Chest x-rays (CXR) and questionnaires, of whom 46 displayed abnormal results. Of these, two TB cases were confirmed and four individuals placed on prophylaxis. In addition, 939 individuals were screened for Hepatitis B and C, of whom 28 had a positive HBsAg (also known as the Australia antigen) result, which indicates chronic Hepatitis infection. 201 individuals have had a history of Hepatitis B in the past and for eight individuals, a Hepatitis C infection (HCV) was confirmed.

930 HIV tests were conducted by HSE Ireland in 2016, of which 34 returned positive. Co-infections with Hepatitis B have been found in two cases, which has also been the case for co-infections with Hepatitis C. 938 Varicella (Chicken pox) screenings were conducted and immunity has been displayed in 850 cases, while in 88 cases, non-immunity was diagnosed. In 274 screenings for Rubella, 261 individuals have displayed immunity, while 13 did not. In addition, 55 pregnant women have been treated and 23 new-born children have been cared for.

In the screenings, 264 cases of mental health issues have been found, while 632 individuals were referred to social workers.

Table 14: Information about health screenings at the main Irish reception centre in 2016

Collated stats from Main Reception centre Asylum seekers 2016	Collected by Ireland HSE, cases
No. given appointment	1682
New attenders	1377
Emergency attendances	2029
TB	
No. TB questionnaire	1377
Abnormal CXR reports	46
TB cases confirmed	2
Placed on TB prophylaxis	4
Hepatitis B and C	
Number screened	939
HBsAg +	28

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[80] The data analysis has been approved by the data provider.

Collated stats from Main Reception centre Asylum seekers 2016	Collected by Ireland HSE, cases
Past history of HepB	201
HCV confirmed +	8
Screened for HIV	930
No. HIV +	34
HBAg /Hepatitis C Positive	0
HIV HBs Antigen Positive	2
HIV /Hepatitis C Positive	2
Screened for Varicella	938
Varicella Immune	850
Varicella Non-Immune	88
Screened for Rubella	274
Rubella Immune	261
Rubella Non-Immune	13
Pregnant women	55
Mental health issue	264
Referrers to S Worker	632
New-born	23
Other specify	331

Source: Annual statistics for 2016 from main reception centre for asylum seekers provided by HSE Ireland

2017: In 2017, HSE offered 1955 appointments and 1544 presented for screening and 2370 emergency attendances were conducted (see Table below). In this year, TB has been tested 1544 times via Chest x-rays (CXR) and questionnaires, of whom, 66 had abnormal results. Of these, three TB cases have been confirmed and three individuals have been placed on TB prophylaxis. Furthermore, 1018 individuals were screened for Hepatitis B and C, of which 35 have displayed a positive HBsAg result, which indicates chronic Hepatitis infection. 191 of the individuals have had a history of Hepatitis B in the past and for 18 individuals, a Hepatitis C infection (HCV) was confirmed.

1012 HIV tests were conducted by HSE Ireland in 2017, of whom 42 were positive. Co-infections with Hepatitis B were detected in 2 cases, which has also been the case for co-infections with Hepatitis C. 1018 Varicella (Chicken pox) screenings have been done and immunity has been displayed in 934 cases, while in 156 cases, non-immunity was diagnosed. In 347 screenings for Rubella, 326 individuals have displayed immunity, while 21 did not. In addition, 52 pregnant women have been treated and 23 new-born children have been taken in.

In the screenings, 325 cases of mental health issues have been found, while 641 individuals were referred to social workers.

Table 15: Information about health screenings at the main Irish reception centre in 2017

Collated stats from Main Reception centre Asylum seekers 2017	Collected by Ireland HSE, cases
No. given appointment	1955
New attenders	1544
Emergency attendances	2370
TB	
No. TB questionnaire	1544
Abnormal CXR reports	66
TB cases confirmed	3
Placed on TB prophylaxis	3
Hepatitis B and C	
Number screened	1018
HBsAg +	35
Past history of HepB	191
HCV confirmed +	18
Screened for HIV	1012
No. HIV +	42
HBAg /Hepatitis C Positive	1
HIV HBs Antigen Positive	2
HIV /Hepatitis C Positive	2
Screened for Varicella	1018
Varicella Immune	934
Varicella Non-Immune	156
Screened for Rubella	347
Rubella Immune	326
Rubella Non-Immune	21
Pregnant women	52
Mental health issue	325
Referrers to S Worker	641

Collated stats from Main Reception centre Asylum seekers 2017	Collected by Ireland HSE, cases
New-born	34
Other specify	395

Source: Annual statistics for 2017 from main reception centre for asylum seekers provided by HSE Ireland

2018: In the year 2018, HSE offered 1699 appointments for screening with 1371 accepted plus NGO funded by HSE also provided 544 appointments (see Table below). In addition, 2396 emergency attendances have been conducted. In combination, TB has been tested via Chest x-rays (CXR) and questionnaires in 1869 cases, of which 82 have displayed abnormal results. Of these, four TB cases have been confirmed and two individuals have been placed on TB prophylaxis. 1224 individuals were screened for Hepatitis B and C, of whom 33 had a positive HBsAg result, which indicates chronic Hepatitis B infection. 297 of the individuals have had a history of Hepatitis B in the past and for 11 individuals, a Hepatitis C infection (HCV) was confirmed.

In addition, 1275 HIV tests were conducted by the two organisations in 2018, of which 54 returned positive. Co-infections with Hepatitis C have not been found, which has also been the case for co-infections with Hepatitis C. 1087 Varicella (Chicken pox) screenings have been done and immunity has been displayed in 926 cases, while in 110 cases, non-immunity was diagnosed. In 398 screenings for Rubella, 368 individuals have displayed immunity, while 30 did not. In addition, 79 pregnant women have been treated and 13 new-born children have been treated.

In the screenings, 426 cases of mental health issues have been found and 406 individuals were referred to social workers.

Table 16: Information about health screenings at the main Irish reception centre in 2018

Collated stats from Main Reception centre Asylum seekers plus NGO 2018	Collected by HSE Balseskin, cases	Collected by NGO, cases	Total cases
No. given appointment	1699	544	2243
New attenders	1371	544	1915
Emergency attendances	2396	0	2396
TB			
No. TB questionnaire	1371	498	1869
Abnormal CXR reports	76	6	82
TB cases confirmed	3	1	4
Placed on TB prophylaxis	2	0	2
Hepatitis B and C			
Number screened	991	233	1224
HBsAg +	23	10	33
Past history of HepB	205	71	276

Collated stats from Main Reception centre Asylum seekers plus NGO 2018	Collected by HSE Balseskin, cases	Collected by NGO, cases	Total cases
HCV confirmed +	9	2	11
Screened for HIV	986	289	1275
No. HIV +	49	5	54
HBAg /Hepatitis C Positive	0	0	0
HIV HBs Antigen Positive	0	1	1
HIV /Hepatitis C Positive	0	0	0
Screened for Varicella	986	101	1087
Varicella Immune	891	35	926
Varicella Non-Immune	95	15	110
Screened for Rubella	315	83	398
Rubella Immune	291	77	368
Rubella Non-Immune	24	6	30
Pregnant women	62	17	79
Mental health issue	250	176	426
Referrers to S Worker	409	-	409
New-born	10	3	13

Source: Annual statistics for 2018 from main reception centre for asylum seekers provided by HSE Ireland (Total has been calculated by Optimity).

Limitations: The figures collected at the Balseskin centre only include asylum seekers, and therefore cannot be used to assess the health status of the whole migrant population.

Organisation: Health Services Executive (HSE)[81]/International Organisation for Migration (IOM)

Sources and Type of Source: Medical examinations in Lebanon prior to travel to Ireland from 2015 to 2017

Population under observation: 325+ medical screenings of Syrian refugees (this figure is a sample; HSE has screened over 2,700 programme refugees to date).

Key findings:

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[81] The data analysis has been approved by the data provider.

Information about the age of the individuals were collected for 325 cases. 55 individuals were under 18 years old, while only two individuals were more than 66 years olds (see Table 17). Of 328 individuals, 158 were male and 170 were female (see Table 18).

Table 17: Age distribution of Syrian refugees in medical screening 2015-17

Age years	Number	%
0 - 4	62	19
5 - 17	112	34
18 - 65	149	45
66 +	2	0.6
Total	325	100%

Source : Health status update programme refugees Ireland 2017 (M Fitzgerald Draft report 2017)

Table 18: Gender breakdown among Syrian Refugees 2015-17

Gender	Number	%
Males	158	48
Females	170	52
Total	328	100%

Source : Health status update programme refugees Ireland 2017 (M Fitzgerald Draft report 2017)

The most common condition detected among the target population was obesity, which was diagnosed in 39 cases (see Table 19). In addition, 22 cases of anaemia were found and 20 cases of musculoskeletal problems were diagnosed. Visual problems were diagnosed in 18 cases, while 14 cases of Ischaemic Heart Disease and hypertension were found. Furthermore, mental health problems were found in 12 cases.

Table 19: Profile of medical conditions from screening/ early presentation

Condition	Cases
Non communicable diseases/ risk factors	
Obesity	39
Smoking history	30+
Diabetes (Type) 1 and 2	4
Ischaemic Heart Disease and hypertension	14

Condition	Cases
Musculoskeletal (RA and other arthritis, degeneration, disc problems)	20
Respiratory (asthma, coad, allergic rhinitis)	11
Abnormal CXR including follow- up inactive TB)	
Anaemia/ Abnormal FBC (Full Blood Count)	22
Infections	
Infectious Blood borne virus HBV and HCV	4
URTI	5
Other conditions renal gastroenterology CA (incl. Breast)	
Dental	7
Visual (mostly reduced VA)	18
Currently Pregnant	4
Mental health	12

Source: Health status update programme refugees Ireland 2017 (M Fitzgerald Draft report 2017)

For children amongst the target population, the main conditions observed included ten cases of asthma and five cases of G6PD deficiency (an inborn error of the metabolism). Three cases of bedwetting were diagnosed (see Table 20). Cases of developmental issues such as speech delay and behavioural problems have yet to be presented by HSE (as of August 2019).

Table 20: Main conditions affecting children

Condition	No.
Asthma	10
G6PD deficiency plus Thalassemia	5
Bedwetting	3
Developmental including speech delay	TBC
Behaviour problems	TBC

Source: Health status update programme refugees Ireland 2017 (M Fitzgerald Draft report 2017)

Limitations: The numbers from IOM derive from screenings in Lebanon before resettlement to Ireland. Thus, this method differs from the other data sources which contain data that have been collected at arrival of migrants and refugees.

Malta

Organisation: Ministry of Health (Malta)[82]

Sources and Type of Source: Data collected at reception centres in Malta.

Population under observation: Health assessments in reception facility for asylum seekers/refugee camps between 2015 and 2019 (n=9,411).

Key Findings:

The Ministry of Health recorded 9,411 arriving asylum seekers between 2015 and the 9th of July 2019 (see Table below). In this time period, 6,118 individuals arrived by plane, while 3,028 arrived by boat. 184 individuals were relocated to Malta, while 79 individuals were airlifted and 2 were born in Malta. The highest number was recorded in 2018 with 2,785 arrivals, and the lowest number in 2015 with 1,276 arrivals.

Table 21: Summary arrivals per year in Malta

Year	Airlifted	Born in Malta	Arrival by Boat	Asylum seekers arrival by plane	Relocated	Total
2015	19	0	89	1,168	0	1,276
2016	30	0	0	1,601	79	1,710
2017	20	1	31	1,295	105	1,452
2018	10	1	1,464	1,310	0	2,785
2019	0	0	1,444	744	0	2,188
Total	79	2	3,028	6,118	184	9,411

Source: Refugee and migrant health screening in Malta January 2015 – July 2019 provided by Infectious Disease Control Unit (IDCU) within Health Regulation Directorate Malta

Of the asylum seekers, 1,817 were female, 7,543 were male and in 34 cases, no information on sex or gender was collected (see Table below).

Table 22: Demographic information on gender of asylum seekers in Malta

Year	Female	Male	N/A	Total
2015	260	1,004	12	1,276
2016	437	1,262	11	1,710
2017	369	1,073	10	1,452
2018	508	2,276	1	2,785
2019	260	1,928	0	2,188

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[82] The data analysis has been reviewed by the data provider.

Year	Female	Male	N/A	Total
Total	1,817	7,543	34	9,411

Source: Refugee and migrant health screening in Malta January 2015 – July 2019, provided by Infectious Disease Control Unit (IDCU) within Health Regulation Directorate Malta

Among the target population, 1,805 asylum seekers who have arrived in the time period were minors, 7,401 were adults and in 205 cases no information on age was available (see Table below).

Table 23: Demographic information on adults or minors of asylum seekers in Malta

Year	Minor	Adult	N/A	Total
2015	158	1,035	83	1,276
2016	255	1,395	60	1,710
2017	276	1,138	38	1,452
2018	633	2,134	18	2,785
2019	483	1,699	6	2,188
Total	1,805	7,401	205	9,411

Source: Refugee and migrant health screening in Malta January 2015 – July 2019, provided by Infectious Disease Control Unit (IDCU) within Health Regulation Directorate Malta

Information on Health

In the 5 years of observation, 144 pregnancies were diagnosed (see Table below). Most pregnancies were observed in 2015 (34), 2018 (33) and 2017 (32).

Table 24: Overview of recorded pregnancies across asylum seekers

Year	2015	2016	2017	2018	2019	Total
Pregnant	34	24	32	33	21	144

Source: Refugee and migrant health screening in Malta January 2015 – July 2019, provided by Infectious Disease Control Unit (IDCU) within Health Regulation Directorate Malta

In terms of malignant conditions, 56 cases of tuberculosis were identified in the aforementioned time period (see Table below). Of these 56 cases of tuberculosis, 9 were extrapulmonary, while 47 were pulmonary.

Table 25: Tuberculosis cases by year

Tuberculosis	2015	2016	2017	2018	2019	Total
Extrapulmonary Tuberculosis	0	1	1	5	2	9
Pulmonary Tuberculosis	5	2	4	9	27	47
Tuberculosis Total	5	3	5	14	29	56

Source: Refugee and migrant health screening in Malta January 2015 – July 2019, provided by Infectious Disease Control Unit (IDCU) within Health Regulation Directorate Malta

Of those individuals affected by tuberculosis, 50 were male and 6 were female (see Table below).

Table 26: Tuberculosis cases by gender

Tuberculosis	female	male	Total
Extrapulmonary Tuberculosis	0	9	9
Pulmonary Tuberculosis	6	41	47
Total	6	50	56

Source: Refugee and migrant health screening in Malta January 2015 – July 2019, provided by Infectious Disease Control Unit (IDCU) within Health Regulation Directorate Malta.

The youngest patient with tuberculosis was seven years old, and the oldest 44 years old, while the median was situated at 21 years (see Table below).

Table 27: Age distribution among tuberculosis cases

Tuberculosis	Mean	Min	Max	Median	Total (n)
Extrapulmonary Tuberculosis	21	16	26	20.5	9
Pulmonary Tuberculosis	23.57	7	44	21	47
Total	23.19	7	44	21	56

Source: Refugee and migrant health screening in Malta January 2015 – July 2019, provided by Infectious Disease Control Unit (IDCU) within Health Regulation Directorate Malta.

Health information obtained from asylum seekers which arrived by boat between January 2019 and July 2019

The information provided in the Table below derives from migrants which arrived by boat during the first 7 months of 2019 (January – July). The diagnoses were collected during public health syndromic surveillance at arrival in Malta. In 2189 screenings, 286 cases of scabies, 18 cases of dental issues, 19 cases of generalised aches and pains and 3 cases of ophthalmic issues were recorded.

Table 28: Other conditions found among arriving asylum seekers

	Subjects (n)	Percentage
Scabies	286	13.1
Dental issue	18	0.8
Generalised aches and pains	19	0.9
Ophthalmic issues	3	0.1

	Subjects (n)	Percentage
Total number of screenings	2,189	100

Source: Refugee and migrant health screening in Malta January 2015 – July 2019, provided by Infectious Disease Control Unit (IDCU) within Health Regulation Directorate Malta

Information obtained from the last 7 boats arrived in Malta from May 2019 to July 2019

Separate information has been reported in the Table below for the last 7 boats that arrived in Malta between May and July 2019, which carried 566 asylum seekers. Of these individuals, 52 showed symptoms such as coughing, one person had a fever and 10 individuals displayed skin issues.

Table 29:Clinical Presentations among migrants arrived by boat in 2019

	Totals (n)	Percentage
Fever	1	0.2
Cough	52	9.2
Diarrhoea / Vomiting	0	0.0
Skin issues	10	1.8
Total number of consultations	566	100

Source: Refugee and migrant health screening in Malta January 2015 – July 2019, provided by Infectious Disease Control Unit (IDCU) within Health Regulation Directorate Malta.

Limitations: Information has only been collected on asylum seekers arriving by boat, and not the general migrant population. Data obtained has limitations due to data reporting by doctors, meaning that due to language barriers, they may not pick up all the symptoms the migrants may have.

Netherlands

Organisation: Social and Cultural Planning (SCP)/ Research and Documentation Centre of the Ministry of Justice and Security

Sources and Type of Source: Syrians in the Netherlands report[83]

Population under observation: Research study on newly arrived Syrians in the Netherlands with SCP data from the Data Archiving and Network Services. Survey data collected in between January 1, 2014 and July 1, 2016.[84]

Key Findings:

Physical health: According to the report, young Syrians in the Netherlands display similar rates of long-term conditions and a (very) good health status compared to young people in the general

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[83] Translated from Syriërs in Nederland report available under the following link: https://www.scp.nl/Publicaties/Alle_publicaties/Publicaties_2018/Syriers_in_Nederland

[84] For comparison reasons, the study compares the Syrian's health with the health of the general population of the Netherlands.

population of the Netherlands, which have been used as a reference in the report. With increasing age, Syrians display more chronic diseases and disabilities and the perceived health is worse. This decline in health among Syrian refugees is stronger than in the general population and middle-aged Syrians are clearly less healthy than their peers in the general population. The share of overweight individuals is high, especially among over 45-year-olds (75 percent), and the number of smokers is situated at 63 percent amongst Syrian men.

Mental health: Five questions about the state of mind in the past four weeks were used as the measure for the state of mental health in the report. This measure found that 41 percent of the Syrians in the study could be considered psychologically unhealthy. Symptoms were nervousness, gloominess and a feeling of being dejected. In the general population, the share of mentally unhealthy individuals was situated at only 15 percent. There were no significant differences across age groups among Syrians.

Children's health: The health of Syrian children was described as (very) good in 93 percent of the cases by parents, which was a similar rate in comparison to the general population. Eighty percent of the children had been to the dentist in the past year and two-thirds had seen a GP in this time period. In addition, 95 percent of the parents reported that their child would sleep well (indicated as 'usually' to 'always').

Limitations: The study only focused on refugees, not on migrants in general. Some of the individuals in the sample arrived before 2015. The data is based on surveys and health assessments relying (partially) on self-rated health, which can be highly subjective.

Organisation: RIVM National Institute for Public and Environmental Health and GGD Groningen (Public health department in Groningen)[85]

Sources and Type of Source: TB entry screenings of migrants

Population under observation: Health assessment in reception facilities for asylum seekers/refugee camps

Key Findings:

The health screening found that in 2016, the prevalence of tuberculosis was highest among Somalian asylum seekers (with a prevalence of 1058 cases in 100,000 individuals, see Table below). The second highest prevalence could be observed among Eritreans/Ethiopians with 337 cases in 100,000 individuals, who also displayed the largest total number (10 cases). Thirdly, a prevalence of 295 cases was found among Afghans. However, these calculations are based on very limited case numbers and should therefore be interpreted with care.

Table 30: Number of asylum seekers and tuberculosis cases by nationality in 2016

Country of Origin	Count of asylum seekers	Percentage	Count of TB incidences	Prevalence
Eritrea/Ethiopia	2,965	22%	10	337
Albania	1,138	9%	0	0

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[85] The data analysis has been reviewed by the data provider.

Country of Origin	Count of asylum seekers	Percentage	Count of TB incidences	Prevalence
Morocco	1,066	8%	1	94
Former Yugoslavia	1,063	8%	0	0
Iraq	775	6%	1	129
Afghanistan	677	5%	2	295
Iran	479	4%	1	209
Algeria	452	3%	1	221
Somalia	378	3%	4	1058
Mongolia	364	3%	0	0
Other countries	3,894	29%	5	128
Total	**13,251**	**100%**	**17**	**128**

Source: Translated from RIVM Tuberculose in Nederland 2016 Surveillance Report (p. 73), available in Dutch under the following link: https://www.rivm.nl/sites/default/files/2018-11/TiN%202016%20surveillancerapport.pdf

In 2017, very few cases of tuberculosis were diagnosed in total among the target population (14, see Table below). The most cases were found among Indians (4), followed by Chinese (2).

Table 31: Number of asylum seekers and tuberculosis cases by nationality in 2017

Country of Origin	Count of Asylum Seekers	Percentage	Count of TB incidences	Prevalence
India	5,635	23%	4	71
China	5,014	21%	2	40
Russia	1,638	7%	0	0
Indonesia	1,332	6%	1	75
South Korea	1,078	4%	0	0
Philippines	981	4%	0	0
Ukraine	886	4%	0	0
Morocco	833	3%	0	0
South Africa	701	3%	1	143
Thailand	668	3%	0	0
Other Country	5,252	22%	6	114
Total	24,018	100%	14	58

Source: Translated from RIVM Tuberculose in Nederland 2017 Surveillance Report (p. 82), available in Dutch under the following link: https://www.rivm.nl/bibliotheek/rapporten/2018-0143.pdf

Limitations: The numbers have been extrapolated from extremely low case numbers (in 17,715 migrants, a total of 25 cases of tuberculosis were identified). An assessment of the prevalence is therefore not recommendable.

Romania

Organisation: Ministry of the Interior – General Directorate for Medical Emergency Management / General Inspectorate for Immigration.[86]

Sources and Type of Source: Data on the number and predominant medical conditions of asylum seekers in Romania. Data was collected to adapt the health system to unforeseeable needs and to respond to medical needs of newly arrived migrants in Europe.

Population under observation: Asylum Seekers in six Romanian reception centres in the years of 2015-2019.

Key Findings:

Most requests for granting a form of protection (such as refugee status) were submitted by citizens of Syria, Iraq, Afghanistan, Pakistan, Turkey, Pakistan and Bangladesh. An overview of the most frequent nationalities and number of medical consultations by year can be found in the table below. The following groups of conditions that were identified include: respiratory, gastrointestinal, dental, osteo-articular, bile colic, metabolic and cardiovascular diseases, dermatological, neuropsychiatric, gynaecological, chronic cardiac, reno-urinary and orthopaedic disorders.

Table 32: Most frequent nationalities and number of medical consultations of asylum seekers by year

Year	2015	2016	2017	2018	2019[87]
Most frequent nationalities	Syria, Iraq, Afghanistan, Turkey	Syria, Iraq, Afghanistan, Pakistan	Syria, Iraq, Afghanistan, Pakistan	Syria, Iraq, Iran	Syria, Iraq, Bangladesh
Number of asylum seekers who have received medical attention	654	1361	3624	2713	950

Source: General Directorate for Medical Emergency Management / General Inspectorate for Immigration

Limitations*:* Data only includes asylum seekers in reception centres.

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[86] The data analysis has been reviewed by the data provider.

[87] First semester of 2019.

Slovenia

Organisation: Government Office for the Support and Integration of Migrants[88]

Sources and Type of Source: Data from Medical examinations in 2018

Population under observation: Asylum seekers at reception centres in the year 2018.

Key Findings:

The data derived from 5181 preventive medical examinations, which were performed in asylum seeker reception centres in 2018. The 5 most commonly detected cases of diseases in preventive medical examinations of migrants were:

Table 33: Data on detected diseases in medical examinations in reception centre in Slovenia

Disease	Number of cases
Parasitic diseases	264
Respiratory disorders	190
Calluses	168
Injury	157
Muscular disorders	89

Source: Data provided by mail by the Government Office for the Support and Integration of Migrants

Limitations: The findings only include asylum seekers and no other migrants. The identified cases give no information on nationalities.

United Kingdom

Organisation: Public Health Wales[89]

Sources and Type of Source: Policy document on the basic health information on migrants in Wales[90]

Population under observation: Asylum seekers and refugees from Syria.

Key Findings:

Since the beginning of the Syrian Vulnerable Persons Resettlement Scheme in late 2015, 854 Syrian refugees came to Wales, dispersed among every local authority (the number of resettled Syrian refugees has since increased to 1,000 in 2019). This number only includes individuals from the Scheme, while the number of refugees arriving through other routes to Wales is significantly higher. The policy document underlined that refugees and asylum seekers are not a homogenous group in terms of their health status. Evidence suggests that the average physical health status of refugees and asylum seekers on arrival was not particularly poor in comparison with the general

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[88] The data analysis has been reviewed by the data provider.

[89] The data analysis has been reviewed by the data provider

[90] See https://gov.wales/sites/default/files/publications/2019-03/health-and-wellbeing-provision-for-refugees-and-asylum-seekers_0.pdf. This document is not a study in itself but summarises existing Welsh Government policy and evidence from a number of sources to support the implementation of that policy.

UK population.[91] The most common health problems of newly arrived refugees and asylum seekers included accidental injuries, hypothermia, burns, gastrointestinal illnesses, cardiovascular events, pregnancy and delivery-related complications, diabetes and hypertension, all of which can lead to more chronic conditions requiring long-term treatment. Women frequently face specific challenges, particularly in maternal, new-born and child health, sexual and reproductive health, and violence. Children face similar issues together with issues such as vaccinations having been missed.

The report mentioned that the vulnerability to communicable and non-communicable diseases (NCDs) is increased through the exposure of refugees and migrants to the risks associated with population movements, such as psychosocial disorders, reproductive health problems, higher new-born mortality, drug abuse, nutrition disorders, alcoholism and exposure to violence. This is mainly due to the interruption of care, either to lack of access or to the decimation of health care systems and providers. Displacement results in interruption of the continuous treatment that is crucial for chronic conditions. Vulnerable groups, especially children, are prone to respiratory infections and gastrointestinal illnesses because of poor living conditions, suboptimal hygiene and deprivation during migration. A cause for skin infections can also be poor hygienic conditions.

Limitations: As mentioned above, the study is not considered a research study, but rather a policy implementation guidance document. The document includes information on Syrian refugees who have been resettled through the Syrian Vulnerable Persons Resettlement Scheme introduced in late 2015. In addition, the document includes information about a number of other schemes through which refugees arrive in Wales, and data regarding spontaneous arrivals of asylum seekers (pages 10-11). The guidance document relies on text-based conclusions made in reports by the World Health Organization, because it is not the result of a research study with its own quantitative or qualitative data collection. Note that the information is not considered a study but summarises existing Welsh Government policy and evidence from a number of sources to support the implementation of that policy. Common health issues highlighted are not based on research in Wales but on information from the World Health Organization. In addition, the accuracy of the guidance’s content is limited to information available at its publication date of December 2018.

4.2. Synthesis of the assessment

As already discussed, most of the data identified and included for this assessment is collected for asylum seekers or refugees, while very little information is available for other types of migrants. The data mostly derives from medical consultations conducted at reception centres (as is the case for Croatia, the Czech Republic, Greece, Ireland, Malta, the RIVM/Netherlands and Slovenia). Some of the data includes information on the self-related health status (Austria) or on communicable diseases (Czech Republic, Greece, RIVM/Netherlands) only. Some of the data has been extracted from reports (Austria, Finland, Greece, both sources from the Netherlands as well as Wales).

The data generally does not allow to draw neither wide-ranging conclusions on the general health status of migrants nor on the health status of migrants in comparison to the general population of the country they are residing in. In contrast, the Austrian ReHIS study provides a comparison of the self-rated health status of newly arrived migrants from Syria, Iraq, Afghanistan and other countries to the general population. In addition, the “Syrians in the Netherlands” study and the

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[91] Note that a reviewer from Public Health Wales added that “while the ‘healthy migrant’ effect is fairly well-known, there is some debate about whether asylum seekers and refugees do indeed arrive with favourable health compared with the UK population, in common with other types of migrant” and of lack of reference in the document. For further evidence on the topic, the reviewer recommends the findings from the Swedish Support Platform for Migration and Health (MILSA), which show that ‘when a migrant is newly arrived, there are many risk factors which influence health, causing the health of the migrant to worsen to below the arrival levels before it begins to increase over a period of approximately 7-10 years. These findings are supported by evidence showing that whilst refugees and asylum seekers often arrive in the UK in good health, this can quickly decline due to issues, such as lack of mental health problems [sic] are made worse by poor housing and a lack of employment and social stimulus’.

Public Health Wales policy document on “Basic health information on migrants in Wales” draw comparisons on physical and mental health between the Syrian and the general population.

Some of the available datasets contain comprehensive information on demographics such as sex or age (e.g. Croatia, Denmark, Finland and Ireland). Data on nationality is also commonly collected as is the case in Austria, the Czech Republic, Denmark, Finland, Greece and the Netherlands. Information on arrival is not as often collected as demographics (the exact date is only available for Croatia), although data is often collected during medical examinations at first arrival reception centres and it can thus be assumed that it was conducted within the first year of arrival.

Communicable diseases seem to be more often screened than other conditions, as many studies contain information on the prevalence of tuberculosis, Hepatitis or HIV. However, non-communicable diseases are also often collected in several datasets or discussed in reports. Mental health conditions are sometimes covered on a self-rated scale but scrutinised in more detail in sources from e.g. Denmark, Finland, Greece and the Netherlands.

The data that fulfils the perquisites of this study the closest is the TERTTU study in Finland, which particularly looks at the situation of asylum seekers in their first year of arrival to Finland and applies a very rigorous research methodology.

5. CONCLUSIONS

This section brings together and summarises the main conclusions on the assessment of the health status of migrants and refugees arriving in Europe since 2015, drawn from the analysis of the findings and discussed in an internal workshop with study expert Elisabetta De Vito. The conclusions aim to provide input to future action by professionals and policy makers.

The study initially set out to (1) identify and evaluate the existing sources and data on the health conditions of newly arrived migrants and refugees to Europe since 2015 (with a focus on the identification of primary data sources, rather than the collation of a bibliographical review), and to (2) assess the actual health status of the target population on the basis of selected sources of health information. In order to do so, an extensive desk research programme and different types of stakeholder consultation at international, EU and national levels were undertaken.

This exercise revealed that little to no systematic data collection of the health status of newly arrived migrants in the EU/EEA since 2015 is conducted. In most countries, data on the health status of migrants and refugees is not collected. Despite the extensive consultation effort, a total of 47 data sources for potential inclusion in the study were identified, of which only 16 were eventually included in the study for further analysis, stemming from 12 European countries. The main reasons for the use of only 16 sources were:

- The **unavailability of data** due to ethical and data protection issues,
- Data that was not **properly synthesised** for analysis or,
- The exclusion of data after closer review as it was **not deemed suitable** for the data analysis of this particular study.

The research revealed that countries have different approaches to data collection on the health status of the target population (i.e. collection of anonymous data; self-reported data), often only collect data on specific health variables (i.e. mental health conditions) and/or look at specific categories of migrants / refugees (i.e. nationalities, age groups, countries of origins) rather than providing a holistic view of the health status of migrants and refugees in their country.

Most of the data compiled on newly arrived migrants focuses on asylum seekers, refugees and individuals held at the border or staying in the EU in an “irregular” manner. Little data is collected on migrants travelling within the EU for work or on study visas. The recording of data is generally done through interviews or surveys being conducted as part of a piece of research, as opposed to a general health assessment.

Quantitative data collected by the identified sources is typically recorded at the national level by public bodies. However, the definition of “migrant” is usually used differently, and the date of arrival is not available in the majority of cases.

This makes a comparison of the available data very difficult, if not impossible. In addition, the quality of data collected does not allow to draw overarching conclusions that are statistically significant, as often data sets are very small or even incomplete.

Only in a minority of cases is data on the health status of migrants and refugees publicly available. In some instances, it is made available in partnership with academic institutions. However, the majority of data is not made publicly available at all.

Finally, collecting data on the health status of migrants and refugees is problematic in many countries due to ethical considerations, as often it is not possible to create special records on these target groups. As already stated, several data sources identified could also not share available data due to data protection issues and could therefore not be included in the study. This finding is in line with findings from a DG JUST report on “Data collection in the field of ethnicity”, which outlined that:

“Currently, domestic law permits the collection of data on racial and ethnic origin through a ‘prohibition with exceptions’. The focus on `objective` criteria, such as citizenship and migration

background may supersede the self-identification of racial minorities, while the lack of consent forms enabling the processing of data on racial and ethnic origin may prevent data collection."[92]

These limitations of the data collected are similar to those limitations identified in other studies, such as the 2018 WHO Report on the health of refugees and migrants in the WHO European Region. Hence, it seems more insightful to look at and analyse each dataset independently, rather than trying to draw conclusions of the health status of refugees and migrants at European level.

In this context, the fact that there is an urgent demand that relevant systems and institutions would be capable to respond properly and timely to migration related health and public health challenges according to an evidence-based manner, on October 7-8, 2019, a consensus conference on "working out the basic principles of a highly coherent and consistent European Migrant Health Database" has been held in Pécs, Hungary.[93] Various stakeholders discussed the current situation of data availability and discussed potential solutions to the current lack of coherent, comprehensive and comparable data.

In the meantime, while a coordinated data collection effort across the EU would be useful to overcome this fragmented data and to provide a holistic and comprehensive overview on the health status of migrants and refugees, no concerted effort is made by European countries to work towards such a system. As a consequence, a comprehensive assessment of the actual health status of the target population is not possible.

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[92] Farkas, Lilla (2017): Data collection in the field of ethnicity. European Commission, Directorate-General for Justice and Consumers, p. 6.

[93] See https://www.mighealth-unipecs.hu/

ANNEXES

Annex 1 – D1 Compendium of health information data sources

Because of our strict data usage protocol, the data compendium, which partially includes sensitive information, was delivered as a standalone file for Commission use only. In this section, an overview of the data collected in the compendium is provided.

Summary about the content of the data compendium

The Data Compendium includes a detailed description of the 47 data sources that have been scrutinised for their suitability to be used in the final data analysis (found in Section 4 of the report). Sixteen data sources have been identified and shared with the study authors for the inclusion in the final data analysis. Regarding the 31 additional sources that have not been found suitable according to the criteria for inclusion, full information is not given in detail, subject to the strict data usage criteria established in Annex 4.4.

This section therefore aims to provide information on the nature of the 16 included and 31 non-included data sources. In detail, the data compendium provides information on the **country of the respective source, the name and type of the organisation that collected the data** as well as **several characteristics of the data.** This includes information on:

- The name of the dataset/study
- The type of the dataset/study (e.g. dataset/article/study)
- The migration status of individuals in the study
- Information on whether the health screening on which the data is based has been conducted within the first year of arrival
- The years covered in the dataset/study
- Communicable diseases that are covered in the dataset/study
- Non-communicable diseases that are covered in the dataset/study
- Mental health conditions that are covered in the dataset/study
- Other types of information relevant to health that are covered in the dataset/study

Furthermore, additional information on the source and the means of contact with the study authors are covered. Finally, suitability with regard to the inclusion criteria (Non-EU migrants, health screening conducted within the first year of arrival and arrival in and after 2015) is discussed and reasons for the inclusion/non-inclusion to the studies are given.

In addition to the summaries for the included and non-included data sources, a very brief summary of stakeholders who have been contacted and could not provide relevant data or did not respond to the request is given.

Summary of 16 data sources included in the study

For **Austria,** the Refugee Health and Integration Survey (ReHIS) has been used for further analysis. The study takes a look at the self-rated physical and mental health status among individuals from Syria, Iraq, Afghanistan and other countries who have arrived in Austria in the year 2015. A comparison of the health conditions with the Austrian population is drawn.

For **Croatia,** anonymised data on the health status of asylum seekers in Croatia from Médecins du Monde Belgique's office in Zagreb has been used for further analysis. The dataset lists information on medical consultations from the years 2016 to 2019 according or the International Classification of Primary Care (ICPC).

Information on the epidemiological situation regarding asylum seekers from reception centres are provided for the **Czech Republic** and are also applied for the final data analysis. The source includes information on the most common epidemiological diseases found among asylum seekers for the years 2015 to 2018.

The **Danish** source provides demographic statistics and information on trauma exposure, anxiety and depression symptoms among newly arrived, traumatised asylum seekers seeking treatment at a centre specialised on this population.

For **Finland,** information on the health status of asylum seekers stems from data provided by the National Institute for Health and Welfare (THL). This includes demographic data, data on self-rated health, as well as information on cardiovascular, musculoskeletal and respiratory diseases for adult asylum seekers who have arrived in Finland in 2018. In addition, the survey conveys information on common communicable diseases, depressive symptoms as well as the experience of traumatic events.

For **Greece,** information stems from three sources. First of all, evidence is provided from activity reports by the operations of Médecins Sans Frontieres in Greece, which includes information on the prevalence of non-communicable, communicable and mental health conditions as well as demographics. The two other sources list information from two research studies published in 2018. The first of those is focused on the prevalence of respiratory, skin, gastro-intestinal, infectious as well as neurological conditions, while the second is focused on the causes of anxiety symptoms for individuals living in Greek reception centres in 2016/2017.

For **Ireland**, two sources of information have been included in the final analysis of the study. The first source provides information on communicable as well as mental health conditions diagnosed among individuals at the Balseskin refugee reception centre in Ireland in the years 2016-2018. The second source includes information on communicable, non-communicable as well as mental health conditions found in 325+ examinations of refugees in Lebanon prior to their resettlement to Ireland. In addition, demographic statistics are provided.

Malta's ministry of health has provided data stemming from health assessments in a reception centre for asylum seekers in between 2015 and 2019. Data is provided on the mode of transport used to travel to Malta and on demographic statistics of the individuals. In addition, information on communicable diseases as well as other conditions and symptoms has been conveyed.

Information on the health situation of migrants in the **Netherlands** is provided through two sources. The first source scrutinises the physical and mental health condition of adults as well as the general health condition of children among newly arrived Syrians in the Netherlands in between 2014 and 2016. The second source provides information on the number of cases of tuberculosis found among asylum seekers in the Netherlands by country of origin.

For **Romania,** data on the number of medical consultations and the most frequent nationalities of individuals seeking medical attention in between 2015 and 2019 is provided. In addition, the most common groups of conditions are listed.

The number of cases from 5181 preventive medical examinations on parasitic diseases, respiratory disorders, calluses, injuries and muscular disorders is provided for **Slovenia**.

Finally, for the **United Kingdom** and more specifically for **Wales,** a policy document provides insights to the health status of newly arrived Syrians and lists the most prevalent diseases.

An overview of the information provided above is given in Table 34 below.

Table 34: Summary of data selected for the final data analysis

Country	Name of Study/dataset	Name of organisation	Information provided in the study/dataset
Austria	Refugee Health and Integration Survey (ReHIS)	Austrian Academy of Sciences and Vienna University of Business and Economics	Self-rated physical and mental health of newly-arrived migrants from Syria, Iraq, Afghanistan

Country	Name of Study/dataset	Name of organisation	Information provided in the study/dataset
			and other countries in the year 2015
Croatia	Anonymised data on health status of asylum seekers arriving or transiting through Croatia who have been provided with medical consultation by MdM	Médecins du Monde (MdM) Belgique office in Zagreb	Information on medical consultations of asylum seekers according to the ICPC scale in the years of 2016 to 2019 in Croatia.
Czech Republic	Summary of the epidemiological situation regarding the asylum seekers at the reception centres Praha – Ruzyně, Zastávka, and the alien detention centres Bělá – Jezová, Vyšní Lhoty, Balková.	Ministry of the Interior of the Czech Republic	Summary of most common epidemiological conditions among asylum seekers in Czech reception centres in the years 2015 to 2018.
Denmark	Data from consultation with traumatised refugees collected by Dignity	Dignity, a highly specialised NGO for the treatment of trauma-affected refugees	Demographic statistics and information on trauma exposure, anxiety and depression symptoms among newly arrived, traumatised asylum seekers.
Finland	Asylum Seekers' Health and Wellbeing Survey (TERTTU) and Immunity Against Vaccine Preventable Diseases Study	National Institute for Health and Welfare (THL)	Demographic data, data on self-rated health, as well as information on cardiovascular, musculoskeletal and respiratory diseases are provided for adult asylum seekers who have arrived in Finland in 2018. In addition, information on common communicable diseases, depressive symptoms as well as the experience of traumatic events is provided.
Greece	Reports on activities in Greece in 2015, 2016, 2017 and 2018, focused on the provision of medical and humanitarian assistance to migrants and asylum seekers in Greece.	Médecins Sans Frontières (MSF) Greece	Data on medical activities from 2015 to 2018 from medical consultations on Greek islands and on the mainland. This includes information on demographics of the individuals, mental health as well as on prevalence of communicable and non-communicable diseases.

Country	Name of Study/dataset	Name of organisation	Information provided in the study/dataset
	“Clinical assessment is a neglected component of outbreak preparedness: evidence from refugee camps in Greece”	Collective of researchers, referred to as Rojek, A.M., Gkolfinopoulou, K., Veizis, A. et al. (2018)	Information on the prevalence of respiratory, skin and gastro-intestinal as well as neurological conditions as well as on the exposure to infectious diseases.
	“Syrian refugees in Greece: experience with violence, mental health status, and access to information during the journey and while in Greece”	Collective of researchers, referred to as Ben Farhat et al. (2018)	Data from 1,293 refugees questioned at 8 Greek refugee camps. Information on the relationship between demographic characteristics, traumatic experiences, vulnerability and duration of travel with the prevalence of anxiety disorders is provided.
Ireland 	Data collected at Balseskin refugee reception centre in Ireland in the years 2016-2018	Health Services Executive (HSE)	Information on communicable as well as mental health conditions diagnosed among individuals at the Balseskin refugee reception centre in Ireland in the years 2016-2018.
	Medical examinations in Lebanon prior to their travel to Ireland from 2015 to 2017	Health Services Executive (HSE) / International Organisation for Migration (IOM)	Data from 325+ medical screenings of Syrian refugees, who have been screened in Lebanon before being resettled in Ireland. Information on demographics, communicable, non-communicable as well as mental health conditions is provided. In addition, main conditions affecting children are examined.
Malta 	Data collected at reception centres in Malta in between 2015 and 2019	Ministry of Health (Malta)	Demographic information as well as information on the mode of transport used to travel to Malta are provided. In addition, health-related data on pregnancy, tuberculosis, scabies, dental issues, generalised aches and pains as well ophthalmic issues are provided. Finally, data on fevers, coughs, diarrhoea/vomiting, skin issues is given.
Netherlands	Syrians in the Netherlands report	Social and Cultural Planning (SCP)/ Research and	Survey data collected in between 2014 and 2016 about newly arrived

Country	Name of Study/dataset	Name of organisation	Information provided in the study/dataset
		Documentation Centre of the Ministry of Justice and Security	Syrians in the Netherlands. Data on physical, mental and children's health is provided.
	TB entry screenings of migrants	RIVM National Institute for Public and Environmental Health and GGD Groningen (Public health department in Groningen)	Data on tuberculosis screenings found in health assessments in reception facilities for asylum seekers/refugee camps. Information on the country of origin is provided.
Romania	Data on the number and predominant medical conditions of asylum seekers in Romania	Ministry of the Interior – General Directorate for Medical Emergency Management / General Inspectorate for Immigration.	The source only provides information on the most frequent nationalities of individuals seeking medical attention and the number of examinations in between 2015 and 2019 as well as the groups of conditions that have been considered.
Slovenia	Data from medical examinations in 2018	Government Office for the Support and Integration of Migrants	The number of cases from 5181 preventive medical examinations on parasitic diseases, respiratory disorders, calluses, injuries and muscular disorders is provided.
United Kingdom	Policy document on the basic health information on migrants in Wales	Public Health Wales	The policy document provides summary information on the most common health problems of newly arrived refugees and asylum seekers including accidental injuries, hypothermia, burns, gastrointestinal illnesses, cardiovascular events, pregnancy and delivery-related complications, diabetes and hypertension.

Source: Optimity Advisors based on stakeholder consultations

Summary of 31 additional data sources

In addition to the 16 data sources listed above, 31 additional data sources have been identified for potential use in the final data analysis. However, these sources have either not been suitable given they did not meet the inclusion criteria (individuals have to be non-EU passport holders only, have arrived in Europe in and after 2015 and have received the health screening within the first year of arrival) or have not been made available to the study authors because of data protection or other issues that made sharing the data not possible.

Because the full table included in the data compendium partially includes sensitive data, the full table included in the data compendium cannot be shared publicly. However, Table 35 gives an overview of:

- The country of origin of the data source
- An anonymised identifier
- The content of the non-included data sources
- The reason(s) for non-inclusion

Full information on the content of the data sources has been provided to the DG SANTE and CHAFEA for further internal use.

Table 35: Summary of data not suitable or not available for the final data analysis

Country	Identifier of studies/data sources not included in final data analysis	Information included in the studies/data sources	Reasons for non-inclusion
Austria	Data source #1	Includes information on non-communicable diseases and met the inclusion criteria.	Data was not available due to data protection reasons
	Data source #3	Includes information on non-communicable diseases and met the inclusion criteria.	Data was not available due to data protection reasons
Bulgaria	Data source #4	Information on communicable, non-communicable and mental health conditions	Data was collected prior to 2015
Croatia	Data source #6	Health data provided to registered physician providing care to migrants	Data were not available due to data protection reasons
Czech Republic	Data source #8	Data on tuberculosis cases by country of birth and abortion cases by women with a foreign passport	First year of arrival was not covered
Denmark	Data source #9	Data acquired in reception centres	Data was not shared at submission of the report
Finland	Data source #11	Data on the health status collected at refugee reception centres	Data could not be shared due to the organisation not being the data holder
	Data source #13	Data collected at reception centres. Met all inclusion criteria and information on communicable, non-communicable and mental health conditions.	Data could not be shared due to data protection issues
France	Data source #14	Information on basic self-reported health, chronic	Data collection was ongoing at the date

Country	Identifier of studies/data sources not included in final data analysis	Information included in the studies/data sources	Reasons for non-inclusion
🇫🇷		diseases and mental health issues.	of submission of this report
	Data source #15	Data on the nature of health consultations, time spent in France and health conditions	Data could not be disaggregated by first year of arrival
	Data source #16	Information on the migration path, health status, access to insurance and healthcare services	Data collection was ongoing at the date of submission of this report
Germany 🇩🇪	Data source #17	Data on mental health as well as self-reported health	Data only to be shared for scientific purposes
	Data source #18	Self-reported health on Turkish, Polish, Romanian, Syrian and Croatian migrants.	Data collection was ongoing at the date of submission of this report
Hungary 🇭🇺	Data source #22	Data from reception centres in Hungary. Included information on communicable and non-communicable diseases as well as the vaccination status	Data was not made available at the data of submission of this report
Iceland 🇮🇸	Data source #23	Data on mental health, self-reported health, the BMI, blood pressure and behavioural variables	Data not made available due to data protection issues and unclear situation whether it is possible to single out migrants in the dataset
Italy 🇮🇹	Data source #26	Study aimed at collecting data on physical, mental, social, religious and legal needs of unaccompanied migrant minors	Study was ongoing at date of submission of this report
Netherlands 🇳🇱	Data source #29	Healthcare data on asylum seekers in Dutch reception centres. Data on communicable, non-communicable and mental health conditions as well as behavioural data.	Study was ongoing at date of submission of this report.
Norway 🇳🇴	Data source #31	Longitudinal data on healthcare needs of Syrian Refugees coming to Norway	Study was ongoing at date of submission of this report.

Country	Identifier of studies/data sources not included in final data analysis	Information included in the studies/data sources	Reasons for non-inclusion
Slovakia	Data source #33	Data on received healthcare of foreigners in Slovakia	Further dissemination of foreigner status not possible
Spain	Data source #35	Data collected in Spanish hospitals on communicable diseases	Data could not be shared due to data protection issues
Sweden	Data source #36	Data on perinatal health of asylum-seeking women in Sweden. Data on maternal and foetal health collected	Data could not be shared due to data protection issues
	Data source #37	Data on health conditions of foreign-born people. Data covered non-communicable diseases as well as mental health conditions.	Migration status could not be further disaggregated and first year of arrival was not collected
United Kingdom	Data source #38	Data on migration and health based on NHS data. Includes information on communicable, non-communicable and mental health conditions as well as information on self-reported health, BMI, blood pressure. In addition, behavioural health data are collected	Data could not be shared due to data protection issues.
	Data source #39	Data collection based on the IOM's Handbook for Health Professionals – Health assessment of refugees and migrants in the EU/EEA	Data was not shared at the date of submission of this report.
Europe	Data source #41	Data on HIV infections among migrants	Data on first year of arrival was not available
	Data source #42	Data on patient discharges by place of residence. Discharges can be disaggregated by certain diseases	Data cannot be disaggregated by migration status or year of arrival.
	Data source #43	Self-reported data on communicable, non-communicable and mental health conditions as well as information on behavioural health data.	Data is not archived properly according to the organisation and was thus not made available for this study.
International	Data source #44	Data for 11 countries on communicable, non-communicable and mental health conditions as well as self-reported health and vaccination status for the	Data was not made available at date of submission of the study

Country	Identifier of studies/data sources not included in final data analysis	Information included in the studies/data sources	Reasons for non-inclusion
		relevant years of observation	
	Data source #45	Data on the health of refugees and migrants in the WHO European Region. Dataset includes information on non-communicable, communicable and mental health. In addition, data on vaccine-preventable diseases, overweight/obesity, diabetes, obstetric and perinatal health, dental health in children, sexual and gender-based violence against unaccompanied children, child maltreatment, female genital mutilation, sexual violence is collected	Possibility for further disaggregation of migrant status unclear. Data was not made available at the date of submission of this report.
	Data source #46	Data on communicable, non-communicable and mental health conditions collected for relevant years of the study	Data was not made available and unclear whether first year of arrival could have been disaggregated
	Data source #47	Data on mental health and behavioural health data as well as living conditions on Greek Islands for child refugees and migrants on Greek islands	Data did not meet all inclusion criteria

Source: Optimity Advisors based on stakeholder consultations

Summary of the 153 organisations who have responded but did not collect relevant data as well as the 223 organisations, which have not responded

Of the 423 organisations and sources which have been contacted, 153 additional organisations have responded to the request for data. Of those, some have referred to additional sources, while others could not provide further information on relevant data for the project. Despite several efforts to establish contact, 223 organisation have not responded to the data request.

Annex 2 – D2 Workshop report

Workshop on the health status of newly arrived migrants and refugees in EU/EEA: Summary of the discussions

Chafea Service Contract No. 20177111[94]

Date of the event: 28 March 2019, 9h00 – 15.00 CET

Location of the event: Avenue des Arts 8, Brussels

Agenda of the event:

Timing	Description of the session	Speakers
09:00 – 09:15	Welcome, aims and objectives of the workshop, and the service overall	Jacque Mallender, Optimity Advisors Isabel de la Mata, DG SANTE
09:15 – 10:45	Presentation of the already identified primary data sources and routinely data collected at EU country level Identification of missing sources that could enable the health status assessment of migrants upon arrival in Europe	Mirja Gutheil, Optimity Advisors Mariana Dates, Optimity Advisors
10:45 – 12:45	Development of consensus on implementation aspects related to systematic data collection and analysis	Discussion facilitated by Jacque Mallender
12:45 – 13:30	Lunch break	
13:30 – 14:45	Discussion on what assessment of the health status of newly arrived migrants and refugees is feasible with the available data	Discussion facilitated by Jacque Mallender
14:45 – 15:00	Concluding remarks	Jacque Mallender

A. Background to the workshop

A.1 Introduction to the objectives of the workshop

The workshop has been organised to achieve the overarching objectives of the study through the discussion of the progress made so far, the assessment of the current approach and collection of advice regarding further strategies and the verification of findings with experts in the field.

The aims of the workshop can therefore be defined as:

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[94] DISCLAIMER: This document was produced under the EU Third Health Programme [2014-2020] in the frame of a service contract with the Consumers, Health, Agriculture and Food Executive Agency (Chafea) acting under the mandate from the European Commission. The content of this report represents the views of the contractor and is its sole responsibility; it can in no way be taken to reflect the views of the European Commission and/or Chafea or any other body of the European Union. The European Commission and/or Chafea do not guarantee the accuracy of the data included in this report, nor do they accept responsibility for any use made by third parties thereof.

- Verifying existing and available primary data sources and identify routinely data collection at EU country level which enables health status assessment of migrants upon arrival in Europe.
- Seeking expert and stakeholder consensus on implementation aspects related to systematic data collection and analysis.
- Seeking expert and stakeholder advice on whether the assessment of the health status of newly arrived migrants and refugees is feasible with the available data.

The workshop has provided the opportunity to the participating experts to share their knowledge on existing data to assess the health status of migrants. They have also been able to provide recommendations for systematic data collection in Europe and inform the methodology for the assessment of the health status of migrants. The results of the study, collected in the present minutes, have been circulated among the participants after the event. The questions that were discussed and attempted to answer at the workshop were as follows:

Session 1 – Mapping of sources across Europe	**Session 2 – Implementation of systematic data collection**	**Session 3 – Methodology for assessing health status of migrants**
➢ Have we identified all potential sources? ➢ What other sources may be systematically collecting data in Europe? ➢ Where should we focus our efforts over the next weeks to have a comprehensive list of data sources?	➢ What health indicators should be monitored? ➢ What are the current barriers and facilitators to data collection?	➢ How can we use the available data to assess the health status of migrants and refugees?

A.2 State of data collection prior to workshop

In order to assess the current state of data collection across the study countries, the study team has identified and contacted the most relevant stakeholders involved in health, migration or asylum in each country that is within the study scope, at EU level and at international level. The relevant organisations were primarily contacted via e-mail, and secondarily via a telephone call. In a second round of requests for assistance, organisations were asked to fill-in an online survey to provide more details about the data they hold or collect, or to disseminate the link among other relevant organisations.

A.2.1 Number of organisations contacted and responses received

In total, 332 national, European and international organisations have been contacted, as can be seen in Figure 16. Data requests have primarily focused on public authorities and agencies: 128 public bodies have been contacted including health and interior ministries, migration agencies, health services, social security, national health insurance bodies and official statistical offices. Non-governmental organisations supporting refugees and asylum seekers, private health initiatives and human-rights interest groups have also been contacted (83 contacted organisations). Requests were sent to 55 public and private public health agencies and associations and to 53 research and academic institutions. Finally, 13 intergovernmental organisations (such as the International Organization for Migration (IOM) and the World Health Organization (WHO) have been contacted to enquire about their knowledge regarding systematic data collection in Europe.

Figure 17 provides an overview of where the contacted stakeholders are located (European, international, national level). Contacts to academic institutions have been recorded separately. The blue bar displays the number of organisations contacted, while the orange bar displays the number of responses. In total, 94 responses of the 332 requests have been received (ca. 28 percent). Of the 33 countries covered in the study, no responses have yet been received from Hungary, Latvia, Poland, Slovakia, Moldova, Iceland or Serbia. The country providing the highest number of responses has been Netherlands (with 6 responses out of 10 requests). In addition, 9 responses out of 15 sent requests have been received from EU-level organisations.

Figure 16: Number of organisations contacted at the national level by stakeholder category

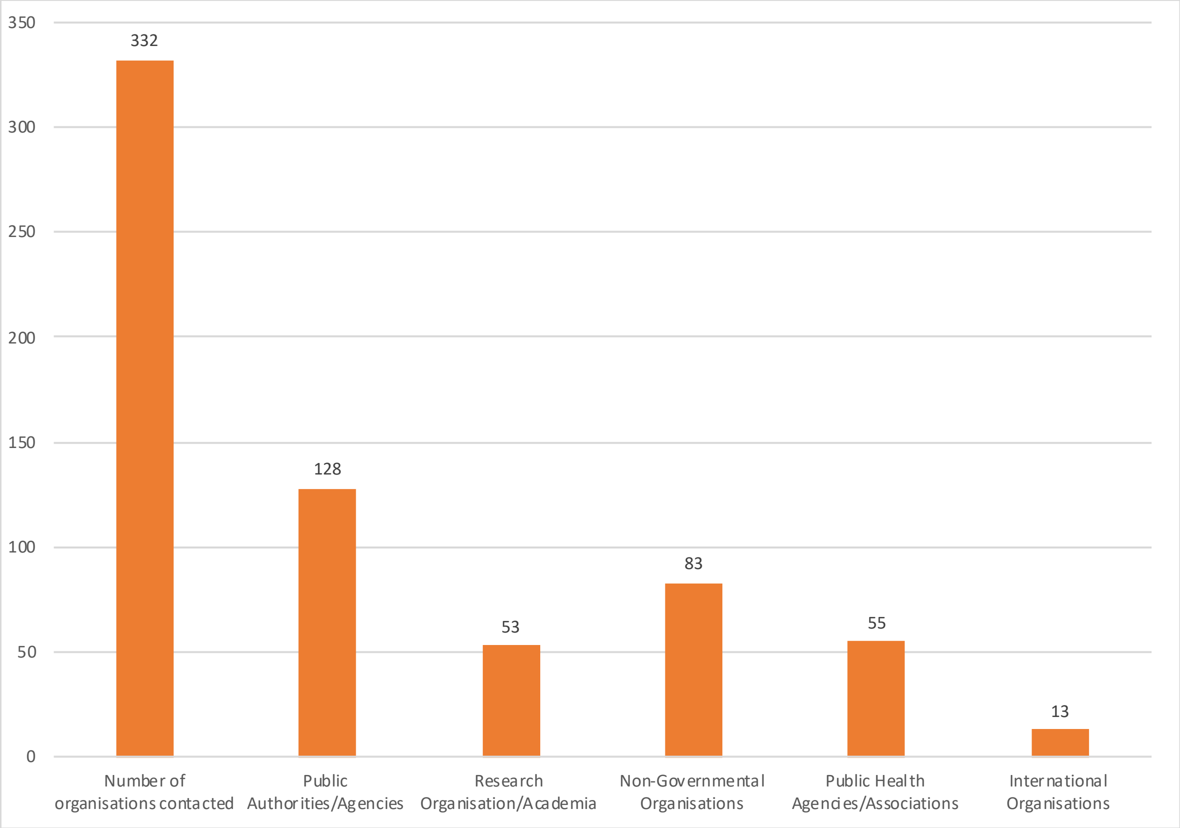
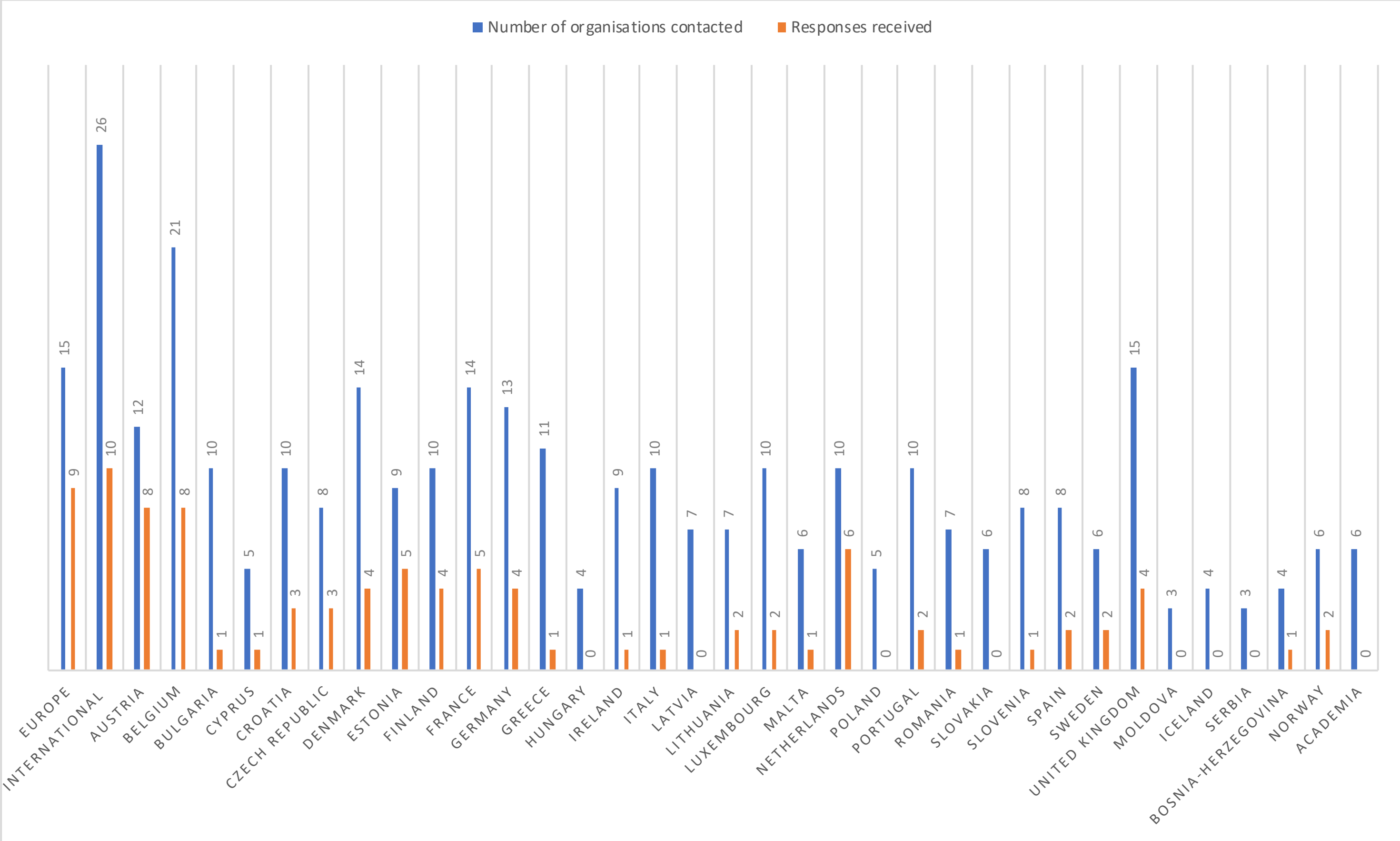


Figure 17: Number of organisations contacted, and number of answers received at international, EU, and national levels



A.2.2 Description of the available data from the survey

Data of a mostly quantitative variety is typically recorded at the national level by public bodies (in 14 cases out of 22 responses in the survey), and the collection is generally conducted by the organisations themselves (in 19 cases out of 22 answers).[95] Data are made publicly available in a minority of cases (only one case out of 16 responses), the majority of data are available, but only in a synthesised manner or provided directly to the European Commission (in 8 cases out 15 responses). Some of the data are not made public at all.

Two thirds of the institutions collect the data employed for their analysis themselves (10 cases out of 15 responses), while the remaining third relies on other sources. The majority of institutions collects both quantitative and qualitative data (9 cases out of 15 responses), while a third collects only quantitative data (5 cases out of 15 responses). One organisation focuses on recording only qualitative data. Furthermore, 12 out of 15 responses institutions responding to the survey collect data covering the relevant period of observation between 2015 and 2018.

The majority of the data are focused on asylum seekers, refugees and individuals held at the border or staying in the EU in an "irregular" manner (11 out of 15 responses). Little data are collected on migrants migrating to the EU for work or on study visas (5 out of 15 answers).

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[95] Note that the results are based on the preliminary responses given to our survey with n=22 and should therefore be taken with caution.

Recording of data are done through interviews / surveys being conducted as part of a piece of research (6 out of 15 responses) as well as through general health assessments in healthcare facilities and reception facilities for asylum seekers and refugees (7 out of 15 responses).

The available datasets appear to generally contain a comprehensive range of common demographic information, although the date of arrival of the individual in the EU is information that is more commonly not available than information regarding date of birth, sex, nationality (the date of arrival in the EU has been collected in 4 cases out of 12 responses).

Overall, more organisations collect information regarding communicable as opposed to non-communicable diseases. Mental health conditions e.g. depression, PTSD appear to be monitored amongst organisations at rates similar to common communicable diseases such as Hepatitis B and C (information on PTSD as well as Hepatitis A and B are collected in 7 cases out of 12 responses).

Annex II provides an overview of the collected data.

B. Proceedings of the event

B.1 Introduction to the workshop

In the initial study phase before the workshop, the study team aimed to identify and approach the main administrative authorities, research institutes and non-governmental organisations (NGOs) that are likely to be responsible for matters of migration and/or are involved in health-related services or studies for migrants. The study team primarily engaged with stakeholder organisations via email or phone. Initial emails enquired about the current state of data availability in the respective countries. In follow-up emails and while approaching recommended contacts, the link to an online survey on the availability of relevant data was sent out. In some cases, individual interviews with the participants were also conducted prior to the workshop.

After carefully reviewing the most relevant sources, the study team, DG SANTE and Chafea selected stakeholders of the most relevant sources to participate in the expert workshop. The workshop consisted of twenty-five active participants representing international organisations, NGOs, national health and migration authorities and academics from a diverse and varied range of Member States and additional countries within the scope of the study. These included Belgium, the Czech Republic, Denmark, France, Finland, Germany, Greece, Italy, the Netherlands, Norway, Portugal, Spain, Sweden and the UK. A complete list of participants is included in Annex I.

The following sections gives a concise summary of the most relevant themes and conclusions of the respective workshop sessions and an overview of potential data sources. In addition, the report reflects the barriers and enablers for future data collection that were discussed at the workshop, as well as the concept of a migrant-aware health system. The conclusions of the workshop and the next steps identified after the discussions are also presented in the report.

B.2 Minutes of the event

Welcome, aims and objectives of the workshop, and the service overall

First, the study and the workshop were introduced by Optimity Advisors' study team, in order to remind the participants about the background and the purpose of the study and to establish the objectives of the workshop. The overall aims of the workshop were discussed and the importance of receiving expert collaboration and consensus on current sources of data were established. Furthermore, the current issues identified in the first stages of the study with regards to implementation of systematic data collection and the feasibility of making an assessment of the health status of newly arrived migrants from the available data were shared with the participants.

Following the introduction, Isabel de la Mata, Principal Advisor for health and crisis management at DG SANTE, contextualised the study with a detailed explanation of the background of the study and a description of the characteristics of the data that are relevant for the study. In particular, primary sources of data, such as data collected during the initial health screening of migrants, were emphasised as the most relevant. Secondary data, such as data from censuses, were discussed as less relevant. In addition, Ms. de la Mata clarified that the scope of the study does not include a summary of prior findings in the literature.

Following the opening remarks from both the study team and Ms. de la Mata, the preliminary findings of Task 1 of the study were presented.

Presentation of the already identified primary data sources and routinely data collected at EU country level and identification of missing sources that could enable the health status assessment of migrants upon arrival in Europe.

Firstly, the study team presented the regional and sectoral coverage of the contacted organisations as well as the number of replies received by country. Secondly, the main substantial findings from email consultations, phone conversations as well as survey responses were established in more detail. The study team furthermore emphasised that the findings from the survey were based on 22 responses and should therefore be taken with caution.

Initial findings from the consultations of the study team indicated that systematic data collection of the health status of migrants as per the study’s definition is not generally conducted.

Quantitative data recorded by consulted sources is typically recorded at the national level by public bodies. The data are publicly available only in a minority of cases. Data are sometimes made available in partnership with academic institutions. However, most of the data are not made public at all.

The majority of the data focuses on asylum seekers, refugees and individuals held at the border or staying in the EU in an “irregular” manner. Little data are collected on migrants travelling within the EU for work or on study visas.

From the available datasets it is possible to ascertain that a comprehensive range of common demographic information is generally contained. In particular, information regarding date of birth, sex, nationality is more commonly collected. Judging from the state of knowledge stemming from the initial consultation phase, information on the date of arrival of individuals within the EU is generally not available. Information regarding communicable diseases is more frequently collected than information on non-communicable diseases. According to the preliminary findings of the survey, information about mental health conditions, i.e. depression or PTSD, is reported as frequently as information about common communicable diseases, such as Hepatitis A/B/C.

A group discussion, facilitated by members of the study team, and a collective intelligence exercise focused on what sources may be systematically collecting data in Europe and highlighted studies in several Member States that may include some of the data requested for this study. In particular, organisations in Norway, Greece and Finland were identified as coming the closest to collecting the desired data sets of interest. Médecins du Monde was also identified as being a data holder.

The ambiguity and subjective interpretation around the timely dimension of ‘arrival’ was brought up and clarified, by reiterating that only health assessments in the first year after arrival were of relevance. In addition, the issue of a lack of clear guidelines for screening was raised. Another important aspect brought up in the discussion was the use of proxies to identify migrants in a dataset as well as the danger of ignoring undocumented migrants when focusing on a one-year period only. For that matter, the aspect of trust in organisations that conduct health screenings was underlined. Lastly, the necessity of looking at general population surveys in addition to targeted surveys, was brought up.

Table 36 below presents an overview of sources on a national and supranational level, which have been described as potential data holders by the workshop participants.

Table 36: Overview of sources recommended by workshop participants

Potential Sources		
Netherlands GZA (Asylum seeker health care), an organisation in charge of providing health care to asylum seekers. Currently, collecting health data are not their priority but they are able to do so.	**Denmark** Danish Red Cross collects data from screening offered to all newly arrived asylum seekers. Danish Research Centre for Migration, Ethnicity and Health (data are from offered screening on arrival to all new asylum seekers to DK).	**Norway** University of Bergen; CHART study. (collaborating with Ireland). Centres for undocumented migrants in Oslo and Bergen (aggregated data).
Spain Periodic health surveys at national and regional level. Red Cross Spain Refugee Reception Centres (CAR) and Migrant Temporary Stay Centres in Ceuta and Melilla (CETI) (both managed by Ministry of Labour, Migration and Social Services) Regional health authorities in main arrival points Study on Primary Care Centres in Catalonia has started and will have data on recent migrants State agency on refugee/asylum seekers	**Sweden** Department of Health and Welfare for Health Data Sweden tax authorities Sweden public health infectious disease surveillance data done by the Public Health Agency of Sweden	**Finland** Specialised clinics for traumatised refugees (the data quality will be high, but most data will be collected after 1 year)
Greece RE-MEAL study, which was conducted in camps Médecins du Monde for Greece Regional health directorate No2 Health Units SA (A.E.M.Y A.E)	**Portugal** ACM (Alto comissariado para as migrações) Cruz Vermelha Portuguesa (Red Cross Portugal)	**Bulgaria** State agency for refugees in Bulgaria Bulgarian council of refugees and migrants
Republic of Ireland		**Across Europe**

Potential Sources		
HIQA, catalogue of national health and social care data collections	**United Kingdom** UK migrant Tuberculosis pre-approval check UK pre-arrival refugee health assessment Public Health Wales	National/ local networks of healthcare professionals supporting 'irregular' migrants Vertical disease control programmes e.g. TB NGOs that are receiving migrants - Red Cross, MSF

A subsequent group discussion and collective intelligence exercise revolved around where the future focus and effort of the study team over the next weeks should be set to have a comprehensive list of data sources. As a result of the discussion, Finland and Norway were identified as being European countries that could be presented in the study as case studies given the current state of data collection on the health status of migrants. In addition to looking at routine data collection, the convenience of holding (online) workshops at a regional level were discussed as potentially helpful for increased levels of engagement. This could be done by conducting online consultations with experts and stakeholders from countries that follow similar approaches in healthcare provision and data collection. Lastly, concerns regarding the use of data and ethics surrounding its collection were raised by participants.

An overview of the recommended focus for the further conduct of the study and the future practice of data collection in migrant health studies is given in the table below, presented by underlying themes.

Table 37: List of recommended areas of focus by themes following the workshop

Focus
Ethics
Ethics of migrant health data to ensure migrant's protection at data collection
Gaining trust of migrants to participate in migrant health studies
Find a balance between visibility and confidentiality
Recommended approaches for further conduct
Utilise workshop attendees
Focus on understanding what 'variables' linked to migrants are available in routine collection system Primary care system - what variables do they have?
Holding a workshop inviting actors in Greece and regionally More workshops with preparation from participants in advance
Additional organisations and authorities to approach
UK asylum accommodation centres that carry out health screening/ assessments (by private healthcare providers – potentially the data are provided to the Home office)
Federal governments of migration
Government records in Finland
Border control agencies
Social security (welfare state system)
Data from health services in Norway (but not available at the individual level for research in Norway) Linking Norwegian register data (but it takes time and money)
German Reception centres run by the federal states

Focus

Social welfare organisations that often run centres e.g. Red Cross

Development of consensus on implementation aspects related to systematic data collection and analysis

This session aimed to get a better understanding of feasible, practical steps that could be taken in Member States to improve the systematic collection of data pertaining the health status of newly arrived migrants. Additionally, the session focused on different indicators that should be collected for scientific and treatment purposes.

As stated above, the goal of the study was to get an overview of the systematic collection of data to assess the health status of newly arrived migrants across the relevant countries within the scope of the study. In the discussion it was emphasised that health indicators should be routinely screened for whole populations, not just migrants, and that migrants should not be singled out. Participants also mentioned that, whilst performing health screening of migrants is a focus, the provision of basic needs is not being met in some circumstances on arrival and new illnesses and disease are being introduced in camps and detention centres in destination or transit countries.

The following questions guided the group discussion:

- Which migrant health indicators would be useful to the EU and at national level?
- What data should be collected to measure these?
- What data capture opportunities exist?
- Which agency should hold this data at national level?
- What are the barriers to collecting data?
- What are the enablers to collecting data?

The reasoning behind why the data would be collected and what it would be used for was raised by workshop participants as a necessary piece of information required to determine health indicators. In addition, issues of health literacy, this is, knowledge about the existence of certain health conditions and their respective symptoms, were raised. Finally, the importance of gender-specific conditions was underpinned.

The variables deemed as most relevant during the session are presented in the table below.

Table 38: Indicators identified to be relevant in the context of data collection regarding migrant health

Useful Migrant Health Indicators						
Health Status		Wider Determinants	Behavioural Health and Trauma-related health	Demographics	Ethical	Access
Vaccination coverage/ immunisation status	All communicable diseases Infectious diseases - HIV, TB, Hepatitis	Health behaviours	Mental health in children - loss, separation, violence	Age and age-specific indicators - children/ youth	Same indicators as general population	Health literacy

Useful Migrant Health Indicators						
Vulnerability	Morbidity	Level of education	Misuse of drugs and medication	Transit countries	Routine vs screening	Language (Inter-cultural communications)
Diseases not usually found in Europe	Mental health	Food security on arrival	Literacy - education	Gender	Time dimension for 1 year	Arrival point
SF 36 Basica questions (self-perceived and self-reported health)	Sexual and reproductive health (and in younger people than one might assume)	Support Collecting network, resources, background info	Trauma exposure - systematic measure of physical trauma	Country of birth Nationality Citizenship (all different)	Non-provision of information to avoid stigmatisation	The possibility to access public health services / The reasons for not being able to access them. The point in time of last access to healthcare.
Physical screening health	Functional framework of mobility	Social determinants of health - housing, poverty, social networks, integration	Violence (physical, mental, economic, cultural and traditional, trafficking and sexual)	Language	Longitudinal perspective (screening at entry and another at one year later with the same people)	Rights of access to healthcare and to cultural mediators
Personal health record	Existing health status information		"Soft" mental health indicators from trauma pedagogics, including social support factors (not only strict clinical surveys)		Positive discriminative	Cultural/ social understanding of medical treatment - understanding in host countries e.g. issues of overtreatment when no medical therapy is necessary.

The subsequent group discussion on the barriers and enablers to collecting and sharing migrant health data took place in order to identify the reasons behind the perceived lack of necessary resources, infrastructure and trust/relationships. The barriers identified can also help explaining the absence of systematic data collection across Europe. Clear enablers were recognised as mitigating the risk of barriers to collection and sharing of data. A frequent concern of migrants raised by participants of the workshop was the fear of denial of service or impediments to their legal status when disclosing health conditions to healthcare providers.

The Table below gives an overview of the enablers and barriers mentioned during the session, grouped into issues affecting the collection and sharing of the data as well as relevant context that complicates data comparability.

Table 39: Overview of barriers and enablers to ensure to data availability

Barriers to collection of data	Barriers to sharing data	Contextual barriers
Migrant's perspective	**Migrant's perspective**	**Migrant's perspective**
• Legal status of migrant • Language barriers • Lack of inter-cultural communication experience • Trust by migrants	• Data consent	
Organisational aspects	**Organisational aspects**	**Organisational aspects**
• Differences between statutory & non-statutory agencies • Willingness of state • No standard system • Lack of continuity of identification • "Not my role" • Wider issue of not having patient centred approach • Attitude of health professionals to collect data regarding migrants • Imposing vs free will • Lack of coordination of data collection • Lack of willingness/ preparedness • Lack of EU coordination • Training not adequate • Lack of collaboration between actors collecting routine data • Lack of understanding the culture of migrants (health culture) • Lack of training on data collection • Lack of instruments	• Data misuse • Data governance • Misuse by media or state • Data can be used to refuse access to shelter and other services • Identification of migrants in HS data • Data can be used to refuse access to shelter and other services • It helps NGOs to build trust if they say they don't share data • Concerning data shared with other public bodies used for immigration enforcement • There is a movement to stop recording data which will be used against them •	• Different Taxonomy • National and regional structure • Possibility to link data in some countries

Barriers to collection of data	Barriers to sharing data	Contextual barriers
• Lack of money/ resource		
Mixed aspects	**Mixed aspects**	**Mixed aspects**
• Willingness of actors • Likely duration of stay • Ethical aspects • Migrant status vs health status • Non-response • Ethical issues if not able to respond	• Legal	• Disparate systems • Different contexts
Enablers facilitating the collection of data	**Enablers facilitating the sharing of data**	
Migrant's perspective	**Migrant's perspective**	
• Translation services and translators • Positive lessons	• Ownership, that is asking migrants for suggestions	
Organisational aspects	**Organisational aspects**	
• Shed more light on healthier migrants and related benefits • Clear statement of purpose for data • Collaboration between actors collecting routine data • Demonstration of economic benefit of knowing • National registry core minimum variables (3-4)	• Shift/reframe the migration health narrative • Consider chances on asylum in collecting data due to different provisions of care? (from an ethical point of view since going into some topics comes with a responsibility to act upon it) • Firewall between health system and immigration services	
Mixed aspects	**Mixed aspects**	
• Communicating the relevance of collecting data	• Myth busting	

- Additional questions that have emerged during the discussion included:

- Do we need a European collection and reporting system similar to ECDC for communicable diseases?
- Do we have the data to adapt to the new situation of migration flows?
- Do we have more cases of mental health problems in the EU?

As a central aspect of debate, the adaption of the current health care systems to the needs and concerns of migrants was discussed. Migrant-aware health systems could enable an easier, more sensitive and more efficient access of migrants to health care. An overview of the most important aspects of such a system discussed during the workshop is given in the table below.

Table 40: Central elements of a migrant-aware health system

Migrant-aware health systems
Accessibility
Barriers: legal (not allowed), ethical, practical instruments (money and time)
Same health assessment as general population
Free interpretation services for GPs, hospitals, midwives etc.
Help/information to navigate health care system, taking into account health literacy
Entitlements and rights to healthcare information given
Policy restrictions
Primary care catchment done by GPs, easy to capture[96]
Cultural Awareness
Integration
Culturally appropriate care Cultural competence in health education
Focus on diversity, not cultural competence
Data and treatment focus
Indicators of social and wider determinants of health
Nationality, country of origin, time of arrival in country - proxy does not work
Incidence and prevalence data
Focus on vaccinations, infectious diseases and mental health

Concluding remarks

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[96] A catchment area refers to the regional coverage within e.g. a city a service or institution is responsible for. See e.g. Jenkins C. & Campbell J. (1996).

In the course of the event, many helpful references to potential data-collecting organisations were provided by participants. In addition, barriers that prevented a more conclusive data collection were discussed and potential remedying enablers were suggested. However, the general consensus reached through the discussion was that the availability of this highly specific data is limited and not aligned across borders.

- Although not central to the study, a theme that emerged at the workshop discussions involved the ethics and confidentiality of what data on the health status of migrants would be used for. The concept of a migrant-aware health system was raised by participants at the workshop. The event concluded by reporting to participants next steps in the execution of the contract and how they would remain informed and involved going forward.

B.3 Actions identified and next steps by the study team[97]

- Draft of a workshop report for distribution among the workshop participants;
- Draft of country profiles to be shared with workshop participants so they can identify national sources missing from the consultation or appropriate contacts in those who have not responded;
- Share a data usage protocol and research ethics guide with participants;
- Arrange conversations with workshop participants who have said they may have data relevant for the study;
- Update data sources repository with newly identified sources. This information could be made available to interested participants;

Share the contact details of workshop participants (after requesting consent).

B.3 Actions after the workshop

After the workshop, the workshop summary was shared with all participants (on 24th April 2019). Participants were asked to send back any comments by 3rd May 2019, and to circulate the online questionnaire among national-level stakeholders in the country they were representing.

At the time of the deadline, only one participant had responded to the study team. Upon further contact, 4 participants were interviewed by the study team reading questions around data availability at national level.

Sub-ANNEX I: List of participating organisations

Organisations participating in the workshop	
1.	Instituto de Salud Global
2.	National School of Public Health, Universidade NOVA Lisboa
3.	Department of Environmental Medicine (IMM), Karolinska Institutet
4.	Danish Research Centre for Migration, Ethnicity and Health, University of Copenhagen, Denmark
5.	OECD
6.	Ministry of the Interior of the Czech Republic
7.	Dignity.dk
8.	Finnish Immigration Service
9.	Expert Council of German Foundations on Integration and Migration (SVR)

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[97] All actions identified at the workshop have been followed up by the study team with positive results.

Organisations participating in the workshop	
10.	Medecins Sans Frontiers (MSF)
11.	National Institute for Health and Welfare
12.	EPHA
13.	University of Cassino and Southern Lazio
14.	NAKMI/ Norwegian Institute of Public Health and University of Bergen
15.	Medecins du Monde Belgique
16.	Amsterdam University Medical Center
17.	Medecins du Monde
18.	University of Edinburgh
19.	Consorci de Salut i Social de Catalunya
20.	The Lancet Commission
21.	International Organization for Migration
22.	DG SANTE
23.	Chafea
24.	Optimity Advisors

Sub-ANNEX II: Description of the results of the survey on information provided in datasets and studies

Table 41: Nature of health information the datasets/studies collected (15 responses)

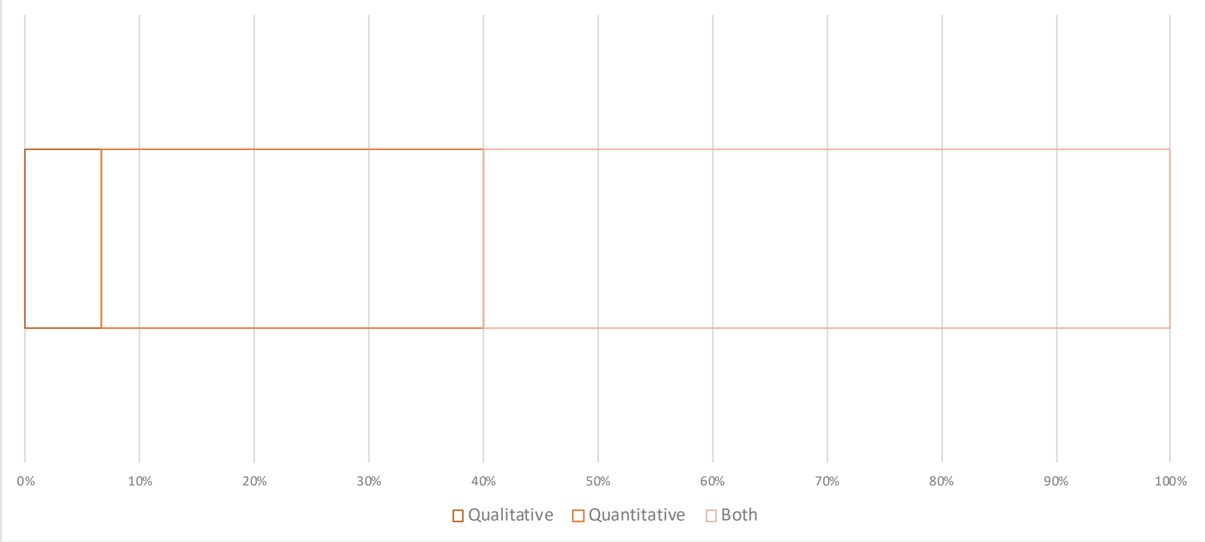


Table 42: Number of datasets/studies collecting demographic information

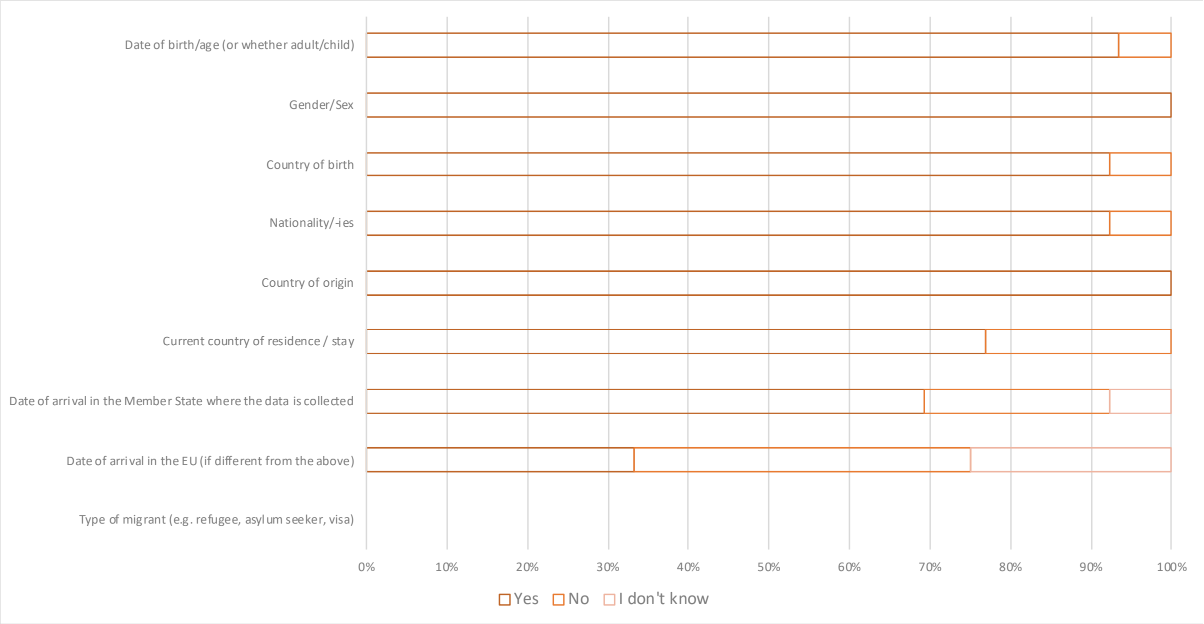


Table 43:Number of datasets/studies collecting information on specific non- communicable diseases

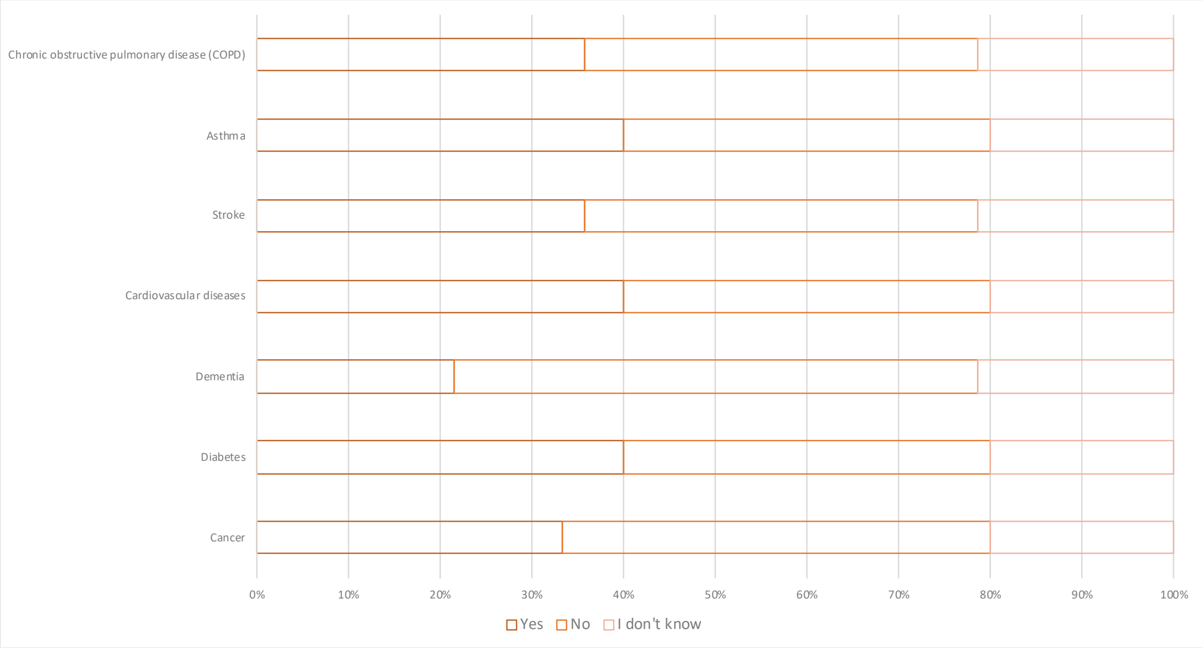
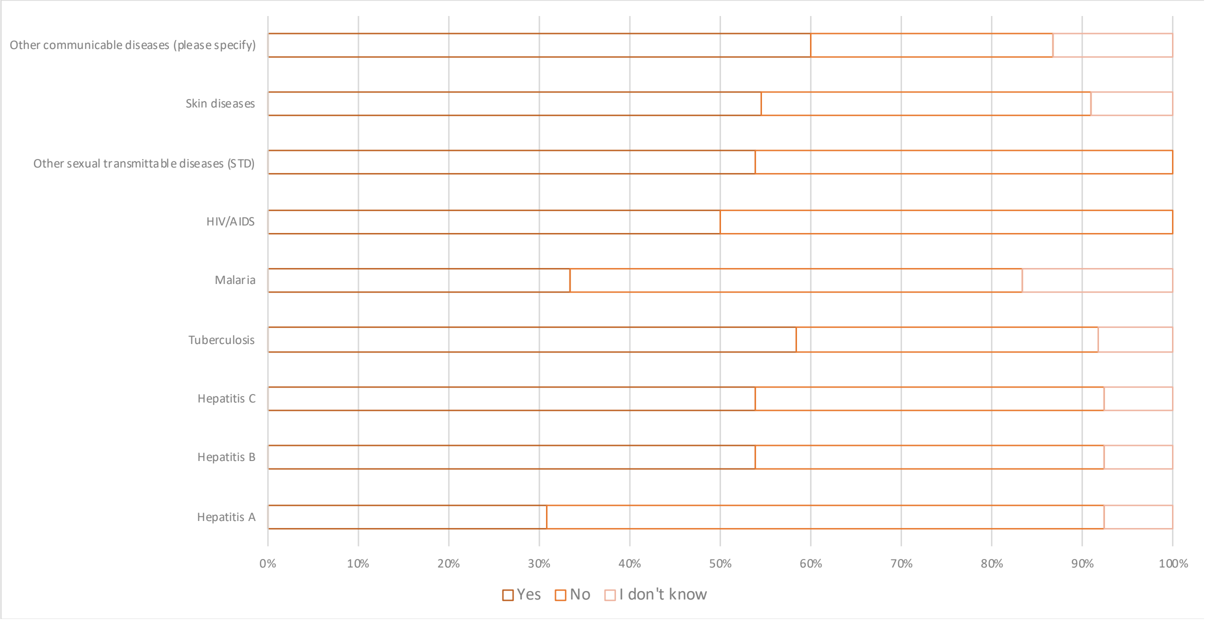


Table 44: Number of datasets/studies collecting information on specific communicable diseases



Annex 3 – D3 Country fiches

Because of our strict data usage protocol, the country fiches, which partially include sensitive information, were delivered as a standalone file for Commission use only. A description of the content is provided below.

Description of the content of the country fiches

D3 consists of 33 country fiches which aim at providing an overview on population statistics of a country, key health indicators and the number of migrants who have arrived in the country since 2015. In addition, information about the systems of health financing as well as the access to health services provided to migrants and asylum seekers, based on national services as well as the Migration Integration Policy Index (MIPEX), is presented. Finally, the list of data sources contacted by country is given in the country fiches.

In detail, the fiches include information on:

- **Population statistics** (based on data by Eurostat); Including information on population size and population density
- **Health statistics** (based on data by Eurostat as well as the State of Health in the EU reports for the respective countries); Including information on life expectancy, fertility rate, mortality rate, total health expenditure as well as the top causes of death in the county
- **Migration statistics** (based on data by Eurostat); Including first time asylum applicants and immigration from Non-EU28 countries
- **Health services for migrants** (based on several national sources); including information on the primary health care procedure of asylum seekers in the respective countries
- **Access to health according to the Migration Integration Policy Index (MIPEX)** (based on the WHO (2018) Report on the health of refugees and migrants in the WHO European Region); including information on the access to healthcare and the extent of provisions in the respective countries
- **List of sources contacted to request relevant data on migrants' health;** including information on the type of source, the name of the national source, the response status (Y/N), information on the relevance for the study considering the answer (Y/N) and a description of the answer.

Annex 4 – Tools for the study

Annex 4.1: Migrants' pathways

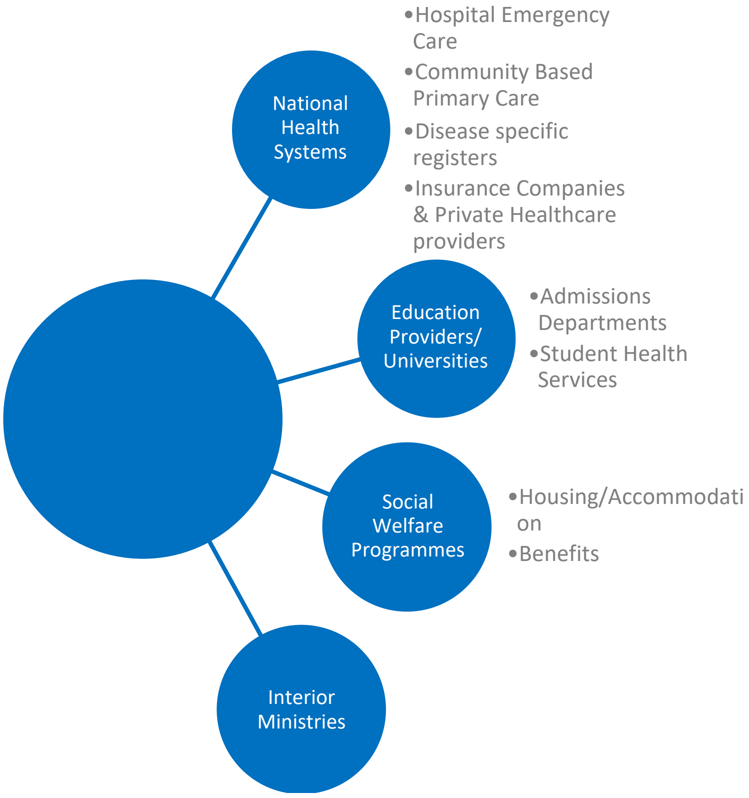
To map a comprehensive list of organisations at national level that could potentially hold relevant data for the study, the study team has started to develop a series of pathways for newly arrived migrants and their possible contacts with organisations and institutions carrying out an assessment of their health status. The types of migrants have been divided according to the following typology:

- Group 1: Legally Residing Residents
- Group 2: Asylum Seekers and Refugees
- Group 3: Detected Irregular Migrant
- Group 4: Undetected Irregular Migrant

Below, the pathways are presented.

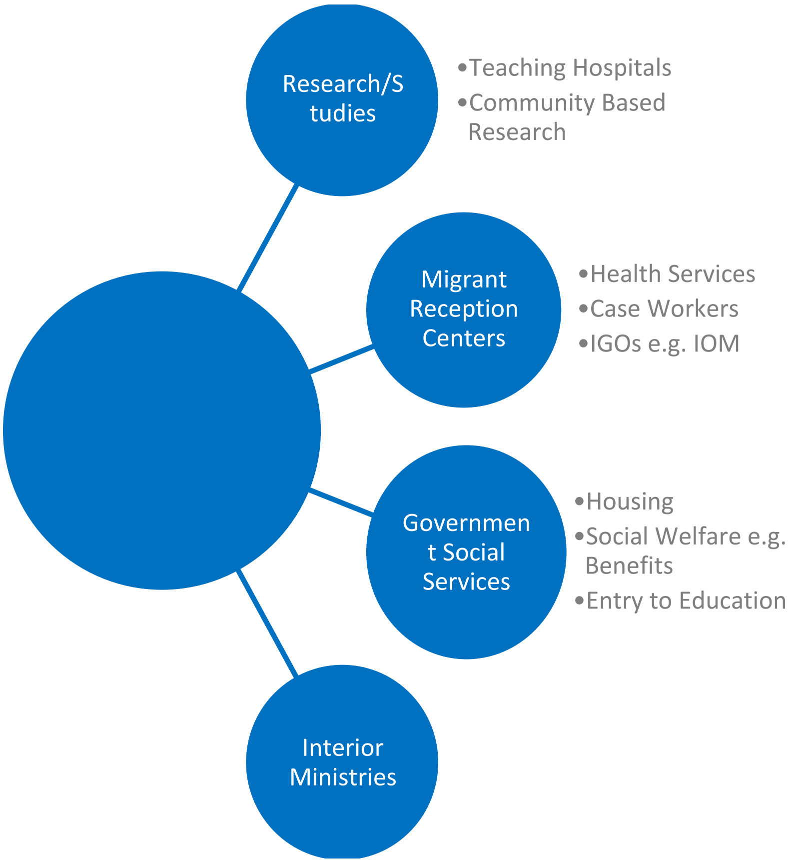
Group 1: Legally Residing Residents

These are third country nationals (non-EU) that arrived in the EU and HP participating countries since 2015 and are residing in the EU in a regular manner through work visas, study/research visas, family reunification visas.



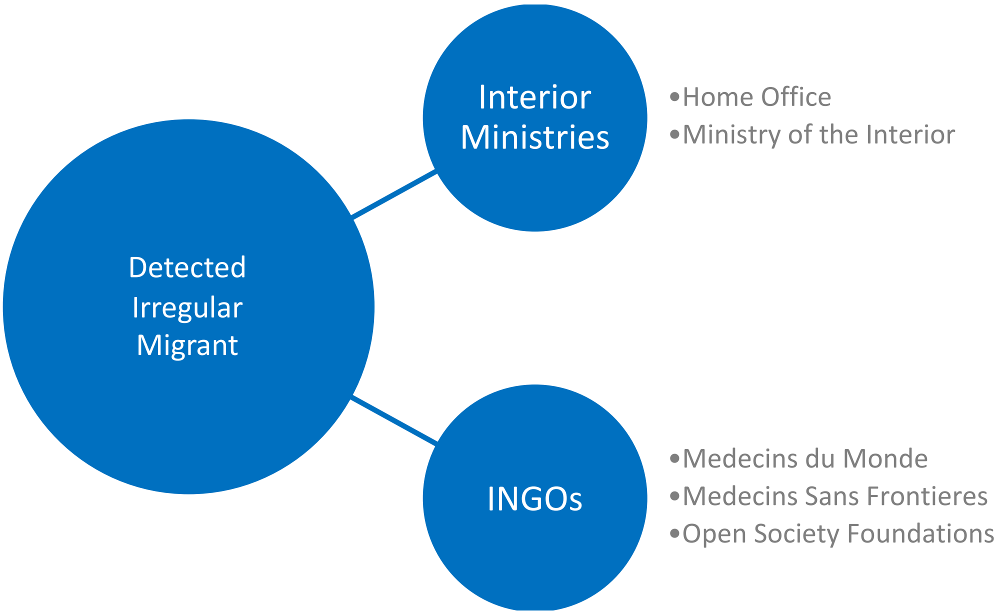
Group 2: Asylum Seekers and Refugees

These are third country nationals that submitted an application for refugee status in the EU since 2015 and which are awaiting the decision, asylum seeker who has been granted refugee status or subsidiary protection status in an EU Member State, and third country nationals that applied for asylum in the EU, but was rejected and is awaiting to be returned.



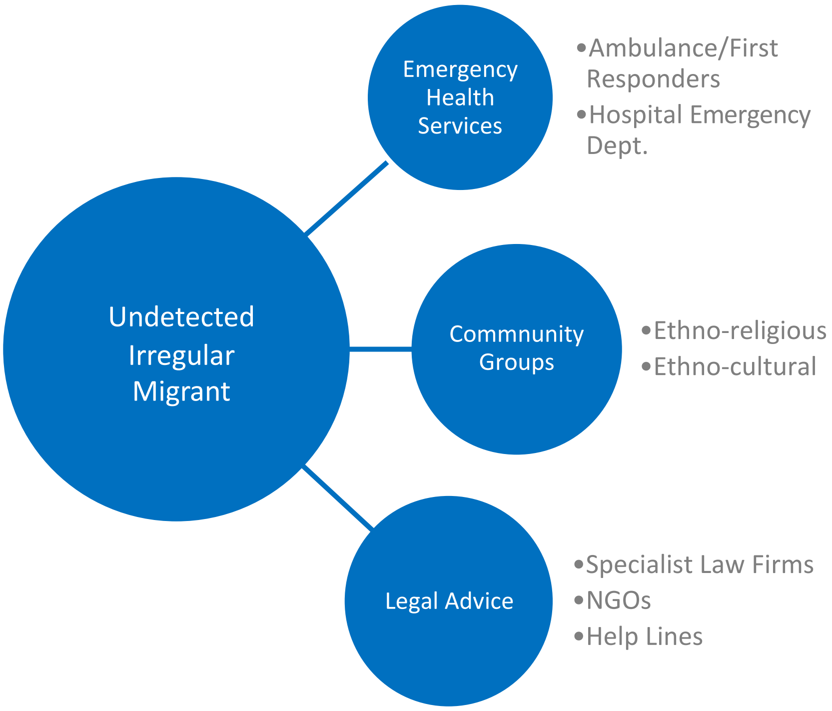
Group 3: Detected Irregular Migrant

These are third country nationals (non-EU) that are apprehended for entering, staying or residing in the EU illegally, and are awaiting to be returned (often whilst being detained).



Group 4: Undetected Irregular Migrant

These are third country nationals that are staying in the EU illegally.



Annex 4.2: Interview questionnaire

- Introduction to the Team and the study objectives.
- Questions:

1. Please could you tell us a bit more about the organisation you work for and your role? More specifically, how does your organisation interact with migrants and/or refugees?
2. Has your organisation been recording/collecting data on the health status of newly arrived migrants and refugees to Europe since 2015? If yes, for what purpose?

If the answer to Question 2 is NO:

A. Do you know any organisations that do record or collect data on the health status of migrants and refugees that arrived in the EU since 2015?

B. Do you know any EU-level or national level datasets on the health status of migrants and refugees within the EU, since 2015?

If the answer to Question 2 is YES: Would you mind going through a few questions to discuss the type of information you collect?

Questions on what type of information the organisation records or collects?	
Questions	**Prompts**
• **Q3:** What is the nature of the health information? Is the health information qualitative or quantitative (e.g. a dataset or a narrative report)?	• Quantitative • Qualitative
• **Q4:** What is the form of the health information (e.g. dataset, report, etc.)?	•
• **Q5:** Is the information collected directly by the source or aggregated from other sources? If so, which ones? •	• Source • Aggregated from other sources •
• **Q6:** Which types of migrants does the information cover?	• Multiple options possible: • All types of people, including migrants and refugees (see Q9) • Regular migrants (e.g. travelling to EU with study visa or work permit); • Asylum seekers; • Refugees; • Migrants arriving to the EU through family reunification; • Migrants held at the border or in detention centres (including rejected asylum seekers and detected “irregular” migrants); • Migrants staying in the EU in an “irregular” manner (e.g. overstaying visa).
• **Q7:** Can the health information of migrants and refugees be disaggregated from the data? (e.g.	• No • Yes (continue with Q8)

Questions on what type of information the organisation records or collects?	
Questions	**Prompts**
is there a marker whether or not the person is a migrant)	
• **Q8:** Which years do the health information cover? Do you collect the year/ month of arrival of the migrant?	• 2015 • 2016 • 2017 • 2018 • • Yes, by month • Yes, by year • No information on the date of arrival in the EU/EEA
• **Q9:** Which country/countries/regions does the health information cover?	• International level • EU-level • National level: one country • National level: more than one country • Other
• **Q10:** In what context was the data collected?	• Health assessment in a specific setting ○ Healthcare facility (please specify) ○ Reception facility for asylum seekers/refugee camps (please specify) ○ Detention facility (please specify) ○ Private Practice • Interview/survey as part of a piece of research • Other •
• **Q11:** Is a health information framework used to collect the data (e.g. national framework, the IOM/ DG SANTE Handbook for Healthcare Professionals, etc.)? Which one?	• No • Yes (please specify)
• **Q12:** Does the health information contain information on each of the following broad categories: • Communicable diseases; • Non-communicable diseases; • Mental health.	• • Yes (please specify which ones): ○ All/some indicators in the Table above; ○ Other indicators missing from the Table above • No
Question whether information can be shared	
• **Q13:** Is the information available or can it be made available to the study team? • Please provide a contact email or phone to enquire about the data	• Yes, raw data can be shared provided that the required data protections safeguards are put in place. *(see Q15)* • Yes, but in a summarised/synthesised report format. *(see Q15)* • *If yes, please specify contact details.* • No (see Q16)
• **Q14:** Why can the data not be shared?	• Data protection issues;

Questions on what type of information the organisation records or collects?	
Questions	**Prompts**
	- Format of the data; - If they cannot share with Optimity, could they share with the EC directly - Other reasons
- **Q15:** Please provide a short summary of the dataset(s) available to share, for example: - Processes and protocols used for health assessment and data collection methods - Indicators included in the dataset	-
- **Q16:** Have there been studies/publications done on the basis of this health information? What are they?	- Yes (please specify) - No

Annex 4.3: Online questionnaire

Introduction:

Under the 3rd EU Health Programme the Directorate General For Health and Food Safety of the European Commission (DG SANTE) committed to the Consumers Health and Food Executive Agency (Chafea) a service contract on "The health status of newly arrived migrants and refugees in EU/EEA".

The objectives of the services, contracted to Optimity Advisors, are two-fold:

- Identification of existing sources and data on the health conditions of newly arrived migrants and refugees to Europe since 2015, with a focus on data from administrative data sources, international organisations and NGO's, whether the publicly available or not;
- Assessment of actual health status of the migrants and refugees on the basis of selected sources of health information that can share their data.

Health status in the context of the study refers to:

- Physical health issues (communicable and non-communicable diseases) and;
- Mental health issues.

The assignment will cover health information of any third country national arriving in the EU/EEA as well as Health Programme participating countries (Serbia, Moldova, Bosnia-Herzegovina) since 2015. This includes information on any type of person not holding an EU passport, including asylum seekers, refugees, migrants in irregular situations, migrants arriving to the EU through family reunification, as well as regular migrants, for example arriving on a study or work permit.

The purpose of this service contract is to provide DG SANTE with the evidence needed to provide better advice and to respond questions that exist on the health of migrants coming to Europe. Moreover, the service will provide DG SANTE with a better understanding whether the health and social services in the EU Member States available to migrants need to be adapted, based on the specific needs of the migrant and refugee population

Questions	Response options
General questions	
1. Which of the following organisation categories describes your organisation the best?	International organisation
	EU institution, body or agency
	NGO / Civil society organisation
	National public body or institute in the field of health and/or social services
	National public body in the field of justice and/or migration
	National statistical office
	Other (please specify)

Questions	Response options
General questions	
2. What is the name of your organisation ?	Open-Ended Response
3. What is your role within the organisation?	Open-Ended Response
4. Could we contact you by email or telephone if we have questions? If yes, please leave your contact details here.	Name
	Organisation
	Address
	Address 2
	City/Town
	State/Province
	ZIP/Postal Code
	Country
	Email Address
	Phone Number
5. Has your organisation been recording/collecting data on the health status of newly arrived migrants and refugees to Europe since 2015?	Yes, we record data on migrants/refugees as part of our operations
	Yes, we record data on migrants/refugees to measure our own performance
	Yes, we record data on migrants/refugees for the purpose of a specific/ongoing piece of research
	Yes, but only prior to 2015
	No, never
	Other (please specify)
Questions for organisations collecting data prior to 2015	
6. Could you please elaborate on the reason why you stopped recording/collecting data on the health status of migrants?	Open-Ended Response
7. Please provide a brief summary of the health information you used to record/collect regarding physical and	Open-Ended Response

Questions	Response options
General questions	
mental health status and in what period (e.g. 2011-2013):	
Questions on availability and sharing of dataset	
8. Is the health information your organisation records/collects publicly available?	Yes, data are publicly available (please provide weblink below)
	Only partially, some data are publicly available (please provide weblink below)
	No, but studies or publications have been done on the basis of this health information (please provide weblink below)
	No
	Other, please specify
	Please provide weblink here:
9. If the information is not publicly available, can it be made available to the contractor by e-mail or a shared online folder, provided that the required data protections safeguards are put in place?	Yes, analysed/synthesised information (e.g. in a report format) can be shared with the contractor
	Yes, analysed/synthesised information (e.g. in a report format) can be shared with the European Commission only
	Yes, but only raw data are available
	No, data cannot be shared
	Other, please specify
10. If the answer to the previous question was no: Why can the data not be shared?	Data protection issues
	Format of the data
	Other
	Please elaborate:
General questions about the data collected	
11. Is the information recorded/collected directly by your organisation or collected from other sources? If so, which ones?	Data are recorded/collected by my organisation
	Data are collected from other sources, namely
12. What is the nature of the health information that your organisation	Qualitative

Questions	**Response options**
General questions	
records/collects? Is the health information qualitative or quantitative (e.g. a dataset or a narrative report)?	Quantitative
	Both quantitative and qualitative
	Please elaborate
13. In what format is the health information available?	Excel spreadsheet
	Report in word or PDF
	Other (please specify)
	Please specify the format here:
14. Which years does the health information cover?	2014 or before
	2015
	2016
	2017
	2018
	Please, use this box to elaborate any issues related to the data, e.g. data are only partially available for some years
15. Which types of migrants does the information cover?	Nationals of my country or (other) EU/EEA country
	Non-EU/EEA nationals: Regular migrants (e.g. travelling to EU with study visa or work permit; non-EU/EEA nationals who have received indefinite leave to remain or residence permit);
	Non-EU/EEA nationals: Asylum seekers
	Non-EU/EEA Nationals: Refugees
	Non-EU/EEA nationals: Migrants arriving to the EU through family reunification
	Non-EU/EEA nationals: Migrants held at the border or in detention centres (including rejected asylum seekers and detected “irregular” migrants);

Questions	Response options
General questions	
	Non-EU/EEA nationals: Migrants staying in the EU in an "irregular" manner (e.g. overstaying visa).
	Other (please specify)
16. Can the health information be disaggregated by the following categories?	Yes, by country of birth
	Yes, by nationality
	Yes, by country or region of origin
	No, data cannot be disaggregated
	Other type of marker (please specify)
17. What is the geographical coverage of the health information?	International level
	EU-level
	EEA level
	National level: one country (please specify countries in comment box)
	National level: more than one country (please specify countries in comment box)
	Regional level: Region within a country (please specify region and country)
	Other (please specify)
	Please specify here:
18. In what context was the data recorded/collected?	Health assessment in Healthcare facility (please specify)
	Health assessment in Reception facility for asylum seekers/refugee camps (please specify)
	Health assessment in Detention facility (please specify
	Health assessment in Private Practice
	Interview/survey as part of a piece of research
	Other (please specify)

Questions	Response options
General questions	
	Please specify here:
19. Is a health information framework used for data collection?	Yes, national framework (please specify)
	Yes, IOM/DG SANTE Handbook for Healthcare Professionals
	Yes, the ECDC Syndromic Surveillance Guidelines
	Yes, the European Core Health Indicators (ECHI)
	Yes, other (please specify)
	No
	Please specify here:
20. Can you please comment on the quality of the data collected by your organisation, especially regarding limitations of the data, for example, its completeness and accuracy?	Open-Ended Response
Questions on the content of the health information collected	
21. Does your organisation record/collect any of the following demographic information?	Date of birth/age (or whether adult/child) - Yes
	Date of birth/age (or whether adult/child) - No
	Date of birth/age (or whether adult/child) - I don't know
	Gender/Sex - Yes
	Gender/Sex - No
	Gender/Sex - I don't know
	Country of birth - Yes
	Country of birth - No
	Country of birth - I don't know
	Nationality/-ies - Yes
	Nationality/-ies - No

Questions	Response options
General questions	
	Nationality/-ies - I don't know
	Country of origin - Yes
	Country of origin - No
	Country of origin - I don't know
	Current country of residence / stay - Yes
	Current country of residence / stay - No
	Current country of residence / stay - I don't know
	Date of arrival in the Member State where the data are collected - Yes
	Date of arrival in the Member State where the data are collected - No
	Date of arrival in the Member State where the data are collected - I don't know
	Date of arrival in the EU (if different from the above) - Yes
	Date of arrival in the EU (if different from the above) - No
	Date of arrival in the EU (if different from the above) - I don't know
	Type of migrant (e.g. refugee, asylum seeker, visa) - Yes
	Type of migrant (e.g. refugee, asylum seeker, visa) - No
	Type of migrant (e.g. refugee, asylum seeker, visa) - I don't know
	Other socio-economic information
22. Does your organisation record/collect information on any of the following communicable diseases?	Hepatitis A - Yes
	Hepatitis A - No
	Hepatitis A - I don't know
	Hepatitis B - Yes

Questions	Response options
General questions	
	Hepatitis B - No
	Hepatitis B - I don't know
	Hepatitis C - Yes
	Hepatitis C - No
	Hepatitis C - I don't know
	Tuberculosis - Yes
	Tuberculosis - No
	Tuberculosis - I don't know
	Malaria - Yes
	Malaria - No
	Malaria - I don't know
	HIV/AIDS - Yes
	HIV/AIDS - No
	HIV/AIDS - I don't know
	Other sexual transmittable diseases (STD) - Yes
	Other sexual transmittable diseases (STD) - No
	Other sexual transmittable diseases (STD) - I don't know
	Skin diseases - Yes
	Skin diseases - No
	Skin diseases - I don't know
	Other communicable diseases (please specify) - Yes
	Other communicable diseases (please specify) - No

Questions	Response options
General questions	
	Other communicable diseases (please specify) - I don't know
	If you selected other, please specify here:
23. Does your organisation record/collect information on any of the following non-communicable diseases?	Cancer - Yes
	Cancer - No
	Cancer - I don't know
	Diabetes - Yes
	Diabetes - No
	Diabetes - I don't know
	Dementia - Yes
	Dementia - No
	Dementia - I don't know
	Cardiovascular diseases - Yes
	Cardiovascular diseases - No
	Cardiovascular diseases - I don't know
	Stroke - Yes
	Stroke - No
	Stroke - I don't know
	Asthma - Yes
	Asthma - No
	Asthma - I don't know
	Chronic obstructive pulmonary disease (COPD) - Yes
	Chronic obstructive pulmonary disease (COPD) - No
	Chronic obstructive pulmonary disease (COPD) - I don't know
	Other (please specify)

Questions	Response options
General questions	
24. Does your organisation record/collect information on any of the following mental health conditions?	Significant mental health condition (e.g. schizophrenia) - Yes
	Significant mental health condition (e.g. schizophrenia) - No
	Significant mental health condition (e.g. schizophrenia) - I don't know
	Suicide attempt - Yes
	Suicide attempt - No
	Suicide attempt - I don't know
	Post-traumatic stress disorder (PTSD) - Yes
	Post-traumatic stress disorder (PTSD) - No
	Post-traumatic stress disorder (PTSD) - I don't know
	Depression - Yes
	Depression - No
	Depression - I don't know
	Psychological distress (e.g. anxiety) - Yes
	Psychological distress (e.g. anxiety) - No
	Psychological distress (e.g. anxiety) - I don't know
	Other (please specify)
25. Does your organisation record/collect information on any of the following?	Vaccination status (e.g. diphtheria, pertussis, poliomyelitis, measles, mumps, rubella, tetanus) - Yes
	Vaccination status (e.g. diphtheria, pertussis, poliomyelitis, measles, mumps, rubella, tetanus) - No
	Vaccination status (e.g. diphtheria, pertussis, poliomyelitis, measles, mumps, rubella, tetanus) - I don't know

Questions	Response options
General questions	
	Self-reported health status - Yes
	Self-reported health status - No
	Self-reported health status - I don't know
	Body mass index - Yes
	Body mass index - No
	Body mass index - I don't know
	Blood pressure - Yes
	Blood pressure - No
	Blood pressure - I don't know
	Regular smoking - Yes
	Regular smoking - No
	Regular smoking - I don't know
	Total alcohol consumption - Yes
	Total alcohol consumption - No
	Total alcohol consumption - I don't know
	Hazardous alcohol consumption - Yes
	Hazardous alcohol consumption - No
	Hazardous alcohol consumption - I don't know
	Drug addiction / Use of illicit drugs - Yes
	Drug addiction / Use of illicit drugs - No
	Drug addiction / Use of illicit drugs - I don't know
	Previous surgeries - Yes
	Previous surgeries - No
	Previous surgeries - I don't know
	Use of medicines - Yes

Questions	Response options
General questions	
	Use of medicines - No
	Use of medicines - I don't know
	Health service utilisation data - Yes
	Health service utilisation data - No
	Health service utilisation data - I don't know
	Other (please specify)
Concluding questions	
26. Do you know any other organisations that record/collect data on the health status of migrants and refugees?	Yes
	No
	If you agree with us contacting these organisations, can you please specify the organisation's name, relevant contacts, and/or website to relevant data set?
27. Many thanks for filling in this questionnaire. Please let us know below, if you have any other remarks or comments:	Open-Ended Response
28. If you did not leave your contact details before, but you agree for the contractor to contact you for any follow up questions, please feel free to leave your contact details here.	Name
	Organisation
	Address
	Address 2
	City/Town
	State/Province
	ZIP/Postal Code
	Country
	Email Address
	Phone Number

Annex 4.4 Data usage protocol

The health status of newly arrived migrants and refugees in EU/EEA: Data Usage Protocol, Research Ethics and Data Protection Policies

Chafea Service Contract No. 20177111[98]

Purpose of the study

Under the 3rd EU Health Programme the Directorate General for Health and Food Safety of the European Commission (DG SANTE) committed to the Consumers, Health, Agriculture and Food Executive Agency (Chafea) a service contract on “The health status of newly arrived migrants and refugees in EU/EEA”.

The objectives of the services, contracted to Optimity Advisors, are two-fold:

- Identification of existing sources and data on the health conditions of newly arrived migrants and refugees to Europe since 2015, with a focus on data from administrative data sources, international organisations and NGOs, whether the publicly available or not;
- Assessment of the actual health status of the migrants and refugees on the basis of selected sources of health information that can share their data.

The assignment covers health information of any third country national arriving in the EU, the EEA (Iceland and Norway) as well as eligible Health Programme participating countries (Serbia, Moldova, Bosnia-Herzegovina), since 2015. This includes information on any type of person not holding an EU passport, including asylum seekers, refugees, migrants in irregular situations, migrants arriving to the EU through family reunification, as well as regular migrants, for example arriving on a study or work permit. The study aims at investigating the physical as well as the psychological health status of newly-arrived migrants.

Data usage protocol

Please note: As part of the study, we do not intend to collect raw data or personal data of migrants and refugees. We are interested in identifying existing datasets that contain processed and already analysed information on the health status of migrants. In addition, we are looking for data not yet processed or analysed in the context of a systemic collection in an establishment or system, as well as data from systematic health authorities’ surveys. However, we are not interested in ad hoc research studies. Any personal, sensitive or confidential information will be handled by Optimity Advisors according the ethical study principles and data protection policy outlined below.

Data to be included in the study:

- Data collected for the timeframe after 2015;
- Data collected on the health status of migrants, i.e. non-EU national’s resident in the EU, Norway, Iceland, Serbia, Moldova and Bosnia-Herzegovina;
- Data of subsets of the migrant population in Europe: asylum seekers, refugees, irregular migrants, migrants arriving to the EU through family reunification, regular migrants e.g. arriving on a work permit or study visa;

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[98] DISCLAIMER:

This document was produced under the EU Third Health Programme [2014-2020] in the frame of a service contract with the Consumers, Health, Agriculture and Food Executive Agency (Chafea) acting under the mandate of the European Commission. The content of this report represents the views of the contractor and is its sole responsibility; it can in no way be taken to reflect the views of the European Commission and/or Chafea or any other body of the European Union. The European Commission and/or Chafea do not guarantee the accuracy of the data included in this report, nor do they accept responsibility for any use made by third parties thereof.

- Data collected on the health status of migrants in the first year of arrival since 2015 (if the data refers to a longer period than one year but does not exceed five years, it could potentially be included in the assessment).

The study team is requesting the following information from sources across the 33 study countries, and at EU and international level:

- The geographical coverage of the dataset (e.g. regional, national, international);
- The country of origin of the individual of observation;
- The date of arrival of the individual of observation;
- The context in which the data was collected (e.g. in a hospital, a reception centre, etc.);
- The key indicators that are collected (physical health (communicable and non-communicable diseases); mental health);
- The conclusions of the analysis of aggregated data.

Information can be provided directly to the study team (Mariana.Dates@optimityadvisors.com) or by completing the following survey: https://www.surveymonkey.co.uk/r/HealthStatusMigrantsStudy

The study team will ensure that:

- For the purpose of the study, contacted organisations that have relevant data will be asked to provide **their own** analysis of the data collected, description of the datasets, as well as limitations and caveats regarding the use of the data to assess the health status of migrants.
- Organisations will be asked to review and validate all information and references regarding their data to be published in the final study report. **Information that has not been signed off by the holder of the data will not be included in the study report.**
- If the data are collected but has not been analysed, the study team, the contracting authorities and the data holders will be able to discuss whether the data can be analysed **by the data holder** for the purposes of the study.

Ethical principles

Optimity Advisors' study team follows the principles of the 2017 European Code of Conduct for Research Integrity[99], the 2018 guidance on Ethics in Social Science and Humanities[100], developed for the European Commission, and the RESPECT project's EU Code of Ethics for Socio-Economic Research[101] , as well as the ethical guidance developed by the UK Government Social Research Unit, the Economic and Social Research Council (ESRC) Framework for Research Ethics, and the British Sociological Association and the Market Research Society. We apply these guidelines to all our projects where stakeholders are involved, or where we are working to collect and/or analyse confidential information.

The following **ethical principles** are embedded in the way in which we carry out our study activities:

- **Informed Consent** to ensure willing participation, purpose of the work, and permission to use the results (e.g. particularly when working with service users on co-production activities). Participants are informed about who is funding the study and for what purpose

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[99] https://ec.europa.eu/research/participants/data/ref/h2020/other/hi/h2020-ethics_code-of-conduct_en.pdf

[100] http://ec.europa.eu/research/participants/data/ref/h2020/other/hi/h2020_ethics-soc-science-humanities_en.pdf

[101] http://www.respectproject.org/ethics/412ethics.pdf

and the study team explains that participation is voluntary. As data subjects should have provided consent for the collection of their data when performing the medical care or health assessment, their explicit informed consent will not be obtained again for this study. This study is processing collected information. Therefore, the owners of databases or datasets will be the ones providing consent.

- **Meeting Confidentiality and Data Protection Requirements**. We will ensure that any information given to the study team will be held securely and confidentially. Any member of the study team who holds personal details of any study participant will inform them that their details are being held securely, not viewed by anyone who does not have a direct reason to access them, and for how long they will be held. With regards to Data Protection Requirements, Optimity Advisors is compliant with the requirements of the General Data Protection Regulation (GDPR).

In study projects, responses to personal questions, scores on tests, etc., are confidential and anonymous so that the reader of the study would be unable to deduce the identity of the individual. Individual data would be quoted by referring to participant 'X' or 'Y', etc. Subjects must be informed that confidentiality will be maintained and feel confident of the researcher's commitment to that, or else many potential subjects may refuse to take part.

With regard to protecting privacy in social research, researchers use codes to represent individuals and separate the coding key from the raw data. In terms of data security, transfer and sharing, this includes the consideration of non-disclosure and the physical aspects involved in data sharing (such as storing and accessing data) and in turn should lead to the setting of clear data protection protocols which comply with the contractual arrangements of the relevant agencies.

- **Enabling the Freedom to Withdraw**. In giving consent, participants have the right to withdraw consent as well as the right not to answer particular questions. Participants are reminded that they have a right to withdraw their consent at any time without any consequences.
- **Systematic Debriefing and Risk Minimisation.** Risks and issues related to conducting and participating in the study - in particular with regards to safeguarding privacy and appropriate measures for processing, handling, and storing data, but also potential psychological discomfort or harm where relevant- are clearly explained and all efforts are made to minimise risks. Risk assessment is a continuous activity in the study, and the risk assessment document is kept up to date.
- **Quality and Integrity of the Study.** The study team endeavours to ensuring honesty and transparency towards study subjects, and to adopting an unbiased attitude and open-minded approach to research, also when the outcome included unwanted findings. A record and audit trail of the study is kept ensuring transparency and reproducibility. Study findings are reported truthfully, accurately, comprehensively and without distortion. Optimity Advisors has a quality management system that is ISO 9001:2015 certified and ensures intellectual rigour and high-quality deliverables.
- **Study Independence and Impartiality.** To avoid potential conflicts of interest, the study team discloses sources of funding.

Data protection procedures

Purpose

The following sections explain the manner in which Optimity Advisors' study team will store and treat personal information related to the study in question. The study team is committed to the highest standards in relation to securing the integrity and confidentiality of all personal data within their control.

Applicable legislation

Optimity Advisors is fully compliant with the General Data Protection Regulation (GDPR) and has been awarded the Cyber Essentials full compliance and certification and ISO 9001 Certification on

Quality Management System Standards. In addition, all members of the Project Team have been trained in handling data in a secure way and according to the GDPR.

General principles applicable to the study

Personal data are defined as data relating to a person's:[102]

a) Racial or ethnic origin
b) Political opinions
c) Religious beliefs or other beliefs of a similar nature
d) Membership of a trade union
e) Physical or mental health or condition
f) Sexual life
g) Actual or alleged criminal offences, criminal proceedings, sentencing and convictions.

The principles set out in the GDPR are applicable to the study:

h) **Lawfulness, fairness and transparency**: personal data shall be processed fairly, lawfully and in a transparent manner.
i) **Purpose limitation**: personal data shall be collected and processed for specific purposes and those purposes are clearly indicated to individuals when collecting their personal data.
j) **Data minimisation**: personal data shall be adequate, relevant and not excessive in relation to the purpose or purposes for which they are processed.
k) **Accuracy**: personal data shall be accurate and, where necessary, kept up to date.
l) **Storage limitation**: personal data processed for any purpose or purposes shall not be kept for longer than is necessary for that purpose or those purposes.
m) **Integrity and confidentiality**: appropriate technical and organisational safeguards that ensure the security of the personal data, including protection against unauthorised or unlawful processing and against accidental loss, destruction or damage, will be installed as needed and using appropriate technology.

Personal data collected for the study shall not be transferred to a country or territory outside the European Economic Area unless that country or territory ensures an adequate level of protection for the rights and freedoms of data subjects in relation to the processing of personal data.

The study team commits to ensuring that any personal data will only be used for purpose for which it is collected. We will ensure that this data is not passed to any third party other than for a purpose required to fulfil the study contract.

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[102] Note that points b, c, d and g will not apply to this study.

Annex 5 - Complementary data from existing data sources

This section includes graphs and tables that have been provided by the organisations listed in subsection 3.2, which have been determined to be of value to the study, but are not crucial for the main data analysis in section 4.

Denmark

Organisation: Dignity, a highly specialized NGO for the treatment of trauma-affected refugees[103]

Sources and Type of Source: Data from consultation with traumatised refugees collected by Dignity, an NGO for traumatised refugees.

Population under observation: Traumatised refugees from Syria, Eritrea, Iraq, Iran and Afghanistan in Denmark.

Table 45: Measurement scales of specific conditions used for Dignity's operations

Measure	Scale
Sociodemographic data	-
Social functioning	World Health Organization Disability Assessment Schedule (WHO-DAS)
Traumatic experiences	Harvard Trauma Questionnaire (HTQ) 1
Head injuries / potential brain damage	HTQ 3
Post-Traumatic Stress Disorder (PTSD) symptoms	HTQ4
Anxiety and depression	Hopkins Symptom Checklist (HSCL)
Pain	Brief Pain Inventory (BPI)
Scope and type of treatment	-

Source: PowerPoint presentation on data collected by Dignity within their own operations.

Finland

Organisation: National Institute for Health and Welfare (THL)[104]

Sources and Type of Source: Asylum Seekers' Health and Wellbeing Survey (TERTTU) and Immunity Against Vaccine Preventable Diseases Study [105].

Population under observation: Asylum Seekers in their first year of arrival in Finland in 2018.

Information on the sample demographic and the participation rate

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[103] Data analysis has been approved by the data providers at Dignity

[104] The data analysis has been approved by one of the study authors of the TERTTU survey.

[105] The full English abstract is available under the following link : http://www.julkari.fi/bitstream/handle/10024/138298/URN_ISBN_978-952-343-351-9.pdf?sequence=1&isAllowed=y

Table 46: Participants of the survey by age group, sex and regional group

	Men	Women	Total
Adults (aged 18 years and older)	n=473 %	n=311 %	n=784[106] %
Russia and the former Soviet Union	28.5	30.2	29.2
Middle-East and North Africa	44.0	43.1	43.6
Africa (excl. North Africa)	15.9	17.4	16.5
Other regions (ex. Asia, Latin America, nationality N/A)	11.6	9.3	10.7
Adolescents (aged 13–17 years)	n=40 %	n=27 %	n=67 %
Russia and the former Soviet Union	22.5	33.3	26.9
Middle-East and North Africa	67.5	44.4	58.2
Africa (excl. North Africa)/ other regions	10.0	22.2	14.9
Primary school aged children (aged 7–12 years)	n=55 %	n=41 %	n=96 %
Russia and the former Soviet Union	47.3	36.6	42.7
Middle-East and North Africa	32.7	36.6	34.4
Africa (excl. North Africa)/ other regions	20.0	26.8	22.9
Under school aged children (aged 0–6 years)	n=70 %	n=70 %	n=140 %
Russia and the former Soviet Union	27.1	32.9	30.0
Middle-East and North Africa	52.9	52.1	52.5
Africa (excl. North Africa)	8.6	8.6	8.6
Other regions (ex. Asia, Latin America, nationality N/A)	11.4	7.1	9.3

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[106] Face-to-face interview data is available for 781 participants because 1 person participated in the interview only partially and 2 persons participated in the health examination only.

Source: TERTTU survey main findings summary provided to Optimity. More information can be found in the full report available via the following link (in Finnish): http://www.julkari.fi/bitstream/handle/10024/138298/URN_ISBN_978-952-343-351-9.pdf?sequence=1&isAllowed=y

Information on somatic diseases by sex and age groups

Table 47: Most common somatic diseases by sex among adults

	Men	**Women**	**Total**
	n=471 % (95 % CI)	n=309 % (95 % CI)	n=780 % (95 % CI)
Cardiovascular disease previously diagnosed by a physician[107]	16.6 (13.5–20.2)	23.0 (18.6–28.0)	19.1 (16.5–22.0)
Musculoskeletal disease previously diagnosed by a physician[108]	14.9 (11.9–18.4)	23.3 (18.9–28.3)	18.2 (15.6–21.1)
Respiratory disease previously diagnosed by a physician[109]	7.2 (5.2–9.9)	13.9 (10.5–18.2)	9.9 (8.0–12.2)

CI = confidence interval; Source: TERTTU survey main findings summary provided to Optimity. More information can be found in the full report available via the following link (in Finnish): http://www.julkari.fi/bitstream/handle/10024/138298/URN_ISBN_978-952-343-351-9.pdf?sequence=1&isAllowed=y

Table 48: Most common somatic diseases by regional group among adults

	18–29 years	**30–39 years**	**40+ years**
	n=291, % (95 % CI)	n=289, % (95 % CI)	n=200, % (95 % CI)
Cardiovascular disease previously diagnosed by a physician[107]	12.0 (8.8–16.3)	14.9 (11.2–19.5)	35.5 (29.2–42.2)
Musculoskeletal disease previously diagnosed by a physician[108]	13.4 (9.9–17.8)	15.9 (12.1–20.6)	28.5 (22.7–35.2)
Respiratory disease previously diagnosed by a physician[109]	7.6 (5.0–11.2)	10.4 (7.4–14.5)	12.5 (8.6–17.9)

Source: TERTTU survey main findings summary provided to Optimity. More information can be found in the full report available via the following link (in Finnish): http://www.julkari.fi/bitstream/handle/10024/138298/URN_ISBN_978-952-343-351-9.pdf?sequence=1&isAllowed=y

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[107] Cardiovascular diseases (ICD-10 I00-I99) previously diagnosed by a physician

[108] Musculoskeletal diseases (ICD-10 M00-M99) previously diagnosed by a physician

[109] Respiratory diseases (ICD-10 J00–J99) previously diagnosed by a physician

Information on mental health by regional group, sex and age groups

Table 49: Mental health symptoms, diagnosis and experiences of potentially traumatic events by regional group

	Russia and the former Soviet union	**Middle-East and North Africa**	**Africa (excl. North Africa)**	**Other regions**
	n=229, % (95 % CI)	n=340, % (95 % CI)	n=127, % (95 % CI)	n=84, % (95 % CI)
Significant depressive and anxiety symptoms (past 7 days)[110]	32.3 (26.4–38.7)	36.6 (31.5–42.0)	61.3 (52.3–69.7)	34.9 (25.5–45.8)
Likelihood of having had experienced traumatic events[111]				
moderately high risk	28.9 (23.4–35.2)	35.1 (30.2–40.3)	43.3 (35.0–52.1)	29.8 (21.0–40.4)
high risk	9.2 (6.1–13.7)	18.9 (15.1–23.4)	18.9 (13.0–26.7)	14.3 (8.3–23.5)
Mental health diseases previously diagnosed by a physician or need for regular medications				
Depression previously diagnosed by a physician	9.2 (6.1–13.7)	13.2 (10.0–17.3)	7.1 (3.7–13.1)	13.1 (7.4–22.1)
Other type of mental health disorder previously diagnosed by a physician	4.4 (2.4–7.9)	3.8 (2.2–6.5)	NA	NA
Self-reported use or regular need for tranquilisers, mood stabilisers or sleep medicine	6.9 (4.2–11.1)	8.5 (5.9–12.0)	7.3 (3.8–13.4)	NA
Potentially traumatic events prior to arrival to Finland				
Imprisoned or kidnapped	30.6 (24.9–36.8)	27.2 (22.7–32.2)	53.2 (44.4–61.7)	29.8 (21.0–40.4)
Tortured	30.8 (25.2–37.2)	38.5 (33.4–43.8)	60.3 (51.5–68.5)	42.9 (32.7–53.6)

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[110] Measured with the 25 item Hopkins Symptoms Check List (HSCL-25)

[111] Measured with the Process of Recognition and Orientation of Torture Victims in European Countries to Facilitate Care and Treatment (PROTECT) tool that estimates the likelihood of having had experienced traumatic events based on somatic and psychological symptoms

	Russia and the former Soviet union	Middle-East and North Africa	Africa (excl. North Africa)	Other regions
Sexual abuse	9.6 (6.4–14.2)	11.1 (8.1–14.9)	34.1 (26.4–42.8)	10.7 (5.7–19.3)
Forced or tricked into something against own will	32.9 (27.1–39.3)	32.1 (27.3–37.3)	57.6 (48.8–66.0)	33.3 (24.1–44.1)

CI = Confidence interval; NA=Estimates not possible because regional group consists n<30 or observation unit size is n<5; Source: TERTTU survey main findings summary provided to Optimity. More information can be found in the full report available via the following link (in Finnish): http://www.julkari.fi/bitstream/handle/10024/138298/URN_ISBN_978-952-343-351-9.pdf?sequence=1&isAllowed=y

Table 50: Mental health symptoms, diagnosis and experiences of potentially traumatic events by sex among adults

	Men	Women	Total
	n=471, % (95 % CI)	n=309, % (95 % CI)	n=780, % (95 % CI)
Significant depression and anxiety symptoms (past 7 days)[112]	34.7 (30.4–39.2)	45.8 (40.2–51.5)	39.1 (35.6–42.6)
Likelihood of having had experienced traumatic events[113]			
moderately high risk	32.6 (28.5–37.0)	36.2 (31.1–41.8)	34.1 (30.8–37.5)
high risk	12.2 (9.5–15.4)	20.7 (16.5–25.6)	15.6 (13.2–18.3)
Mental health diseases previously diagnosed by a physician or need for regular medications			
Depression previously diagnosed by a physician	8.7 (6.5–11.6)	14.6 (11.0–19.0)	11.0 (9.0–13.4)
Other type of mental health disorder previously diagnosed by a physician	3.6 (2.3–5.7)	3.6 (2.0–6.3)	3.6 (2.5–5.2)
Self-reported use or regular need for tranquilisers, mood stabilisers or sleep medicine	6.6 (4.6–9.2)	8.8 (6.0–12.6)	7.4 (5.8–9.5)
Potentially traumatic events prior to arrival to Finland			
Imprisoned or kidnapped	40.2 (35.8–44.7)	21.4 (17.1–26.3)	32.7 (29.5–36.1)

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[112] Measured with the 25 item Hopkins Symptoms Check List (HSCL-25)

[113] Measured with the Process of Recognition and Orientation of Torture Victims in European Countries to Facilitate Care and Treatment (PROTECT) tool that estimates the likelihood of having had experienced traumatic events based on somatic and psychological symptoms

	Men	Women	Total
Tortured	48.3 (43.8–52.8)	28.2 (23.4–33.4)	40.3 (36.9–43.8)
Sexual abuse	7.7 (5.6–10.5)	24.4 (19.9–29.6)	14.4 (12.1–17.0)
Forced or tricked into something against own will	37.7 (33.4–42.2)	35.0 (29.8–40.5)	36.6 (33.3–40.1)

CI = Confidence Interval; Source: TERTTU survey main findings summary provided to Optimity. More information can be found in the full report available via the following link (in Finnish): http://www.julkari.fi/bitstream/handle/10024/138298/URN_ISBN_978-952-343-351-9.pdf?sequence=1&isAllowed=y

Table 51: Mental health symptoms, diagnosis and experiences of potentially traumatic events by age group among adults

	18–29 years	30–39 years	40+ years
	n=291, % (95 % CI)	n=289, % (95 % CI)	n=200, % (95 % CI)
Significant depression and anxiety symptoms (past 7 days)[114]	44.2 (38.5–50.1)	36.0 (30.5–41.8)	36.1 (29.6–43.2)
Likelihood of having had experienced traumatic events[115]			
moderately high risk	32.6 (28.5–37.0)	36.2 (31.1–41.8)	34.1 (30.8–37.5)
high risk	12.2 (9.5–15.4)	20.7 (16.5–25.6)	15.6 (13.2–18.3)
Mental health diseases previously diagnosed by a physician or need for regular medications			
Depression previously diagnosed by a physician	8.2 (5.6–12.0)	10.7 (7.6–14.9)	15.5 (11.1–21.2)
Other type of mental health disorder previously diagnosed by a physician	2.4 (1.2–5.0)	3.1 (1.6–5.9)	6.0 (3.4–10.3)
Self-reported use or regular need for tranquilisers, mood stabilisers or sleep medicine	8.5 (5.7–12.3)	4.7 (2.7–7.9)	9.8 (6.4–14.9)

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[114] Measured with the 25 item Hopkins Symptoms Check List (HSCL-25)

[115] Measured with the Process of Recognition and Orientation of Torture Victims in European Countries to Facilitate Care and Treatment (PROTECT) tool that estimates the likelihood of having had experienced traumatic events based on somatic and psychological symptoms

	18–29 years	30–39 years	40+ years
Potentially traumatic events prior to arrival to Finland			
Imprisoned or kidnapped	34.5 (29.2–40.1)	29.2 (24.2–34.7)	35.2 (28.8–42.1)
Tortured	40.5 (35.0–46.3)	37.5 (32.1–43.2)	43.9 (37.2–50.9)
Sexual abuse	13.2 (9.7–17.6)	16.4 (12.6–21.2)	13.1 (9.0–18.5)
Forced or tricked into something against own will	33.6 (28.3–39.2)	39.4 (33.9–45.2)	37.1 (30.6–44.0)

CI = Confidence Interval; Source: TERTTU survey main findings summary provided to Optimity. More information can be found in the full report available via the following link (in Finnish): http://www.julkari.fi/bitstream/handle/10024/138298/URN_ISBN_978-952-343-351-9.pdf?sequence=1&isAllowed=y

Information on self-rated health of adults by sex and age group

Table 52: Self-rated health and self-reported long-term illness or health problem by sex among adults

	Men	Women	Total
	n=470 % (95 % CI)	n=310 % (95 % CI)	n=780 % (95 % CI)
Self-rated health good/rather good	67.4 (63.1–71.5)	63.5 (58.0–68.7)	65.9 (62.5–69.1)
Self-reported long-term illness/health problem	37.4 (33.2–41.9)	48.7 (43.2–54.3)	41.9 (38.5–45.4)

CI = Confidence Interval; Source: TERTTU survey main findings summary provided to Optimity. More information can be found in the full report available via the following link (in Finnish): http://www.julkari.fi/bitstream/handle/10024/138298/URN_ISBN_978-952-343-351-9.pdf?sequence=1&isAllowed=y

Table 53: Self-rated health and self-reported long-term illness or health problem by age group among adults

	18–29 years	30–39 years	40+ years
	n=291 % (95 % CI)	n=289 % (95 % CI)	n=200 % (95 % CI)
Self-rated health good/rather good	66.3 (60.7–71.5)	70.4 (64.8–75.4)	58.8 (51.8–65.4)
Self-reported long-term illness/health problem	*30.6 (25.6–36.1)*	*45.3 (39.7–51.1)*	*53.5 (46.6–60.3)*

CI = Confidence Interval; Source: TERTTU survey main findings summary provided to Optimity. More information can be found in the full report available via the following link (in Finnish): http://www.julkari.fi/bitstream/handle/10024/138298/URN_ISBN_978-952-343-351-9.pdf?sequence=1&isAllowed=y

Information on self-rated health of primary school aged children (aged 7-12 years) and under school aged (aged 0-6 years) boys and girls.

Table 54: Self-rated health and self-reported long-term illness or health problem by sex among primary school aged children (aged 7–12 years)

	Total
	n=65 % (95 % CI)
Self-rated health good/rather good	83.1 (72.0–90.4)
Self-reported long-term illness/health problem	27.7 (18.2–39.7)

CI, Confidence Interval; Source: TERTTU survey main findings summary provided to Optimity. More information can be found in the full report available via the following link (in Finnish): http://www.julkari.fi/bitstream/handle/10024/138298/URN_ISBN_978-952-343-351-9.pdf?sequence=1&isAllowed=y

Table 55: Self-rated health and self-reported long-term illness or health problem by sex among under school aged children (aged 0–6 years)

	Boys	**Girls**	**Total**
	n=70 % (95 % CI)	n=70 % (95 % CI)	n=140 % (95 % CI)
Self-rated health good/rather good	92.8 (83.7–97.0)	88.6 (78.8–94.2)	90.6 (84.6–94.5)
Self-reported long-term illness/health problem	15.7 (8.9–26.2)	10.0 (4.8–19.5)	12.9 (8.2–19.5)

CI = Confidence Interval; Source: TERTTU survey main findings summary provided to Optimity. More information can be found in the full report available via the following link (in Finnish): http://www.julkari.fi/bitstream/handle/10024/138298/URN_ISBN_978-952-343-351-9.pdf?sequence=1&isAllowed=y

Limitations: Note that the findings in the tables above are unadjusted, meaning that differences in prognostic factors (or baseline characteristics) between groups that may influence the outcome are not adjusted for.[116]

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[116] https://www.evidencepartners.com/glossary/adjusted-analysis/

__Malta__

Organisation: Ministry of Health (Malta)[117]

Sources and Type of Source: Data collected at reception centres in Malta.

Population under observation: Health assessments in reception facility for asylum seekers/refugee camps between 2015 and 2019 (n=9,411).

Table 56: Demographic information on age of asylum seekers in Malta

Year	Median	Max	Min	Mean
2015	27	83	0	27.057
2016	27	84	0	26.47024
2017	25	75	0	25.28129
2018	23	80	0	23.45448
2019	22	71	0	23.088
Total	24	119	0	24.67484

Source: Refugee and migrant health screening in Malta January 2015 – July 2019, provided by Infectious Disease Control Unit (IDCU) within Health Regulation Directorate Malta

Table 57: Countries of origin by year of arrival

Nationality	2015	2016	2017	2018	2019	Total
Libya	691	674	358	308	118	2,149
Syria	261	267	394	388	216	1,526
Somalia	24	200	320	421	166	1,131
Sudan	8	10	9	405	544	976
Eritrea	28	243	71	246	185	773
Bangladesh	0	0	0	243	63	306
Ukraine	51	98	30	31	17	227
Ivory Coast	18	6	2	124	70	220
Nigeria	3	7	27	33	145	215

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[117] The data analysis has been reviewed by the data provider.

Nationality	2015	2016	2017	2018	2019	Total
Gambia	6	4	2	74	127	213
Morocco	3	3	6	60	89	161
Pakistan	2	6	15	41	54	118
Egypt	22	17	10	29	37	115
Mali	30	1	4	44	35	114
Venezuela	5	12	32	29	23	101
Iraq	5	28	50	13	1	97
Senegal	23	2	1	30	37	93
N/A	21	39	18	11	2	91
Guinea	0	3	2	39	42	86
Ethiopia	5	12	13	31	8	69
Chad	0	0	0	11	40	51
Palestine	3	15	8	18	2	46
Ghana	1	4	0	11	24	40
South Sudan	0	0	0	0	35	35
Cameroon	2	0	0	19	12	33
Algeria	5	7	4	4	8	28
Macedonia	12	4	11	0	1	28
Iran	9	8	4	1	4	26
Born In Malta	0	1	1	19	2	23
Sierra Leone	0	1	4	10	7	22
Nepal	2	0	0	1	18	21
Guinea-Bissau	11	0	0	3	6	20
Tunisia	3	3	3	7	2	18
Georgia	0	2	9	4	2	17

Nationality	2015	2016	2017	2018	2019	Total
Afghanistan	0	8	5	1	2	16
Colombia	0	0	3	10	3	16
Russia	0	4	7	3	0	14
Serbia	3	6	4	0	0	13
Turkey	1	2	5	5	0	13
Niger	0	0	0	0	12	12
Burkina Faso	1	0	0	6	2	9
China	1	2	2	4	0	9
Sri Lanka	0	0	2	5	1	8
Togo	0	2	0	5	1	8
Yemen	0	0	0	4	4	8
Bangladesh	2	1	0	3	1	7
Benin	1	0	0	0	5	6
Congo DR	0	0	0	0	6	6
India	0	2	2	1	1	6
Jordan	5	0	0	1	0	6
Kurdistan	0	0	5	0	1	6
Lebanon	1	0	2	3	0	6
Armenia	2	0	1	1	0	4
Comoros	0	0	0	2	2	4
Mongolian	0	0	0	3	0	3
Somalia	2	1	0	0	0	3
USA	0	0	1	2	0	3
Zimbabwe	0	0	1	2	0	3
Albania	0	2	0	0	0	2
Central African Rep.	0	0	0	1	1	2

Nationality	2015	2016	2017	2018	2019	Total
Congo	0	0	0	1	1	2
Kenya	0	0	0	2	0	2
Liberia	0	0	1	1	0	2
Malta	0	1	0	1	0	2
Mauritania	0	0	0	2	0	2
Saudi Arabia	0	0	0	2	0	2
Uzbekistan	1	0	0	1	0	2
Yemen	1	0	1	0	0	2
Angola	0	0	0	1	0	1
Brazil	0	0	0	0	1	1
Canada	0	0	0	1	0	1
Chile	0	0	0	1	0	1
Costa Rica	0	1	0	0	0	1
Cuba	0	0	1	0	0	1
El Salvador	0	0	0	1	0	1
Greece	0	0	0	1	0	1
Indonesia	0	1	0	0	0	1
Kazakhstan	0	0	0	0	1	1
Kosovo	0	0	1	0	0	1
Kuwait	1	0	0	0	0	1
Netherlands	0	0	0	0	1	1
Total	1,276	1,710	1,452	2,785	2,188	9,411

Source: Refugee and migrant health screening in Malta January 2015 – July 2019, provided by Infectious Disease Control Unit (IDCU) within Health Regulation Directorate Malta

Information on TB and TB tests (Chest X-Rays and Mantoux test)

Table 58: Tuberculosis cases by category

Tuberculosis	**Air Lifted**	**Arrival by Boat**	**Arrival by plane**	**Total**
Extrapulmonary Tuberculosis	3	4	2	9
Pulmonary Tuberculosis	4	33	10	47
Tuberculosis Total	7	37	12	56

Source: Refugee and migrant health screening in Malta January 2015 – July 2019 provided by Infectious Disease Control Unit (IDCU) within Health Regulation Directorate Malta

Table 59: Tuberculosis cases by category

Tuberculosis	**Air Lifted**	**Arrival by Boat**	**Arrival by plane**	**Total**
Extrapulmonary Tuberculosis	3	4	2	9
Pulmonary Tuberculosis	4	33	10	47
Tuberculosis Total	7	37	12	56

Source: Refugee and migrant health screening in Malta January 2015 – July 2019, provided by Infectious Disease Control Unit (IDCU) within Health Regulation Directorate Malta

Table 60: Results First Chest X-Ray

Result First Chest X-Ray	**Freq.**	**Percent**
Abnormal	328	3.64
Normal	8571	95.16
Not Performed	62	0.69
N/A (Pregnancy)	8	0.09
Born Malta	1	0.01

Source: Refugee and migrant health screening in Malta January 2015 – July 2019 provided by Infectious Disease Control Unit (IDCU) within Health Regulation Directorate Malta

Table 61: Results of Mantoux Test, a test for immunity to tuberculosis using intradermal injection of tuberculin

1st Mtx reading	**Freq.**	**Percent**
Mantoux Negative	1,834	87.04
Mantoux >10mm & <15mm	121	5.74
Mantoux Positive (>15mm)	146	6.93
N/A	6	0.28
Total	2,107	100

Source: Refugee and migrant health screening in Malta January 2015 – July 2019 provided by Infectious Disease Control Unit (IDCU) within Health Regulation Directorate Malta

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