Healthcare Leadership and Management Development Institute (HLMDI)

Access of Migrants to Health Services in Balkan Countries

Analytical report

Gevgelija, North Macedonia, July 2019. Photo: Victor Lacken/IFRC

This research was conducted by Healthcare Leadership and Management Development Institute (HLMDI) in close collaboration with Red Cross of Bosnia and Hercegovina, Red Cross of Montenegro, Red Cross of Republic of North Macedonia and Red Cross of Serbia.

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GLOSSARY

GCR: Global Compact on Refugees[1]

Health literacy: "Health literacy implies the achievement of a level of knowledge, personal skills and confidence to take action to improve personal and community health by changing personal lifestyles and living conditions. Thus, health literacy means more than being able to read pamphlets and make appointments. By improving people's access to health information, and their capacity to use it effectively, health literacy is critical to empowerment." (WHO Health Promotion Glossary, 1998)

HLMDI: Healthcare Leadership and Management Development Institute[2]

IFRC: International Federation of Red Cross and Red Crescent Societies

Migrants: Regarding 'migrants', basically we used the terms of IFRC, but naturally migrants, refugees and asylum seekers staying in the camps were adopted according to the rules and legislation of the given country.

IFRC[3]: The approach of the Movement to migration is strictly humanitarian and based on the recognition of each migrant's individuality and aspirations.
It focuses on the needs, vulnerabilities and potentials of migrants, irrespective of their legal status, type, or category.
In order to capture the full extent of humanitarian concerns related to migration, IFRC description of migrants is deliberately broad:
Migrants are persons who leave or flee their habitual residence to go to new places – usually abroad – to seek opportunities or safer and better prospects. Migration can be voluntary or involuntary, but most of the time a combination of choices and constraints are involved.
Our use of the term 'migrant' thus includes:

- labour migrants
- stateless migrants
- migrants deemed irregular by public authorities
- migrants displaced within their own country
- refugees and asylum-seekers

UPMS: University of Pécs Medical School, Hungary[4]

VPD: Vaccine preventable diseases

WCC: World Health Organization Collaborating Centre for Migration Health Training and Research at UPMS[5]

1 https://www.unhcr.org/the-global-compact-on-refugees.html
2 http://www.hlmdi.org/en.html
3 https://www.ifrc.org/en/what-we-do/migration/what-is-a-migrant/
4 https://aok.pte.hu/en
5 https://www.mighealth-unipecs.hu/who-cc

INTRODUCTION

Dr. István Szilárd

General conditions of the research

Geographical coverage:
Bosnia and Herzegovina, Montenegro, North Macedonia, Serbia

Migration related general situation in the region, based on UNHCR reports and analysis:

Macedonian soldiers patrol the border with Greece, near Gevgelija, North Macedonia, in September 2019. Although the Balkan migrant route has been officially closed since March 2016, small groups of migrants are still illegally passing the border between Greece and North Macedonia on their way tov Western Europe. Some travel this road by foot, while others use the transport offered by migrant smugglers. Beside the North Macedonian police and army, the border with Greece is being patrolled by police forces from other European countries. (UNHCR: EPA-EFE/GEORGI LICOVSK)

Largely owing to its strategic geopolitical location, the Western Balkans has become an important hotspot on one of the main migration routes to the EU. An increasing number of refugees and migrants originated from outside the region, in particular Afghanistan, Pakistan, Palestine, Syria, Somalia and North Africa. They are arriving from Turkey and/or Greece and transiting the region using what is known as "the Western Balkan route."[6]

Although the Balkan migrant route has been officially closed since March 2016, under a deal between Brussels and Turkey, but in reality, it was never stopped. While the numbers are lower, tens of thousands still flow through the region annually, escaping war and poverty in Asia, the Middle East and North Africa. Small groups of migrants are still illegally

6 UNHCR: Refugee Protection and International Migration in the Western Balkans – Suggestions for a Comprehensive Regional Approacht. https://www.unhcr.org/en-ie/531d88ee9.pdf

passing the border between Greece and North Macedonia on their way to Western Europe. Some travel this road by foot, while others use the transport offered by migrant smugglers.

Several thousands of them are stranded in the countries in the Western Balkans. "Those countries are now undertaking a major task for the whole of Europe." – states the report of the Danish Minister of Foreign Affairs. The majority of the irregular migrants remain there without any money, and thus no chances to go back home. In the same time according to GALLUP survey the migrants related attitude of the population of the West Balkan countries was significantly worsening (See table below!)

Gallup developed the index to gauge people's acceptance of migrants not only in Europe, but throughout the rest of the world.[7]

Least- and Most-Accepting Countries for Migrants

GALLUP WORLD POLL

Least accepting of migrants

Macedonia	1.47
Montenegro	1.63
Hungary	1.69
Serbia	1.80
Slovakia	1.83
Israel	1.87
Latvia	2.04
Czech Republic	2.26
Estonia	2.37
Croatia	2.39

Table 1.

Most of accepting of migrants

Iceland	8.26
New Zealand	8.25
Rwanda	8.16
Canada	8.14
Sierra Leone	8.05
Mali	8.03
Australia	7.98
Sweden	7.92
United States	7.86
Nigeria	7.76

Table 2.

Note: Based on 138 countries surveyed in 2016; U.S. and Canada surveyed in 2017; top possible score is 9.0.

On 17 December 2018, the United Nations General Assembly affirmed the Global Compact on Refugees[8] (GCR), after two years of extensive consultations led by UNHCR with Member States, international organizations, refugees, civil society, the private sector, and experts.

The Global Compact on Refugees is a framework for more predictable and equitable responsibility-sharing, recognizing that a sustainable solution to refugee situations cannot be achieved without international cooperation.

7 https://news.gallup.com/opinion/gallup/245528/revisiting-least-accepting-countries-migrants.aspx
8 https://www.unhcr.org/the-global-compact-on-refugees.html

The GCR indicators framework

It provides a blueprint for governments, international organizations, and other stakeholders to ensure that host communities get the support they need and that refugees can lead productive lives.

It constitutes a unique opportunity to transform the way the world responds to refugee situations, benefiting both refugees and the communities that host them.

GCR four key objectives are to:

- Ease the pressures on host countries;
- Enhance refugee self-reliance;
- Expand access to third-country solutions;
- Support conditions in countries of origin for return in safety and dignity.

Outcomes

Outcome 1.1: Resources supporting additional instruments and programmes are made available for refugees and host communities by an increasing number of donors.

Outcome 2.1: Refugees are able to actively participate in the social and economic life of host countries.

Outcome 3.1: Refugees in need have access to resettlement opportunities in an increasing number of countries.

Outcome 4.1: Resources are made available to support the sustainable reintegration of returning refugees by an increasing number of donors.

GENERAL AND SPECIFIC OBJECTIVES OF THE RESEARCH

General objectives:

- To obtain information on accessibility of health services (different kinds of access barriers which may inhibit migrants, refugees and asylum seekers from seeking care);
- The provision of a realistic picture on their health status and health assistance need of them stranded in four countries of the Western Balkans;
- To obtain the information regarding responsiveness of the services (refers to polices governing the responsiveness of services to migrants' particular needs (availability of interpreters, trainings for cultural sensitivity and diversity, participation of the migrants in the service delivery, etc.);
- To obtain data regarding the access on information regarding use of the health services (health system) information and education for migrants and refugees about the health care system of the host country, as well as health education and promotion;
- Data on vulnerable target groups: health and well-being of women, children and adolescents, migrants with disability, older migrants.
- Information on collaboration of different institutions on national level, ensuring minimal loss of health care information, as well as the practice of international, governmental and nongovernmental organizations active in humanitarian assistance provision, and last but not least
- Information about the activity of national Red Cross organizations in the region.

Specific objectives:

1. Work out a feasible research plan, considering the time frame and available capacities; Work out the tools feasible for using them among refugee camps conditions;
2. Work out and launch the training program for project activists;
3. Evaluate the research tools/ questionnaires;
4. Conduct field visits for studying personally the migrant reception camps' living, hygienic and health conditions;
5. Provide an overall evaluation with conclusions and suggestions.

CHAPTER 1.

Methodological approaches, development of reseach plan and instruments

Dr. István Szilárd

Research plan development

As a result of repeated consultations between IFRC Europe Regional Health and Care Unit and the research team of HLMDI and WHO Collaborating Centre for Migration -Health Training and Research at University of Pécs Medical School (WCC-UPMS), the following reseach plan was developed and agreed that the research consists of three main items:

Questionnaire studies:

- among migrants/ refugees/ asylum seekers stranded in reception centres in four countries (Bosnia and Herzegovina, Montenegro, North Macedonia, and Serbia);
- among members of international, governmental, and non-governmental organizations providing assistance for them.

Field visits

in Bosnia and Herzegovina, Montenegro, North Macedonia, and Serbia in order to:
1: study their country specific profile and activities in health assistance provision for migrants and refugees;
2: activities of governmental, international and non-governmental organizations providing health/ mental health and humanitarian assistance.
Note: as a consequence of the COVID-19 pandemic, field visits had to be cancelled and they were replaced with online interviews/consultations.

Preparatory work, namely

- develop/design the questionnaires;
- develop and launch preparatory training for interviewers.

Preparatory work:

1. Development of the tools feasible for using them among refugee camps conditions

1.1 Migrants' health and health care access questionnaire

The scientific staff of HLMDI and WCC-UPMS has a broad experience in assessing migrants' health on both way: questionnaire study and analysis of medical records. This was the starting point when we have developed the questionnaire designed for this survey. It was containing the following items:

- basic demographics;
- migrants' self-assessed awareness of their access to health services in the countries of their current stay;

- migrants' self-assessed health status;
- risk-taking health behaviours;
- migrants' self-assessed awareness of infectious diseases;
- self-interpretation of potential barriers in accessing health care services;
- open question for general comments and recommendations how to improve health assistance provision.

Note: According to the original study plan we aimed to collect at least fifty questionnaires from all of the four countries, but because of the COVID-19 pandemic generated movement restrictions, we could not reach this - from the statistical analysis point of view - optimal figure.

1.2 Service providers' questionnaire[9]

HLMDI and WCC-UPMS has a broad experience as well in studying and analysing humanitarian and health assistance providers working conditions, attitudes and self-assessment on their limitations similar to the migrants' health assessment with questionnaires.[10]

The newly developed anonymous, self-administered questionnaire contains the following items:

- demographic data
- information of her/ his institution
- experience on working in cooperation with humanitarian organizations
- opinion on the availability of humanitarian assistances for migrants
- type of available health assistance and services for most vulnerable group of migrants
- knowledge on most common infectious diseases may occur among migrants
- knowledge, practice and attitude on preventive measures like health screening and vaccination
- perceived health, mental health risk at work and occupational tasks related training.

Note: According to the original study plan – similarly to the migrants' health care access questionnaire –, we aimed to collect at least fifty questionnaires from all of the four countries, but because of the COVID-19 pandemic generated movement restrictions and the limited unavailability of co-workers of the respective organizations, we could not reach this – from the statistical analysis point of view – optimal figure.

1.3 Develop of preparatory training for interviewers[11]

See attached the training program's schedule, the presentations and the list of participants.

Interviewing people needs special knowledge, technic and skills. Performing it with persons

9 See attached its PDF version.

10 Szilard I, Katz Z, Berenyi K, Csepregi P, Huszar A, Barath A, Marek E.: Perception of Occupational Risks and Practices of Self-protection from Infectious Diseases Among Workers in Contact with International Migrants of Hungary's Border. J Rural Med;2014, 9:(2) 59-73.

11 See attached the training program's schedule, the presentations and the list of participants.

who have troubled history, uncertain living conditions and likely were exposed to and still suffering with traumatic events, makes it even more difficult. That is why HLMDI and IFRC agreed that an intensive preparatory training would be essentially important.

HLMDI and WCC-UPMS has designed the two-day intensive training and arranged the availability of the trainers, while IFRC has recruited the interviewers in cooperation with the RC national organizations in the region and provided the necessary infrastructure and conditions for it.

2. Preparatory training for interviewers

Following the design of the questionnaires and the content, structure and timetable of the preparatory training, IFRC European Office in Budapest has organized and hosted it, recruiting participants from the National Red Cross Societies of the region. It was delivered on 05-06 March 2020. (See attached the list of the participants!) It was envisaged that the participants will train/ instruct additional interviewer in their home countries.

The training was built around four main components:[12]

- Introduction into the migration related health/ public health aspects (See attached);
- Interview technics and its social, behavioural and psychical aspects (See attached!);
- Introduction of the questionnaires and explanation of the scientific background of their content (See attached!);
- Practical aspects through the simulation/ roll play of interview situation.

Participants were offered to contact directly the trainers in case of uncertainties/ problems during the interviews in their home countries.

Note: unfortunately, the COVID-19 pandemic has badly influenced to perform their duties because of the limitation of travel and in-camp movement. It resulted lower number of interviews as it was planned originally.

List of attachments:

1. list of the participants
2. training's timetable
3. presentations:
    - Introduction into the migration related health/ public health aspects;
    - Verbal and non-verbal communication;
    - Migrant-health questionnaire;
    - Service providers questionnaire.

12 See the timetable of the training in the appendix..

CHAPTER 2.

Migrants' health and access to healthcare during transition in selected Balkan countries

Dr. Erika Marek

DEMOGRAPHIC DATA REGARDING MIGRANT STUDY-PARTICIPANTS

Location(s) of the survey in the selected Balkan countries (number of completed questionnaires):

Country	Location 1.	Location 2.	Total nr. received	Total nr. analysed
Bosnia-Herzegovina	Sarajevo (24)	---	24	24
Montenegro	Spuz (Podgorica) (27)	Danilovgrad (5)	32	28
North-Macedonia	Gevgelija (20)	Kumanovo, Tabanovce (15)	35	34
Serbia	Subotica (9)	Sombor (5)	14	14
Total			105	**100**

Table 3.

Finally, our research team received altogether 105 questionnaires, out of those 5 were excluded from analysis (as more than 90% of the questionnaire was left unfilled, 4 from Montenegro and 1 from North-Macedonia), and **a final 100 questionnaires were analysed.**

Gender-distribution of study participants (by country of current stay)

Gender	Male	Female	No response
Bosnia-Herzegovina	22	0	2
Montenegro	22	5	1
North-Macedonia	30	2	2
Serbia	13	0	1
Total	**87**	**7**	**6**

Table 4.

A great majority of migrants involved in this study were males (87%), there were only 7 females, and another 6 participants did not answered to this question.

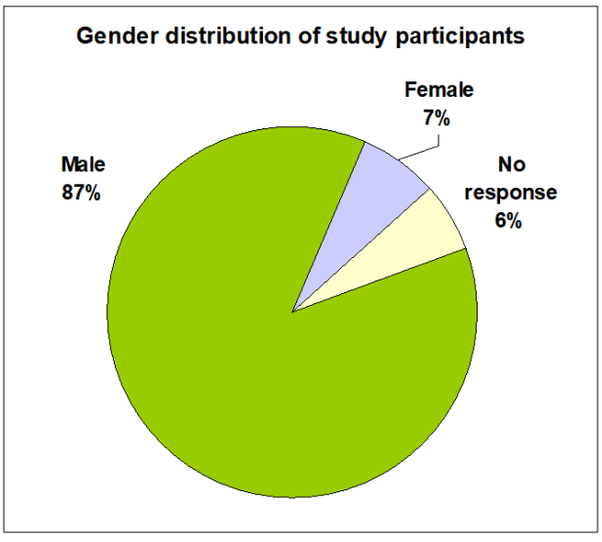

Figure 1.

Age-distribution of study participants (by country of current stay)

Country	Between 18-29 years	Between 30-39 years	Between 40-49 years	Above 50 years	No response
Bosnia-Herzegovina	15	8	1	0	0
Montenegro	5	10	7	3	3
North-Macedonia	24	8	2	0	0
Serbia	12	1	0	0	1
Total	**56**	**27**	**10**	**3**	**4**

Table 5.

Country	Mean age (SD)	Lowest	Highest
Bosnia-Herzegovina	28.9 (5.5)	21	42
Montenegro	37.9 (8.22)	24	53
North-Macedonia	25.8 (6.6)	18	41
Serbia	24.8 (5.1)	18	37
Total	**29.6 (8.36)**	**18**	**53**

Table 6.

Altogether 56% of study population was between 18 and 29 years of age; another 27% were between 30 and 39 years of age, and 10% between 40 and 49 years of age. There were only 3 people above 50 years, with the highest age of 53 years. Mean age of study participants was 29.6 years.

Study participants' country of origin (CoO) (by country of current stay)

Distribution of study participants by countries of origin:

Country of stay / Country of origin	Bosnia-Herzegovina		Montenegro		North-Macedonia		Serbia		Total	
Total	**24**	**100%**	**28**	**100%**	**34**	**100%**	**14**	**100%**	**100**	**100%**
Afghanistan	1	4%	0	0%	4	12%	6	43%	**11**	**11%**
Algeria	10	42%	1	4%	0	0%	0	0%	**11**	**11%**
Bangladesh	0	0%	0	0%	1	3%	0	0%	**1**	**1%**
Cuba	0	0%	5	18%	0	0%	0	0%	**5**	**5%**
Egypt	0	0%	1	4%	2	6%	0	0%	**3**	**3%**
India	3	13%	0	0%	0	0%	0	0%	**3**	**3%**
Iran	0	0%	11	39%	1	3%	2	14%	**14**	**14%**
Iraq	0	0%	0	0%	2	6%	1	7%	**3**	**3%**
Libya	1	4%	0	0%	1	3%	0	0%	**2**	**2%**
Morocco	4	17%	0	0%	2	6%	2	14%	**8**	**8%**
Pakistan	5	21%	4	14%	15	44%	0	0%	**24**	**24%**
Palestine	0	0%	0	0%	3	9%	0	0%	**3**	**3%**
Russia	0	0%	1	4%	0	0%	0	0%	**1**	**1%**
Somalia	0	0%	0	0%	0	0%	1	7%	**1**	**1%**
Syria	0	0%	0	0%	2	6%	1	7%	**3**	**3%**
Tunisia	0	0%	0	0%	1	3%	0	0%	**1**	**1%**
Turkey	0	0%	4	14%	0	0%	0	0%	**4**	**4%**
No response	0	0%	1	4%	0	0%	1	7%	**2**	**2%**

Table 7.

Almost one quarter (24%) of study participants has arrived from Pakistan. The second main source country of this study was Iran (14%), followed by Afghanistan and Algeria (11% both). Eight percent of study population arrived from Morocco, all other nationalities were represented by 5% of study population, or below. Participants have originated altogether from 17 different countries, and 2 participants did not indicate their countries of origin.

In order to undertake a meaningful analysis of the data, the countries of origin of participants were grouped into regions based on the classification of The World Factbook (Central Intelligence Agency (CIA), 2015). Migrants from Algeria, Egypt, Lybia, Morocco, Somalia and Tunisia were classified into the 'Africa' region; migrants from Afghanistan, Bangladesh, India, Pakistan and Russia into the 'Asians'; migrants from Iran, Iraq, Palestine, Syria and Turkey into the 'Middle East'; and migrants from Cuba were classified into the 'Central America' region.

Distribution of study participants by geographical regions:

	Africa	Asia	Middle-East	Central America	No response
Bosnia-Herzegovina	15	9	0	0	0
Montenegro	2	5	15	5	1
North-Macedonia	7	20	7	0	0
Serbia	3	6	4	0	1
Total	**27**	**40**	**26**	**5**	**2**

Table 8.

Most African migrants involved in this study were residing in Bosnia-Herzegovina (15/27), while the half of all Asian migrants were staying in North-Macedonia (20/40). The highest number of Middle-Eastern migrants were residing in Montenegro (15/26), and all of the 5 Central-American (Cuban) migrants were staying in Montenegro.

Religion and family background of study participants

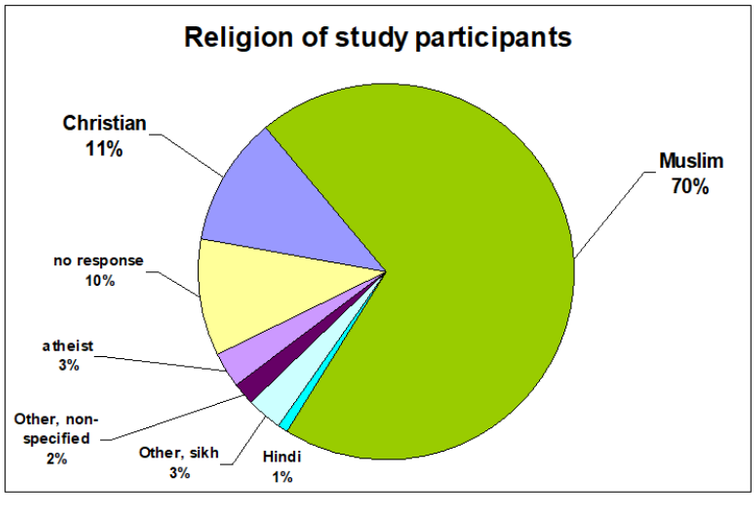

Figure 2.

Great majority of the participants (70%) identified themselves as 'Muslims', and the second most common religion was Christianity (11%). One in every ten participants did not want to answer to this question. Three-three people identified themselves as atheist or member of the sikh community, while only one participant was Hindi.

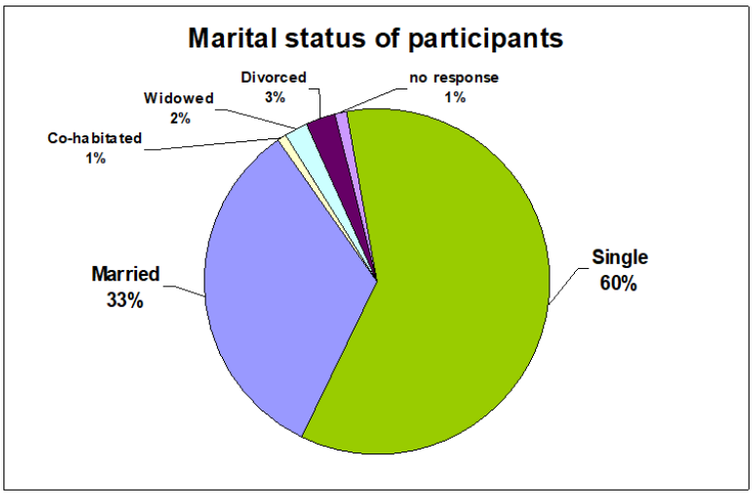

Figure 3.

According to family background and marital status, majority (60%) were single, while one-third of respondents were married (33%). One participant said he was cohabitated, 3 respondents divorced and 2 men were widowed.

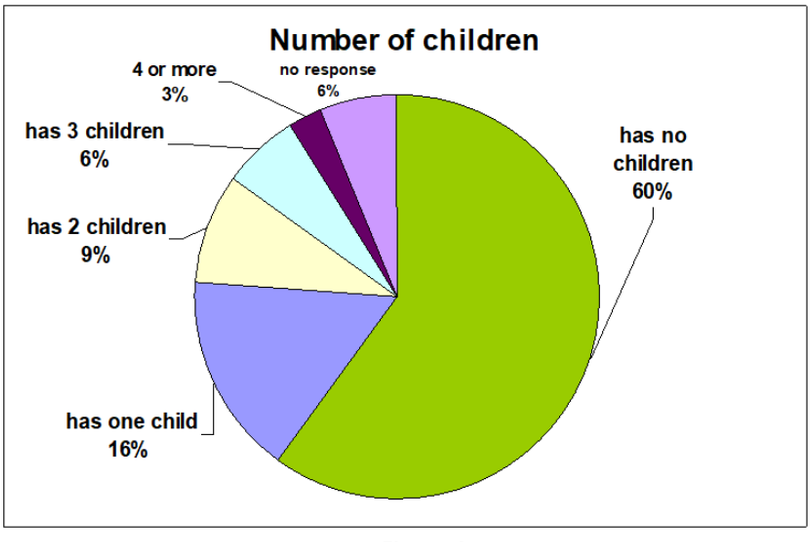

Figure 4.

Sixty percent of respondents reported not to have any children. Sixteen people said to have one child, and among them one woman was right then pregnant with her second child. Nine percent had 2 children, 6 % had 3 children and 3% had 4 or more children (one of them reported to have 9 children).

Educational level and knowledge of foreign languages

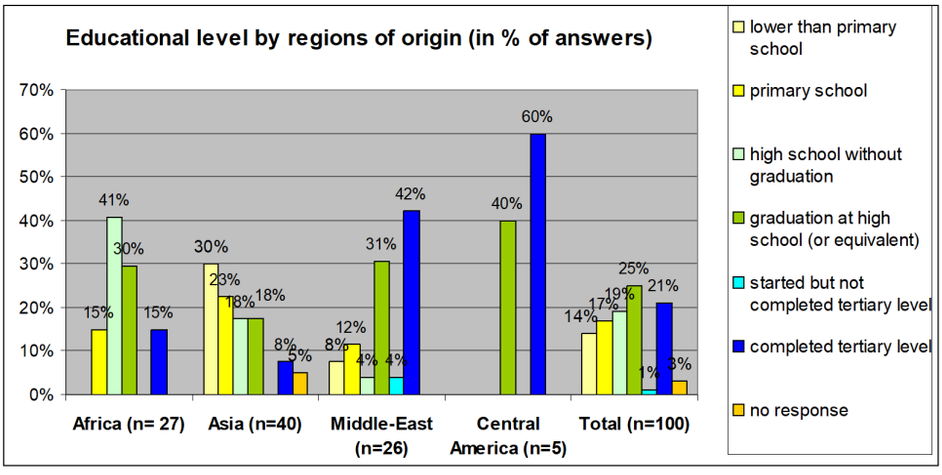

Figure 5.

The lowest educational level occurred among migrants from Asian countries, particularly from Pakistan with 30% not completing primary level education, and another 23% has completed only their primary school. An additional 18% of Asians has just started their high school studies, but did not graduate. On the contrary, the highest level of education was demonstrated (apart from the 5 Central Americans) among participants from the Middle Eastern countries, as reported, 42% of the 26 respondents from the region has completed their tertiary level education (and for one (Turkish) migrant it was interrupted, he could not finish). Overall, 31% of study participants have primary level education as the highest level, 19% has started, and a quarter of the study population has finished their secondary level education, and one-fifth of respondents reported to have completed tertiary level education.

Participants were asked to report on their language knowledge: the number of foreign languages they speak apart from their native language.

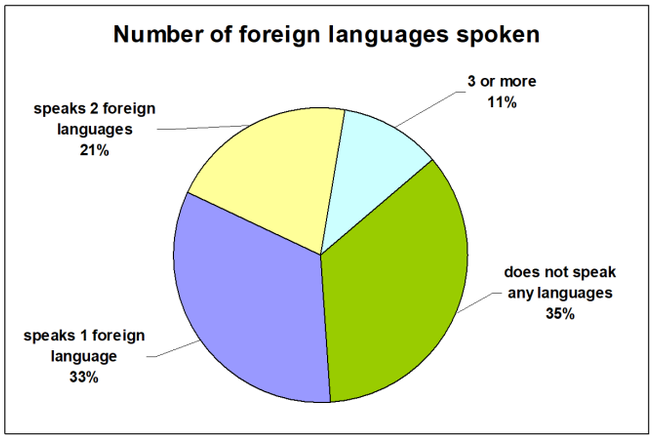

Figure 6.

Thirty-five percent of respondents does not speak any foreign languages, while 33% speaks one foreign language apart from their native language. One fifth (21%) reported to speak 2 additional languages, and 11% claimed to speak 3 or more foreign languages.

Length of stay in current country and status within the asylum process

Participants were asked to report on the length of their stay in the currect recipient country:

	not registered by the local authorities	registered but not applied for asylum	applied for asylum in current country (waiting for decision)	applied for asylum in another country	recognised as refugee (or other form of inter-national protection)	rejected asylum application (expulsed)	no response
Bosnia-Herzegovina	0	18	2	2	0	0	2
Montenegro	0	8	20	0	0	0	0
North-Macedonia	5	26	0	0	0	3	0
Serbia	2	2	2	0	5	0	3
Total	**7**	**54**	**24**	**2**	**5**	**3**	**5**

Table 9.

Twenty-three participants reported to arrive within one week to their current recipient country (22 to North-Macedonia), while 12-12% of respondents reported to arrive later than one week but not later than one month, or, between 1 or 3 months. Fifteen percent of study population reported to arrive 3-6 months ago, and 36% claimed to stay in the current recipient country for even more than 6 months. The highest number of people staying the longest time in the same country were reported from Montenegro, where out of the 28 participants 23 reported to stay there more than 3 months ago (13 more than 6 months ago).

Participants' current state within asylum recognition process

Another question was inquiring about participants' current state within asylum recognition process, and their answers were the followings (chosen from a list):

How long have you been staying in this country?	less than a week	between 1 week--- 1 month	between 1-3 months	between 3-6 months	more than 6 months	no response
Bosnia-Herzegovina	1	0	4	3	14	2
Montenegro	0	4	1	10	13	0
North-Macedonia	22	8	4	0	0	0
Serbia	0	0	3	2	9	0
Total	**23**	**12**	**12**	**15**	**36**	**2**

Table 10.

Most respondents (54%) did not apply for asylum in the current recipient country, only one-quarter did so (24%), mainly in Montenegro (20/24). Two people applied for asylum in another country (In Slovenia), and 3 participants has already received their 'rejected' decision in a country, and have been expulsed. Only 5 participants have already been recognized as refugee, or get other forms of international protection (all in Serbia: 4 Afghani and 1 Iraqi).

MIGRANTS' SELF-ASSESSED AWARENESS OF ACCESS TO HEALTH SERVICES IN COUNTRY OF CURRENT STAY

The following data are analysed either by country of current stay or region of origin.

Migrants' self-assessed familiarity with their access and obligations in relation to health services

	Response option	Bosnia-Herzegovina (n=24)		Montenegro (n=28)		North-Macedonia (n=34)		Serbia (n=14)		Total (n=100)	
		24	**%**	**28**	**%**	**34**	**%**	**14**	**%**	**100**	**%**
Familiarity with RIGHTS-BASED ACCESS TO HEALTHCARE PROVISION in current country	**yes**	8	33%	22	**79%**	13	38%	6	43%	**49**	49%
	partly	4	17%	1	4%	2	6%	2	14%	**10**	10%
	no	12	50%	4	14%	19	56%	4	29%	**39**	39%
	no response	0	0%	1	4%	0	0%	1	7%	**2**	2%
Familiarity with OBLIGATIONS on cooperating with healthcare system in current country	**yes**	3	13%	22	**79%**	12	35%	4	29%	**41**	41%
	partly	4	17%	3	11%	2	6%	2	14%	**11**	11%
	no	17	71%	3	11%	20	59%	7	50%	**47**	47%
	no response	0	0%	0	0%	0	0%	1	7%	**1**	1%
Got INFORMATION about access to health services in current country after arrival	**yes**	8	33%	20	**71%**	13	38%	5	36%	**46**	46%
	partly	7	29%	6	21%	3	9%	4	29%	**20**	20%
	no	9	38%	2	7%	17	50%	5	36%	**33**	33%
	no response	0	0%	0	0%	1	3%	0	0%	**1**	1%

Table 11.

Participants were asked to assess their familiarity with their **RIGHTS-BASED ACCESS TO HEALTHCARE** services, and their **OBLIGATIONS** according to cooperating with local health authorities in their current country of stay. They highest awareness was reported (79% saying 'yes') from Montenegro, and also study participants from Montenegro reported the most (71%) that they got the necessary information about their access to health services after arrival. The scores were the lowest in Bosnia-Herzegovina, where only 13% of participants said they are familiar with their obligations. In general, 46% of total study population reported to get information about their access to health services after arrival.

Participants were asked to identify the source of information on the available health services as follows: *'WHERE did you get information about access to services?'* Respondents may circle more options from a list, and may add additional sources.

Option of response	Bosnia-Herzegovina (n=24)		Montenegro (n=28)		North-Macedonia (n=34)		Serbia (n=14)		Total (n=100)	
	24	%	28	%	34	%	14	%	100	%
soon after arrival from border police or immigration authorities	7	29%	0	0%	1	3%	6	43%	14	14%
from immigration authorities in the camp	5	21%	3	11%	9	26%	4	29%	21	21%
from health/social care staff at the camp	3	13%	12	43%	0	0%	1	7%	17	17%
from international NGO staff at the camp	1	4%	11	39%	7	21%	1	7%	19	19%
other	0	0%	4	14%	0	0%	0	0%	4	4%
no response	8	33%	2	7%	17	50%	5	36%	32	32%

Table 12.

In Bosnia-Herzegovina and Serbia, as reported, the main sources of information were the immigration authorities either soon arrival to the country or after placement in a refugee camp. In Montenegro 'health/social care staff at the camp' or 'international NGO staff at the camp' were identified as main sources of information, in most cases the Red Cross staff. From North-Macedonia, half of study participants had not answered to this question, and more than half of those who answered (9 out of 17) declared that they were informed by 'immigrant authorities in the camp'. For some migrants (4/100), other sources of information were the followings: 'internet' and 'community members, other migrants'. In 42% of the 100 respondents they were informed orally, through a common language (mainly English) without interpreter, 20% reported to get information orally with the help of interpreter, 9% by written documents through a 3rd, common language (i.e. English), 8% by translated written documents in their own language. Four percent reported to get information through wall posters/leaflets in the reception centre, and another 2% got information through recommended websites. 28% of study population gave no answer to this question about the forms of getting information.

Migrants' perception on the availability of qualified interpreters during administrative procedures and healthcare services

	Response options	Bosnia-Herzegovina (n=24)		Montenegro (n=28)		North-Macedonia (n=34)		Serbia (n=14)		Total (n=100)	
		24	%	28	%	34	%	14	%	100	%
DURING ADMINISTRATIVE PROCEDURE AT IMMIGRATION AUTHORITY	yes, always	7	29%	7	25%	13	**38%**	2	14%	29	29%
	generally, not always	6	25%	3	11%	3	**9%**	6	43%	18	18%
	only occasionally	8	33%	3	11%	1	3%	2	14%	14	14%
	no	3	13%	15	54%	13	38%	3	21%	34	34%
	no answer	0	0%	0	0%	4	12%	1	7%	5	5%
DURING HEALTHCARE PROVISION AT RECEPTION FACILITIES (CAMPS)?	yes, always	3	13%	6	21%	16	**47%**	1	7%	26	26%
	generally, not always	6	25%	3	11%	10	**29%**	7	50%	26	26%
	only occasionally	10	42%	4	14%	0	0%	4	29%	18	18%
	no	5	21%	14	50%	7	21%	1	7%	27	27%
	no answer	0	0%	1	4%	1	3%	1	7%	3	3%

Table 13.

Qualified interpreter was available at the highest rates in North-Macedonia, both during the administrative procedures at the immigration authorities (38%, and 9% generally) and also during healthcare services at the reception centres (47% always and 29% generally). In Montenegro, 25% and 21% of study participants stated that interpreters are always available during the administrative and healthcare procedures, respectively, while in Bosnia, interpreters were reported to be available in 29% always and 25% generally during administrative procedures, while during healthcare these rates decrease to 13% always and 25% generally. When qualified interpreter is not available the language barriers are addressed in different forms (more options may be indicated).

	Response option	Bosnia-Herzegovina (n=24)		Monte-negro (n=28)		North-Macedonia (n=34)		Serbia (n=14)		Total (n=100)	
		24	%	28	%	34	%	14	%	100	%
DURING ADMINISTRATIVE PROCEDURE AT IMMIGRATION AUTHORITY	by using a third, common language (e.g. English)	9	38%	17	61%	13	38%	9	64%	48	**48%**
	by using a bilingual **STAFF member** of the authority as interpreter	11	46%	4	14%	4	12%	4	29%	23	23%
	by using an **adult family/community** member as interpreter	3	13%	9	32%	1	3%	5	36%	18	18%
	by using a **child family/ community** member as interpreter	0	0%	0	0%	0	0%	2	14%	2	2%
	without interpretation, using only metacommunication methods (body-language)	0	0%	13	46%	17	50%	1	7%	31	31%
	other option (e.g. telephone)	1	4%	3	11%	6	18%	0	0%	10	10%
	no answer (or do not know)	1	4%	3	11%	1	3%	4	29%	9	9%
DURING HEALTHCARE PROVISION AT RECEPTION FACILITIES (CAMPS)?	by using a third, common language (e.g. English)	14	58%	18	64%	9	26%	10	71%	51	**51%**
	by using a bilingual **STAFF member** of the authority as interpreter	1	4%	4	14%	13	38%	2	14%	20	20%
	by using an **adult family/community** member as interpreter	8	33%	9	32%	3	9%	5	36%	25	25%
	by using a **child family/ community** member as interpreter	0	0%	0	0%	0	0%	3	21%	3	3%
	without interpretation, using only metacommunication methods (body-language)	0	0%	11	39%	9	26%	1	7%	22	22%
	other option (e.g. telephone)	1	4%	4	14%	8	24%	0	0%	12	12%
	no answer (or do not know)	0	0%	2	7%	3	9%	1	7%	6	6%

Table 14.

In approximately half of all cases, both during administrative procedures at immigrant authorities and also during healthcare services at the refugee camps the most common way of communication between migrants and care providers is the use of a 3rd, common language, generally English (48%, 51%, respectively). At immigrant authorities this is followed by 'without interpretation, using only metacommunication methods (body-language)' which was indicated by 31% of study participants. Between 18% and 25% of cases a bilingual **STAFF member** or an **adult family/community** member is used as interpreter both during administrative procedures at immigrant authorities and also during healthcare services at camps, but the use of a child **family/community** member as interpreter is negligible (2-3%). As 'other options' when interpreter is not available, the use if internet-based translators ('Google translator') was mentioned at the highest rate, in 10-12% of all cases.

Migrants' participation in health-screening in current country of stay

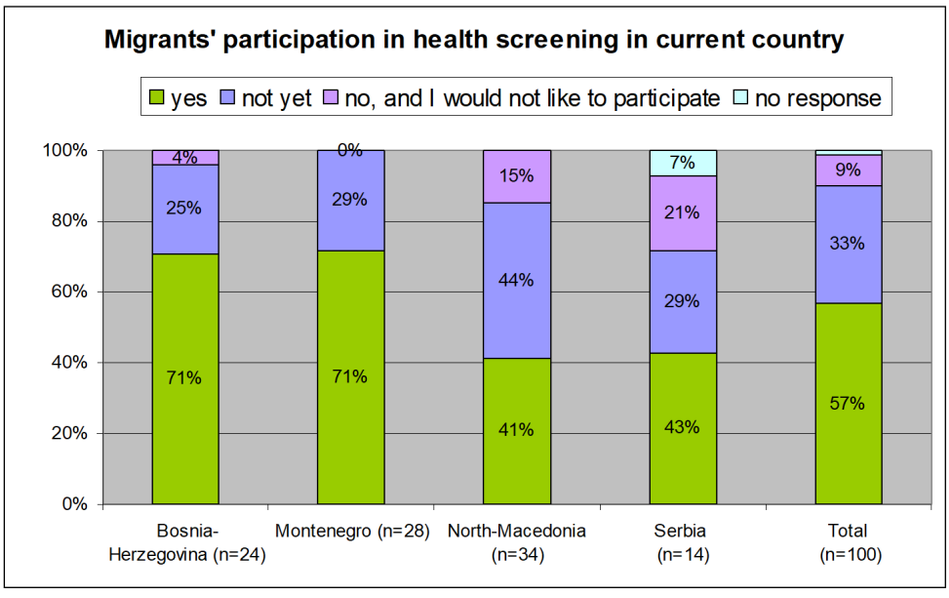

Figure 7.

Totally, as reported 57% of study population had already participated at health screening at their current country of stay, the highest proportion was observed in Bosnia-Herzegovina and Montenegro, with 71% participation in both countries.

Those people, who answered to the previous question positively (’yes’), were further questioned about the timing and the actor organization of the health screening.

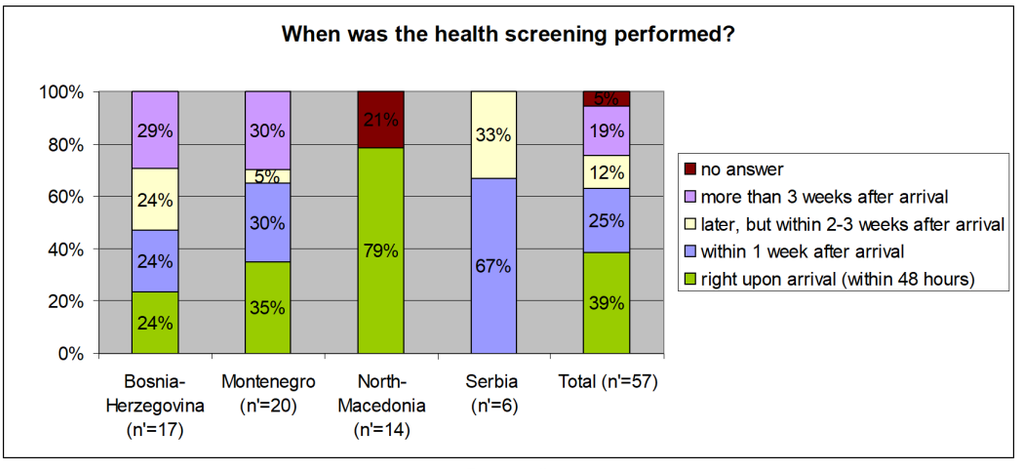

Figure 8.

As reported, in nearly 40% of all cases the health screening was performed within 48 hours after migrants’ arrival to the camp, with the highest rates reported from North-Macedonia, where 79% of respondents stated that the health screening was performed soon after arrival. Please, note that according to this question the total numbers are refer only to those participants who answered to the previous question ’yes’ (n’=57), therefore to this question the number of respondents from each participating country is much lower than the total number of study participants (indicated as ‘no’)!

The same group of study participants (i.e. those who participated already at medical screening procedure) were asked to report on the organization which had the screening performed (if they knew). Their answers were shared as follows (more options were indicated in some cases!):

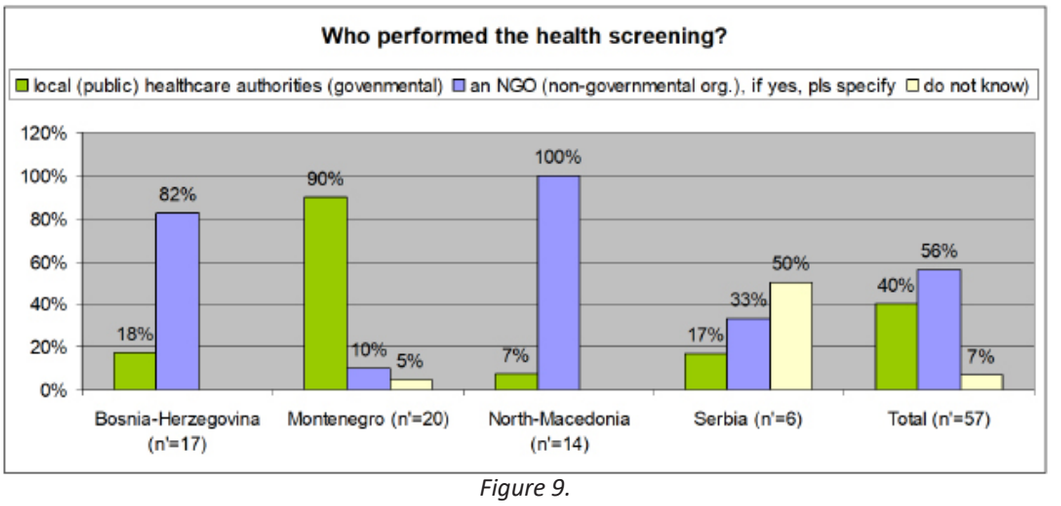

Figure 9.

In majority of total cases, as reported, members of a non-governmental organization (NGO) preformed the health check-ups (56%), 40% of the respondent reported that screenings were performed by public healthcare authorities. Answers differed greatly by countries of current stay, for example, in Montenegro, in 90% of cases it was the local public health authorities who were reported as performing the screenings, while in Bosnia-Herzegovina and North-Macedonia, in majority of cases an NGO was indicated as health service providers. From Serbia, out of the total 14 study participants, only 6 reported to participate at any kind of health screening, and out of these 6 people, only 3 answered to this question, one saying 'public health authority' while 2 saying 'an NGO' performed the screenings.

Four different NGOs were named by study participants: Danish Refugee Council in 7 cases (DRC), in 1 case Doctors Without Borders, in 6 cases International Organization for Migration (IOM) and in most cases (23) Red Cross (RC), mainly from Bosnia-Herzegovina (12/23) followed by North-Macedonia (10/23).

Participants were asked to select from a list different kinds of health assessment methods that apply for their previous health screenings. They could select more options:

Optional answers	Bosnia-Herzegovina (n'=17)	Montenegro (n'=20)	North-Macedonia (n'=14)	Serbia (n'=6)	Total (n'=57)
1. discussion, questions regarding my health	94%	80%	86%	83%	86%
2. my skin was checked for ectoparasites (lice, scabies)	65%	10%	86%	83%	53%
3. physical examination was completed	59%	20%	21%	33%	33%
4. blood sample was taken	0%	5% (1 case!)	14%	17% (1 case!)	7%

Optional answers	Bosnia-Herzegovina (n'=17)	Montenegro (n'=20)	North-Macedonia (n'=14)	Serbia (n'=6)	Total (n'=57)
5. faces sample was taken	0%	0%	0%	0%	0%
6. I was referred to chest X-RAY screening	0%	0%	7% (1 case!)	0%	2%
7. I participated in chest X-RAY screening	0%	0%	0%	17% (1 case!)	2%
8. mental health assessment by tests	12%	0%	7%	17% (1 case!)	9%
9. my vaccination level was asked	53%	10%	7%	0%	21%
No response	0%	5%	0%	0%	2%

Table 15.

As reported, health screening in most cases included a general discussion about participants health status (86%), complemented by checking for ectoparasites, such as scabies and lice (53% of all examinations (n'=57), but only in 10% of cases in Montenegro). Based on our study participants' opinions, physical examination is mostly completed in Bosnia-Herzegovina (59%), while only in one-third to one-fifth of examinations include physical examinations at other study sites. Faeces test is not performed at any sites, and blood sample is also taken in 1-2 cases, maybe not as part of health screening but as diagnostic measure. Chest X-ray was also performed in 1 case only, in Serbia, but not as part of general medical screening. Vaccination status was only asked in Bosnia-Herzegovina (53%) and in 2 cases in Montenegro.

Examinations and specialized care other than medical screenings

Participants were also asked whether they get any further medical examination, care, or treatment in their current country of stay. Only very few people got specialized care in each of the recipient countries:

Responses	Bosnia-Herzegovina (n=24)	Montenegro (n=28)	North-Macedonia (n=34)	Serbia (n=14)	Total (n=100)
I had to participate in medical **age-assessment** procedure:	0	1	6	0	7
I got **vaccination(s)**	0	0	2	1	3
I was referred to a **specialist(s)**	0	7	4	0	11
I was **hospitalized**	0	0	3	1	4
I had **a surgery**	0	0	0	0	0
I was referred to a **mental health specialist**	1	3	0	1	5

Table 16.

Seven percent of total study population reported to participate at age-assessment procedure, 6 from North-Macedonia and one person from Montenegro. Two participants from Montenegro reported to get vaccinations (identified both as tetanus), and one person was vaccinated in Serbia (the type of vaccine was non-specified). Altogether 11 migrants were referred to specialized care, 7 people in Montenegro (due to e.g. asthma, or high blood pressure, etc. to internalist, orthopaedic and neurology). Four people were referred to specialized care in North-Macedonia: one due to eye-infection to ophthalmologist, one was hospitalized due to diabetes, one person was admitted to infectology and one visited an internalist, the reason was non-specified. Altogether 4 people were hospitalized, 3 in North-Macedonia. Five study participants were referred to mental-health specialist, 3 in Montenegro, 1-1 in Bosnia-Herzegovina and Serbia, due to fear of death, anxiety and depression. No one reported to undergo a surgery.

Migrants' self-reported childhood vaccinations and vaccination documents

The following data are analysed by region of origin.

Question	Option of response	Africa (n= 27)	Asia (n=40)	Middle-East (n=26)	Central America (n=5)	Unknown country of origin (n=2)	Total (n=100)
Did you receive childhood vaccination when you were a child at home?	yes	78%	45%	88%	100%	100%	**69%**
	no	11%	23%	8%	0%	0%	**14%**
	don't know	11%	33%	4%	0%	0%	**17%**
	no response	0%	0%	0%	0%	0%	**0%**
Do you know what kind?	yes	15%	23%	35%	20%	50%	**24%**
	no	74%	40%	54%	60%	0%	**53%**
	no response	11%	38%	12%	20%	50%	**23%**
Do you have vaccination documents?	yes	11%	13%	19%	0%	50%	**14%**
	no	89%	75%	77%	100%	0%	**79%**
	no response	0%	13%	4%	0%	50%	**6%**

Table 17.

Great majority, approximately 70% of study population reported to get childhood vaccinations at their home countries, all participants from Central-America (Cubans); 88% of participants from Middle-Eastern countries, 78% of participants from African countries, while fewer than half (45%) of participants from Asian countries. One quarter of participants (24 people) reported to be aware of the type of their childhood vaccines, however, when we asked them to name their childhood vaccines, only a few could do so (they listed the followings: against measles (2 Afghans); 7 mentioned polio (3 Pakistanis, 1 Iranian, 1 Algerian, and 1 Turkish); 2 people mentioned hepatitis (1 from Afghanistan and 1 from Pakistan); 3 tetanus (Iranian, Pakistani and Turkish), and 2 mentioned tb vaccine (1 Iraqi and 1 Pakistani). 80% of study participants reported not to have any vaccination documents, only 14 people claimed that they have some vaccination documents (but not necessarily of their childhood vaccinations).

MIGRANTS' SELF-ASSESSED HEALTH STATUS

The following data are analysed by region of origin.

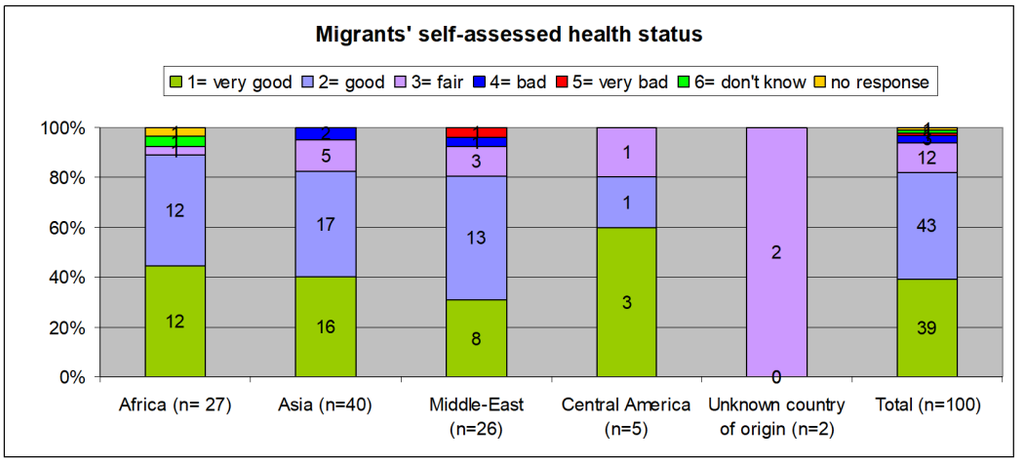

Figure 10.

A great majority, altogether 82% of all study participants assessed themselves as healthy, and scored their own health status either 'very good' or 'good'.

When participants were asked about their existing longstanding chronic conditions [long-standing = which have lasted, or are expected to last, for 6 months or more], the vast majority (78%) reported not to have any. Only 16 participants reported to have chronic com-

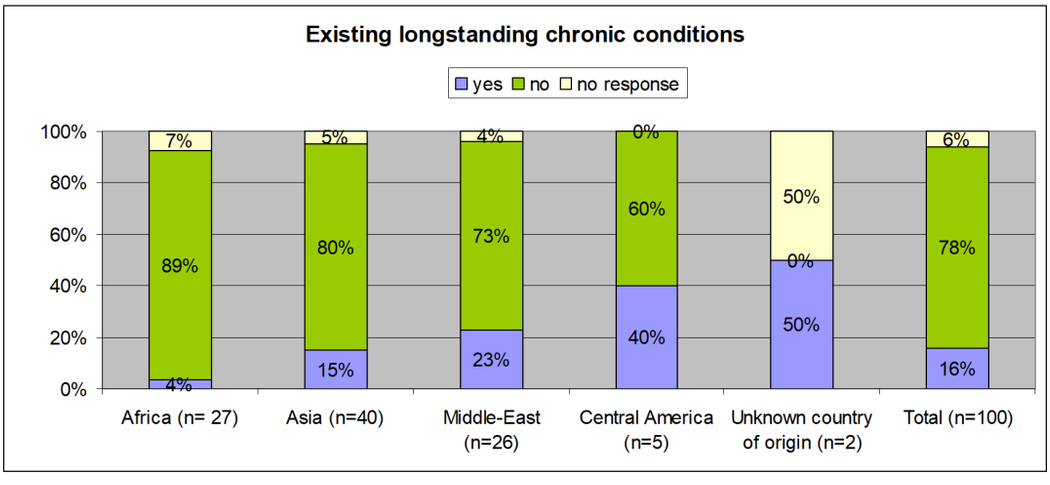

Figure 11.

plaints:

However, in the course of a following question, several chronic conditions were listed. Participants were asked to assess whether they have any of these listed conditions, and an additional 26 people reported to have longstanding health problems. Therefore, a final 42 participant reported to have some (75) chronic conditions:

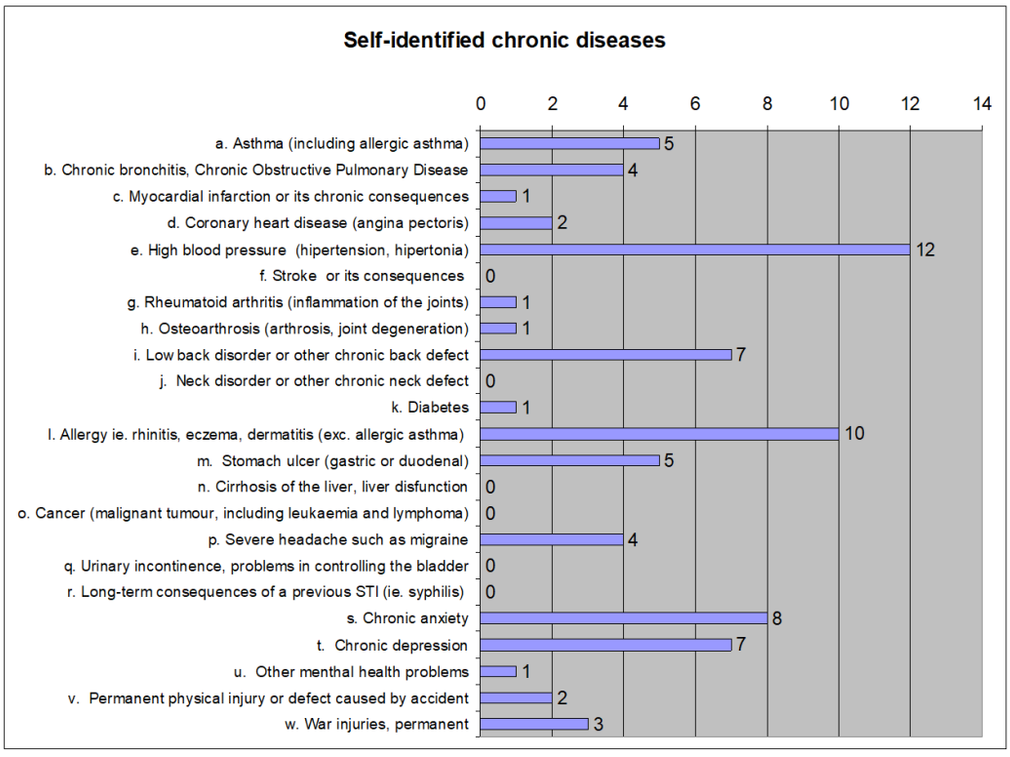

Figure 12.

Participants were asked whether they get any kind of treatment to their chronic problems. As reported, 40 chronic conditions are under treatment, in 12 cases participants reported not to get any kind of treatment to their chronic problems, and 21 cases there were no answer to this part of the question. The highest rates of receiving treatment were reported from North-Macedonia and Montenegro, while the lowest rates were reported by migrants from Bosnia-Herzegovina.

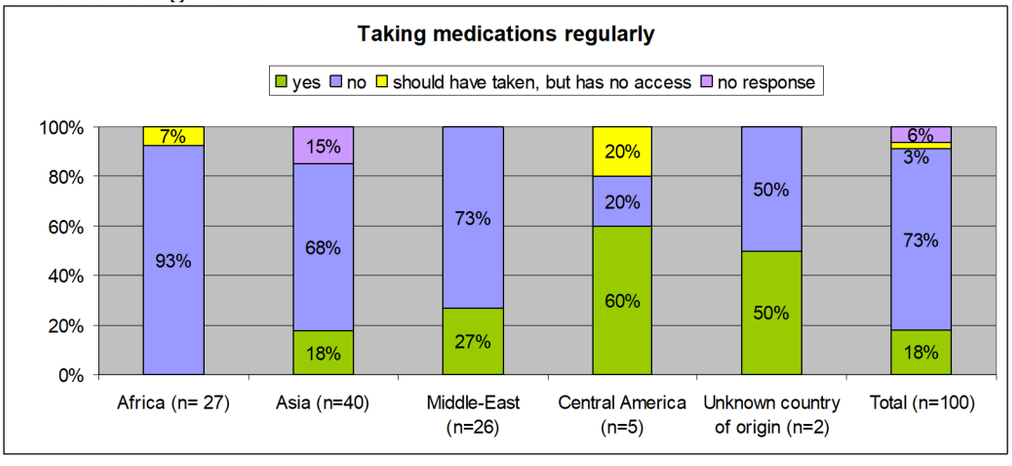

Figure 13.

As reported by study participants, approximately 18% of them should take medications regularly, and another 3% (3 people) should have taken, but reported having no access. Great majority (73%) do not need medications regularly. Those, who reported a need for regular medications (18 people), they specified their complaints as follows: 5 people for asthma, 4

people for high blood pressure, and 1-1 person for each of the followings: rhinitis, backpain, diabetes, gastritis, pregnancy (folic acid) for one woman, allergy, headache and one person indicated sore throat.

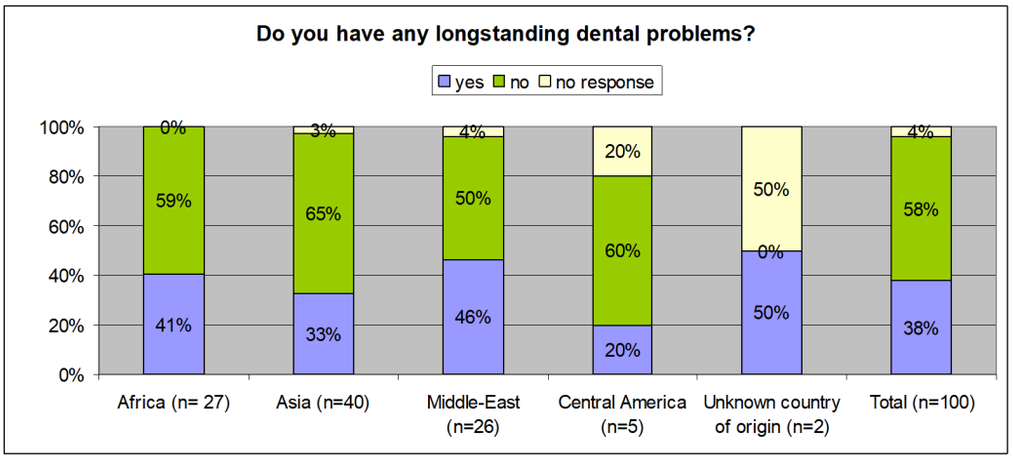

Figure 14.

Thirty-eight percent of study population reported to have long-standing dental problems.

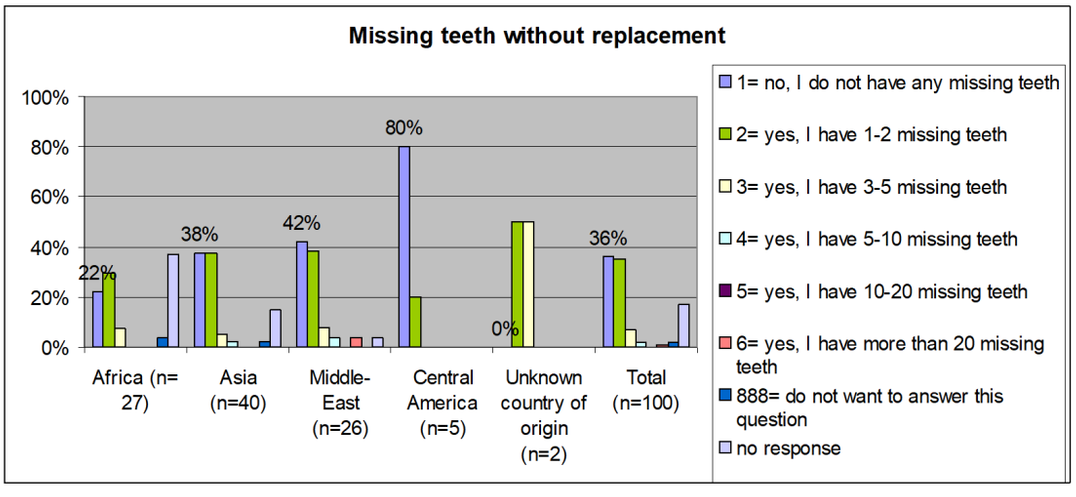

Figure 15.

According to the number of migrants' missing teeth without replacement, approximately 36% has no missing teeth, a similar proportion (35%) has only 1-2 missing teeth, 7% has 3-5 missing teeth, 2 % has 5-10 missing teeth, and only 1 person has even more missing teeth without replacement. Altogether 19 people did not answer to this question.

MIGRANTS' SELF-ASSESSED RISK-TAKING BEHAVIOURS

The following data are analysed by region of origin.

Participants self-reported smoking habits

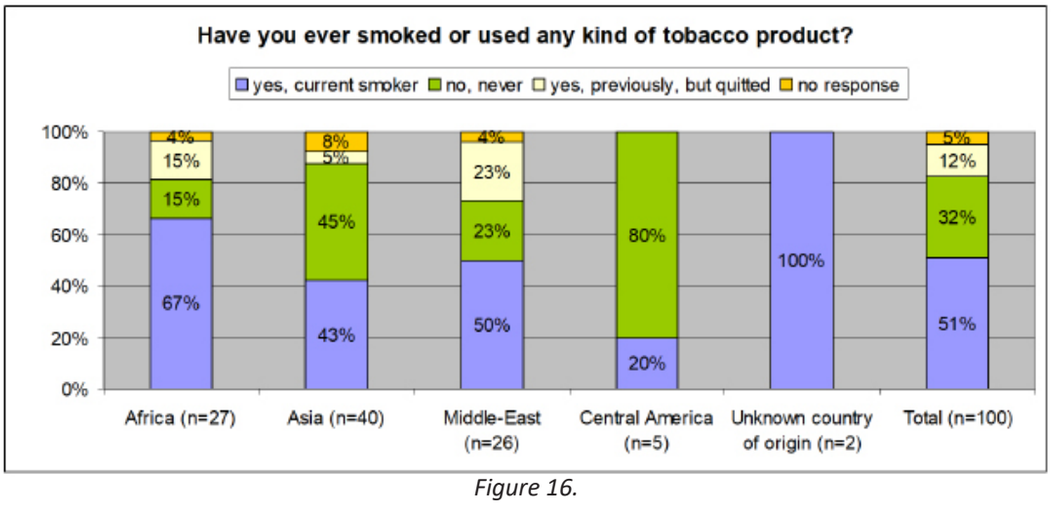

Figure 16.

Nearly half of study population are current smokers, and an additional 12% used to smoke but already quitted. Proportionally, the highest rates of current smokers are from Africa (67%) that accounts for 18 people, while 17 migrants from Asia are also current smokers (43% of Asian migrants).

Number of cigarettes per day	Africa (n=27)	Asia (n=40)	Middle-East (n=26)	Central America (n=5)	Unknown country of origin (n=2)	Total (n=100)
more than 20 cigarettes a day	19%	15%	19%	0%	50%	17%
10-20 cigarettes a day	30%	18%	23%	0%	50%	22%
1-10 cigarettes a day	19%	13%	4%	20%	0%	12%
1-10 cigarettes weekly	4%	0%	8%	0%	0%	3%
1-10 cigarettes monthly	4%	0%	0%	0%	0%	1%
even less, only occasionally	0%	3%	8%	0%	0%	3%
no response	26%	53%	38%	80%	0%	42%

Table 18.

Seventeen percent of study participant smokes more than 20 cigarettes a day, and another 22% approximately daily 10-20 cigarettes. An additional 12% smokes 1 to 10 cigarettes daily, and these 3 patterns accounts for the total 51% smokers. Some other people (7%) use cigarettes more rarely.

Participants self-reported alcohol usage

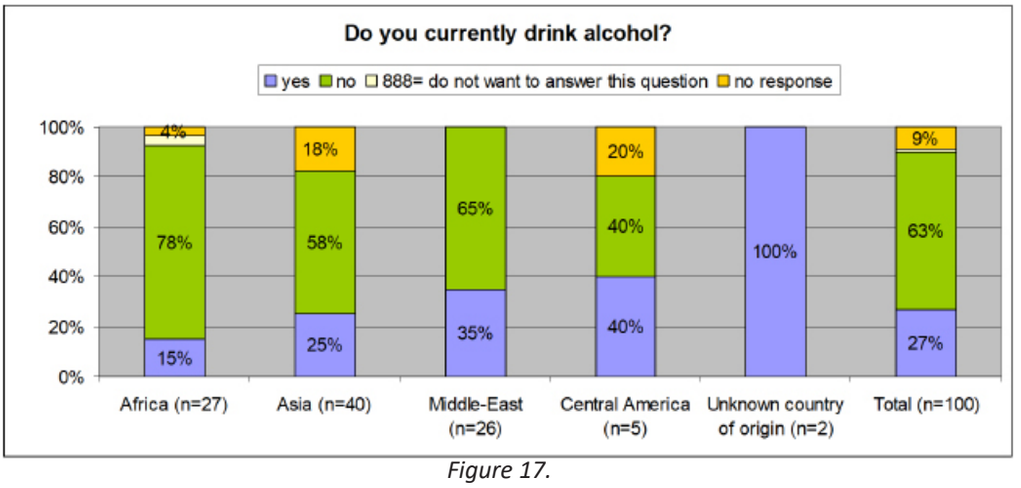

Figure 17.

Majority of participants reported not to drink alcohol, 27% claimed to drink and 10% did not answer to this question.

Frequency of alcohol usage was reported as follows:

Frequency of alcohol usage	Africa (n=27)	Asia (n=40)	Middle-East (n=26)	Central America (n=5)	Unknown country of origin (n=2)	Total (n=100)
more than 2-3 drinks every day	0%	8%	4%	0%	0%	4%
1 drink every day	0%	0%	8%	0%	0%	2%
weekly 2-3 drinks, not every day	4%	0%	15%	0%	0%	5%
monthly 4-5 drinks, occasionally	7%	10%	4%	0%	50%	8%
even less, only few times a year, occasionally	0%	8%	0%	40%	0%	5%
no response	4%	0%	4%	0%	50%	4%

Table 19.

Altogether 5-10% of study population drink alcohol on a daily basis, with the highest proportion of Asian participants (8% daily). Another 15-20% drink rarely, only occasionally.

MIGRANTS' SELF-ASSESSED AWARENESS OF INFECTIOUS DISEASES

The following data are analysed by region of origin.

Participants' self-estimated awareness of 'infectious diseases that are common in Europe' was assessed: general awareness, knowledge of their signs and symptoms, ways of transmission and methods of prevention. These latter 3 aspects were measured through a 1-to-5 Likert scale (where 1 referred to 'very good' and 5 to 'very bad').

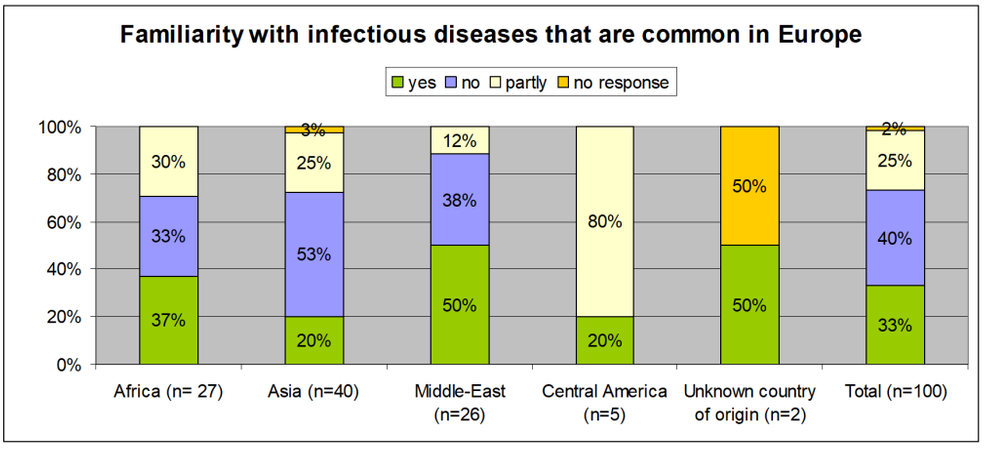

Figure 18.

Approximately one-third (33%) of study participants estimated that they are familiar with infectious diseases that are common in Europe, and an additional quarter of respondents assessed themselves as 'partly familiar' (25%). The proportion of those who admitted not to be aware was 40%, with the highest proportion among Asian migrants, where 53% of participants answered 'no'.

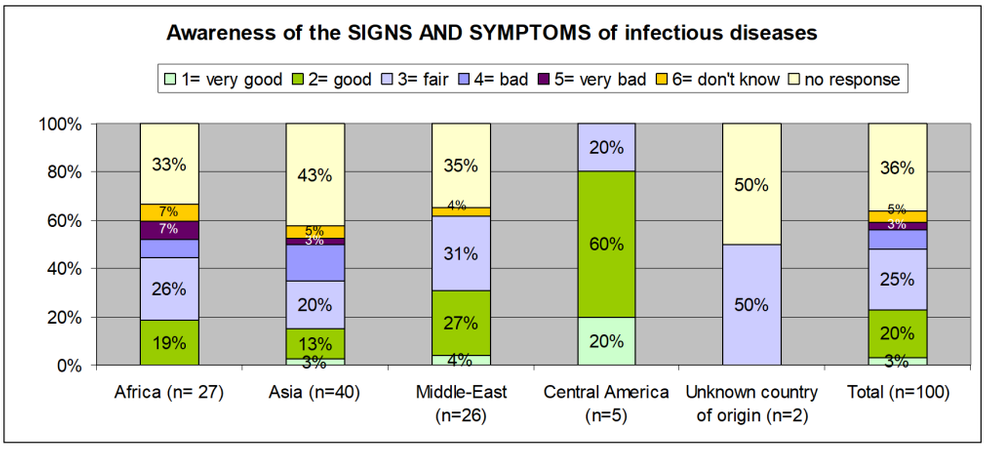

Figure 19.

When participants were asked to assess the level of their knowledge in relation to the **signs and symptoms** of infectious diseases that are common in Europe, fewer than one-quarter of all respondents assessed their knowledge as 'good' or 'very good' (23%). The lowest level of knowledge was estimated by Asian migrants (16%), while those from Central America (Cuba, 5 people) thought that they have better knowledge on this issue (one reported 'very good' and 3 'good').

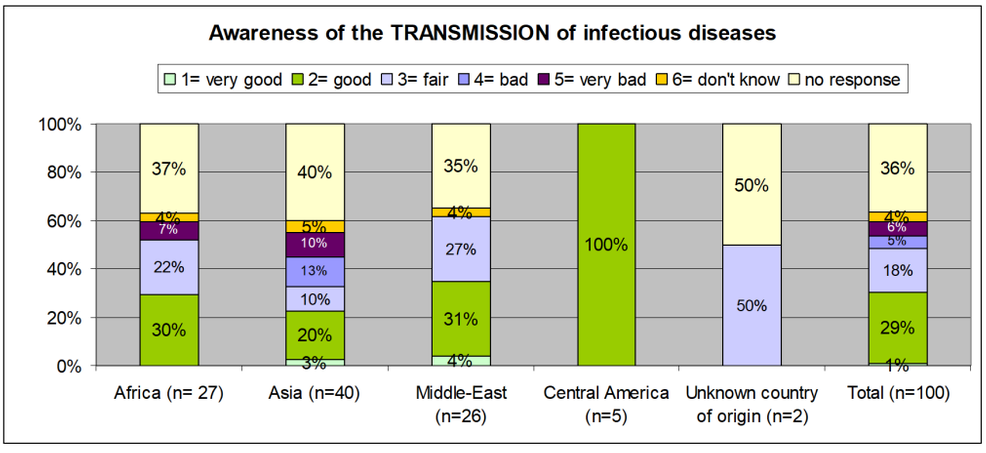

Figure 20.

According to the **transmission of infectious diseases,** participants' self-assessed awareness was generally higher: 30% stated to be aware of the main routes of transmission (has 'good' or 'very good' knowledge).

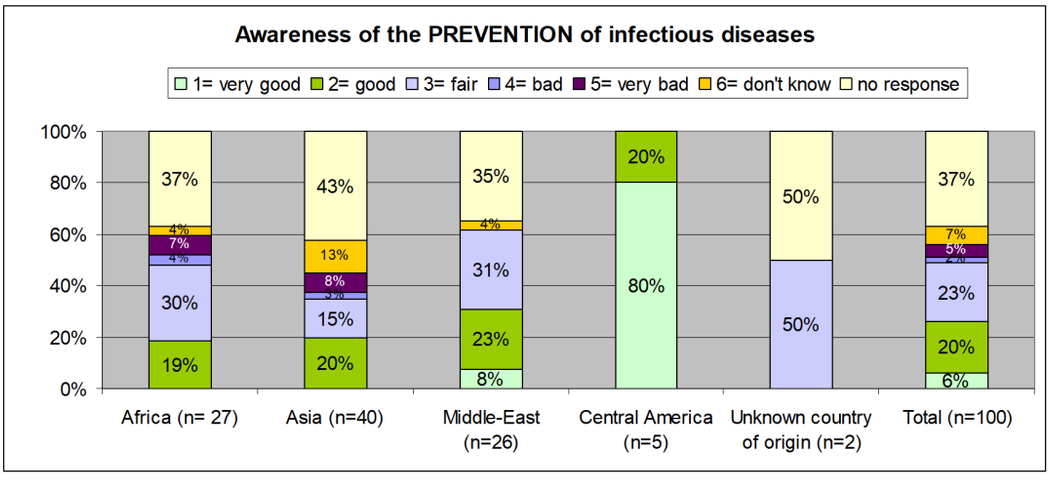

Figure 21.

When talking about **prevention,** generally, the level of self-assessed awareness was a bit lower: 26% of total population estimated their knowledge as 'good' or 'very good', with the highest proportions reported by participants from Middle-Eastern countries (8% as 'very good' and 23% as 'good') and by Cuban participants, as well.

DIFFICULTIES IN ACCESSING HEALTHCARE

The following data are analysed by country of current stay.

In the course of the following some potential difficulties were gathered that the migrants may face during their attempts to get sufficient health care in recipient countries. As a first approach, participants were asked to identify the 3 most significant difficulties that they may have faced to get the necessary healthcare.

Migrants staying in **Bosnia-Herzegovina** (24 people) mainly referred to the lack of 24/7 health services (17 people referred to this problem out of the 19 who answered to this question, 5 people did not answer). 14 people out of the 19 respondents mentioned the language problems, the lack of interpreters, 5 people to the lack of money, financial problems (maybe in general, not related to access to health services), 2 people emphasized hygienic problems, 1-1 to religious and cultural issues, lack of dentist, and lack of health information (education).

In **Montenegro,** out of the 28 study participants 20 answered to this question, at least partly. Among them 14/20 referred to language barriers as the most significant difficulty in accessing care, 4 people indicated to have dental problems, but there is no dental care available; 3 people emphasized that the previous doctor was 'very bad' (discriminated, etc.), but the current doctor is OK. Financial problems were also mentioned, in relation to accessing dental and ophthalmological care (there's a need for glasses, but not supported financially). One person mentioned the lack of doing tests (i.e. blood test), 2 people mentioned the lack of health services and staff in the camp.

In **North-Macedonia,** among 34 study participants 12 did not answer to this question and another 7 stated not to have any difficulties in accessing care, answers to this question was received by 15 study participants. Among them, the most commonly referred difficulties were 'language difficulties', 'financial difficulties' mentioned in 5-5 cases, followed by 'problems with transport' by 3 participants, and other, rather personal problems, such as 'being pushed back by police' in 2 cases, and in 1-1 cases: 'fear of diagnoses'; 'staying alone, left by the group'; 'do not want to stay in the camp'; 'do not know where to go'; 'police did not let them going to hospital' (2 cases) or 'police did not let him taking his wife to hospital'.

Finally, from **Serbia** 12 out of the 14 study participants answered to this question, but unfortunately not really adequately (saying as difficulty: 'hospital', 'ambulance' (in 4 cases)). Out of the 8 usable responses all referred to language barriers; 4 mentioned financial problems, the lack of money; cultural barriers were listed in 2 cases and in 1-1 case the lack of information and lack of offices were listed.

In the course of another question that aimed to analyse difficulties, participants were asked to assess the importance of certain listed difficulties on a 1-to-5 Likert scale (where 1 was standing for 'not at all' and 5 was standing for 'very much').

Out of the 100 study participants 16 did not answer to this question, and 6 people answered 'I don't know'. Finally, we received 78 more or less completed tables, that could be analysed. The following table reflects to the most significant barriers that have received **either scores 4 'somewhat' or 5 'very much'** by study participants.

Types of barriers	Bosnia-Herzegovina (n=24)	Montenegro (n=28)	North-Macedonia (n=34)	Serbia (n=14)	Total (n=100)
48.1. language barriers, lack of qualified interpreters	**79%**	**50%**	12%	**71%**	**47%**
48.2. cultural barriers, misunderstandings	25%	11%	0%	64%	**18%**
48.3. religious barriers	21%	0%	9%	43%	**14%**
48.4. lack of **migrants'** information on entitlements	46%	11%	12%	21%	**26%**
48.5. lack of **providers'** information on entitlements	**58%**	25%	24%	7%	**30%**
48.6. lack of migrants' documentation (ID, passport)	**42%**	4%	**41%**	29%	**29%**
48.7. lack of migrants' health insurance	17%	18%	35%	14%	**23%**
48.8. lack of migrants' vaccination documents	**38%**	4%	35%	**43%**	**28%**
48.9. lack of **migrants'** information about health system	**46%**	18%	24%	14%	**26%**
48.10. health workers are not prepared (legal aspects)	17%	0%	12%	21%	**11%**
48.11. health workers are not prepared (interculturally)	13%	0%	12%	21%	**10%**
48.12. health workers are not prepared (risks, etc.)	13%	7%	9%	7%	**9%**
48.13. discrimination from healthcare providers	13%	4%	12%	**36%**	**13%**
48.14. too lengthy asylum procedures	**42%**	11%	**38%**	**50%**	**33%**
48.15. lack of cooperation between actors (NGO, etc.)	25%	7%	6%	7%	**11%**
48.16. lack of health education for migrants	**42%**	29%	15%	14%	**25%**
48.17. lack of special services for victims of violence	17%	7%	9%	14%	**11%**
48.18. lack of special services for females	13%	7%	9%	7%	**9%**
48.19. lack of mental health services	21%	14%	15%	7%	**15%**
48.20. lack of proper housing, social services	13%	18%	**41%**	29%	**26%**
48.21. lack of translation of documents	17%	25%	29%	14%	**23%**
48.22. personal financial problems	13%	36%	26%	**50%**	**29%**
48.23. lack of translated informational materials	13%	36%	15%	21%	**21%**

Table 20.

The most significant barrier was the 'language barrier', as indicated by 47% of all study participants, however this received the lowest scores in North-Macedonia among the countries involved in this study (12%). This is followed by the 'too lengthy asylum procedures' which received scores 4 or 5 in 33% of all answers, however this was not really commonly mentioned by participants from Montenegro, only one in 10 participants mentioned (11%). Personal financial problems, the lack of migrants' personal and vaccination documentation, as well as the lack of both migrants' and providers' information on entitlements were also mentioned by 26-30% of study participants, with different emphasis in different countries of current stay. The 'lack of health education' and 'lack of migrants' information about the local health system' was mentioned by one quarter of all study participants (25-26%), with the highest proportion (42-46%) by migrants from Bosnia-Herzegovina. Discrimination by health providers was generally not commonly reported (13%), however, this was more commonly mentioned from Serbia (36%). The 'lack of proper housing' was mainly reported from North-Macedonia (41%).

ASSESSING FEMALE PARTICIPANTS' NEED FOR ANTENATAL CARE

The following data are analysed by country of current stay.

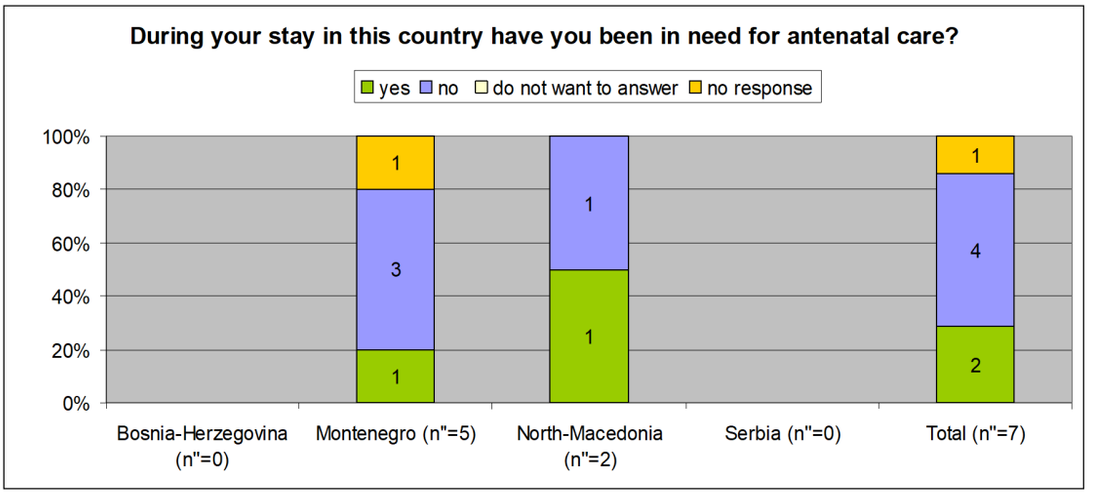

Figure 22.

Among 100 study participants there were only 7 females, 5 in Montenegro and 2 in North-Macedonia. Altogether 2 of them required antenatal care during their stay in current recipient countries: one in both countries. One woman did not answer to these questions. Those, who required antenatal care were asked to report whether they got the necessary care: one of them (the one in Montenegro) declared to get the necessary care and also did not indicated any difficulties in accessing care; while the one woman, who required antenatal care in North-Macedonia, claimed that she did not get the necessary care, and faced difficulties: as she stated, 'the police did not allowed her to stay with her children'.

MIGRANTS' COMMENTS and RECOMMENDATIONS

A final section in the survey offered space for stud participants to express their comments and recommendation for healthcare providers in transit/destination countries. Only a few participants took advantage of this offer (23 people) some expressed their satisfaction and gratitude, and some made critical comments, and complaints.

Below there are some selected quotes from study participants:

„only that we would prefer to have health system information translated to mother tongue of our country" (Cuban man in Montenegro)

„Police didn't allow to stay with my kids in the camp" (Iraqi women, North-Macedonia)

„No bad comments, only about dinner which quality is not good and enough." (Algerian man in Montenegro)

„They are great here in Macedonia" (Pakistani man, North-Macedonia)

„better human care from authorities" (Iraqi man, North-Macedonia)

„previous doctor didn't took seriously any problem, and he tell me to go out of the office and just was there for 5 minutes. He gave me to drink tea for my chronical bronchitis. If I want healthcare I have to pay it. Currently the doctor is very good, but I am afraid what will happen when he leaves" (Iranian man, Montenegro)

„translation problems, needing more presence of translators, also previous doctor was very bad" (Egyptian man, Montenegro)

„in North-Macedonia healthcare is good" (Bangladeshi man, North-Macedonia)

„Red Cross doctors are so polite and help me a lot. I had a contusio toracis" (Afghani man, North-Maceodonia)

„more informations, more office" (Moroccan man, Serbia)

Specific conclusions and recommendations based on survey results about migrants' health and access to healthcare during transition in selected Balkan countries

The **length of stay in current recipient country** varies greatly between arriving migrants: altogether 23% reported to arrive within one week (65% of all respondents from North-Macedonia), while 15% reported to arrive 3-6 months ago, and another 36% claimed to stay in the current recipient country for even more than 6 months. The highest number of people staying the longest time in the same country were reported from Montenegro, where out of the 28 participants 23 reported to stay there more than 3 months ago (82%) and 13 even more than 6 months ago (46%). On the other hand, all these 28 participants from Montenegro reported being stuck in recognition process: 8 people registered already but not applied for asylum, while 20 people applied for asylum and were still waiting for decision. Only one-quarter of total study participants applied for international protection (24%) in current recipient country (mainly in Montenegro (20/24)), and at the time of the study only 5% received positive answer from the authorities.

These data suggest, that the migrants in the Balkan countries are **really in transition, a great majority of them aim to move further to other destination countries** meanwhile waiting for optimal conditions and opportunities. Data also reflect to the **uncertain situation of migrants** as the **asylum procedure may be lengthy,** and **may last for even more than half a year.** To reduce this long-lasting uncertainty (and accompanying vulnerability) the acceleration of the lengthy asylum procedures by immigrant authorities would be beneficial for both migrants as well as for the recipient countries, and involved organizations.

Our data revealed **differing levels of education** by regions of origin of migrants involved in this study. The lowest educational level occurred among migrants from Asian countries, particularly from Pakistan (71% completing primary level education or less), while the highest level of education was demonstrated among participants from the Middle Eastern countries, 42% (11/24) reported having completed tertiary level education. As in general, 31% of total study participants have primary school as the highest completed level of education (with the lowest levels reported from South-western Asian countries, i.e. Pakistan), **both transit and destination countries should be well-prepared to increase the literacy and educational levels of the newly arriving migrants.** It is of crucial importance particularly for **newly arriving migrant children to avoid their drop off from continuous education.** Both of the transit countries, but especially destination countries shall be prepared to **include also the adult migrants** in their educational system, to „fill in the gaps", and providing various educational programs, which should not be limited to language courses. However, providing language courses for migrants are extremely important as language barriers were identified as the most significant obstacles in accessing not just healthcare, but other services as well. As one-third of respondents does not speak any foreign languages, therefore offering language courses at least in a common, intermediate language (i.e. English) would be helpful, particularly as interpreters are not always available.

Participants assessed their **familiarity with their right-based access to healthcare servic-**

es, as well as their obligations according to cooperating with local health authorities in their current country of stay. Participants staying in Montenegro were found to be the most well-informed: 79% assessed themselves 'aware' and (71%) stated to get the necessary information of health services after arrival. On the other hand, the scores were the lowest in Bosnia-Herzegovina, where only 13% of participants said they are familiar with their obligations. This may be because the majority of migrants staying in Bosnia-Herzegovina have only been registered by authorities, but did not apply for asylum. Still, as participant of this study reported to stay for the longest periods of time in Bosnia-Herzegovina, it is important to inform the newly arrived migrants in all transit countries properly about their right-based entitlements and their obligations, as the provision of necessary information is not just a basic human right, but also may promote their cooperation with local authorities during this critical period. As found, locally acting NGOs in the refugee camps may have a huge role in providing this information, and one in five (19%) study participants referred to them as the major source of information, right following immigrant authorities (21). Therefore, staff member of locally acting NGOs shall be well-informed and prepared of the entitlements and obligations of migrants in different status or levels of international protection. The use of multilingual informational materials may also be beneficial developed in cooperation with national immigration authorities.

Availability of qualified interpreters during administrative procedures at immigration authorities and during healthcare provision at reception facilities varies between involved transit countries, as total, approximately in half (47-52%) of cases qualified interpreters are available during administrative and/or healthcare services. When qualified interpreter is not available the language barriers are generally addressed by using a third, common language (i.e. English) (48-51%), or by involving an adult family/community member in communication who is competent in a common language (18-25%). The use of a bilingual staff member is similarly common: they facilitate communication in 20-23% of all cases, as reported by study participants. In similar proportion of cases (22-31%) there are no interpreters available and communication is solely based on body-language. Therefore, **increasing employment and involvement of multilingual staff members** may be recommended to overcome language barriers, which is the most commonly reported obstacle in migrants' access to health services, and as a consequence, may have negative effect on health outcomes as well. Furthermore, the use of multilingual staff members may promote overcoming cultural barriers as well, particularly when they have migrant background and a longer history in staying at the recipient country. Inclusion of migrants in language courses during their stay may also be reasonable. The use of children community member as interpreters is avoidable, however, in case the children attend local schools they may have better language competencies than adult community members. Still, medical information shall be considered as 'sensitive', particularly when talking about serious health issues of a child's close relative or adult family member.

A total 57% of study population had already **participated at health screening** at their current country of stay at the time of study, with the highest proportion (71%) reported from Bosnia-Herzegovina and Montenegro. In nearly 40% of all cases the health screening was performed **within 48 hours** after migrants' arrival to the camp, particularly in North-Macedonia. In majority of cases, members of a non-governmental organization (NGO) performed the health check-ups (56%), while 40% of the respondent reported that screenings

were performed by public healthcare authorities. For example, in Bosnia-Herzegovina and North-Macedonia, in majority of cases an NGO was reported as health service providers which completed the screening, while in Montenegro, in 90% of cases the local public health authorities were indicated. Apart from the initial health screening, 11% of study participants were referred to specialized care, 5% to mental health care and 4% were hospitalized. Out of the 7 female participants 2 required antenatal care and one had some difficulties, but not in relation to accessing care (as she claimed the police did not allow her to be with her child). Consensus approach and coordinated actions would be crucial in the provision of medical assessment of newly arriving migrants starting from the very basis: screening or not, when to screen, what to screen, how to screen, how to document test results and follow-up – along with the **'test and treat'** approach: provision of the continuous, necessary care for all detected health problems. Based in international literature, inclusion of mental health assessment as well as screening for intestinal parasites may be reasonable to include in screening protocols along with testing for certain infectious diseases that has a higher prevalence in countries of origin and may also be considered as public health threat (i.e. HIV, hepatitis B/C, TB, etc.). Untreated chronic, non-communicable diseases (i.e. diabetes, asthma, etc.) may also increase the vulnerability of migrants as well as the lack of receiving childhood vaccinations. Financial resources for both screening and treating should be allocated. To avoid confusion and unnecessary, repeated examinations, clear tasks and responsibilities and strong cooperation would be required among governmental and non-governmental actors and health service providers, as well as traceable (international) migrant health database.

Great majority, approximately 70% of study population reported to get **childhood vaccinations** at their home countries, with the lowest proportion (45%) reported by participants from Asian countries. 80% of study participants reported not to have any vaccination documents, only 14 people claimed that they have some vaccination documents (but not necessarily of their childhood vaccinations). Similarly to screening protocols, evidence–based, harmonized, European-level vaccination protocols would be required according to newly arrived migrants: how to check immunization status, how to deal with missing vaccination documents and how to replace missing vaccinations, who shall be vaccinated, against what, to vaccinate only children or adults also, etc. Furthermore, financial resources should be allocated and clear international regulation, protocols and database.

A great majority, altogether 82% of all **study participants assessed themselves as healthy,** and scored their own health status either 'very good' or 'good', and baseline, 16% reported to have chronic complaints. However, when participants were asked to assess whether they have any conditions from a listed, and an additional 26 people reported to have long-standing health problems. Finally, 42 participants reported having any kind of (75) chronic conditions, most commonly high blood pressure, allergies, chronic anxiety or back pains were reported. As participants reported, 40/75 chronic conditions were under treatment, while in 12 cases participants reported not to get any kind of treatment, and more than 20 participants did not answer to this part of the question. The highest rates of receiving treatment were reported from North-Macedonia and Montenegro, while the lowest rates were reported by migrants from Bosnia-Herzegovina. Approximately 18% of study participants should take medications regularly (for asthma, high blood pressure, diabetes, allergy, etc.), and another 3% should have taken, but reported having no access. Both undetected

and also untreated chronic, non-communicable diseases (NCDs) increase the vulnerability of migrants, and may put an avoidable, increased burden on health systems when these patients will need care later, at an advanced stage of their diseases. Therefore, in addition to health screening for infectious disease upon arrival, and providing urgent care for those in emergency situation, health systems in both transit and destination countries shall be alert and precautious in assessing the prevalence of chronic NCDs among migrants with a special focus on high-risk populations (i.e. smokers, obese or elderly migrants), and providing continuous check-ups, and treatment, including medications.

When participants **'self-estimated awareness of 'infectious diseases that are common in Europe'** was assessed (general awareness, knowledge of their signs and symptoms, ways of transmission and methods of prevention) we found – not surprisingly – correlation between study participants' levels of awareness and educational levels, therefore associations with regions of origin: i.e. lowest educational levels were reported from Asian region (mainly Pakistan) and similarly, lowest self-reported health awareness from the same region, while the highest from Middle-Eastern countries. For the first, general question, more than half of total study participants (58%) assessed themselves as being at least 'partly familiar' with infectious diseases that are common in Europe, but when going into details (signs and symptoms, transmission and prevention) the ratios of those who assessed their level of knowledge as 'very good' or at least 'good' decreased by half: to 23-30% as highest scores. As educational level, and consequently the 'health literacy' and health awareness level of newly arriving migrants differ greatly by countries/regions of origin, and additionally, due to their disadvantaged socio-economic status these people shall be considered as particularly vulnerable for infectious diseases (lack of proper nutrition, overcrowded temporary housing conditions, lack of hygiene, etc.). Therefore, in addition to providing migrants with as appropriate conditions as possible, during this transition period organizing targeted, interpreted health educational programs may be beneficial in order to increase their health awareness in relation to preventing infectious diseases,[13] thus reducing the risk of spreading infectious diseases within the communities.

When analysing **the role of potential barriers in accessing healthcare** for migrants in countries involved in this study, the most significant barrier reported was 'language barrier', as indicated by 47% of all participants. This was followed by the 'too lengthy asylum procedures' (receiving scores 4 or 5 in 33% of all answers). Personal financial problems, the lack of migrants' personal and vaccination documentation, as well as the lack of both migrants' and providers' information on entitlements were also mentioned by 26-30% of study participants, with different emphasis in different countries of current stay. The 'lack of health education' and 'lack of migrants' information about the local health system' was mentioned by one quarter of all study participants (25-26%), with the highest proportion (42-46%) by migrants from Bosnia-Herzegovina. Discrimination by health providers was generally not commonly reported (13%), however, this was more commonly mentioned from Serbia (36%). The 'lack of proper housing' was mainly reported from North-Macedonia (41%). These answers may reflect to the complex health needs and most commonly faced difficulties of the newly arriving migrants, and may also provide a feed-back to local authorities in recipient/transit countries. As previously discussed, the 'language barriers' may be con-

13 Experiences of such a program have been reported from Hungary in a peer-reviewed scientific article. Available: https://academic.oup.com/heapro/article-abstract/34/5/e36/5090807

sidered as the most significant barrier in accessing care, therefore in addition to improving organized interpretation services, the involvement of multilingual staff members, and language courses for migrants may be beneficial. Increasing both the migrants' and also the service providers' awareness of status-dependent, right-based entitlements and migrants' obligations according to cooperation with local authorities is of vital importance, and also increasing migrants' health awareness (i.e. how to prevent infectious diseases in communities). Supervision, and/or organized training programs for service providers may also help to improve their anti-discriminatory attitudes and coping strategies as they may also be barriers. As it was also discussed earlier, **harmonized European-level health screening and vaccination protocols, as well as traceable migrant-health database** may avoid complications due to the lack of documentation, and would prevent both migrants and service providers from unnecessary, repeated examinations and interventions.

CHAPTER 3.

Report on questionnaire survey conducted among representatives and staff members of organizations working in frontline with migrants

Dr. Zoltán Katz

Research design and Methodology

An anonymous, self-administered questionnaire survey was launched in four Balkan countries: Bosnia-Herzegovina, North Macedonia, Serbia and Montenegro. The target population was members of governmental, international and non-governmental (NGO) organizations who are providing humanitarian and health/ mental health assistance for migrants, asylum seekers and refugees in migrant reception centres and/or in any other facilities responsible for hosting and assisting migrant people. In advance of the survey representatives of the National Red Cross Societies participated a preparatory training for this type of surveys and - although this was a so called 'self-administrated questionnaire' -, in case of need (e.g.: better understanding the 'direction' of the question, they were providing assistance for the interviewed persons. Professionals who were not providing direct assistance but were well aware about the principles and actions of their organization, were covered as well.

The COVID-19 pandemic made members of some organizations unreachable for the interviews and it resulted significant shortage of complete questionnaires for the final analysis.

Data analysis was conducted through MS Excel. MS Excel was judged suitable for the processing and the analysis considering the size of the sample and data. MS Excel provided also a simple and user-friendly interface for checking, editing, and correcting data.

The main **inclusion criteria** were that the participant is at least 18 years old and is an employee/volunteer/etc. of any national/international organisation involved in the assistance and support of migrants.

Uncompleted questionnaires with insufficient amount of data, resulted significant information loss, were **excluded** from the analysis.

The survey has covered 68 questions categorised into the following eight subtopics:

1. Demographic data of study participants
2. Institutional collaboration
3. Access to health services – Legal, financial, geographical, cultural challenges
4. Access to information use of health services – Informing migrants and refugees
5. Responsiveness of the services
6. Health and well-being of vulnerable groups
7. Communicable disease related aspects
8. Occupational health – Perceived health risks at work

Demographic data of study participants

Table 1 summarizes the locations and the number of completed questionnaires in four Balkan countries.

Country	Location 1.	Location 2.	Location 3.	Location 4.	Not specified	Total number received	Total number analysed
Bosnia-Herzegovina	Sarajevo (20)	Blažuj (4)			1	25	**25**
Montenegro	Podgorica (24)	Danilovgrad (4)	Spuz (2)			30	**30**
North-Macedonia	Skopje (8)	Gevgelija (11)	Kumanovo (4)	Tabanovce (2)	8	33	**33**
Serbia	Belgrade (7)	Sombor (5)	Subotica (2)		1	25	**15**
Total						113	**103**

Table 21.

Altogether 113 staff members completed the questionnaire. 10 questionnaires were excluded from the study before analysis because entire uncompleted topics. 103 questionnaires were analysed.

Gender-distribution of study participants by country

Country/Gender	Male	Female
Bosnia-Herzegovina	13	12
Montenegro	8	22
North-Macedonia	17	16
Serbia	5	10
Total	43	60

Table 22.

43 (41,7%) male and 60 (58,3%) female respondents answered the questions. The largest difference was represented by Serbia (33,3% male, 66,7% female), but in Montenegro was experienced very similar distribution (36,4% male, 63,6% female). The gender distribution in Bosnia-Herzegovina and North-Macedonia were close 50-50%.

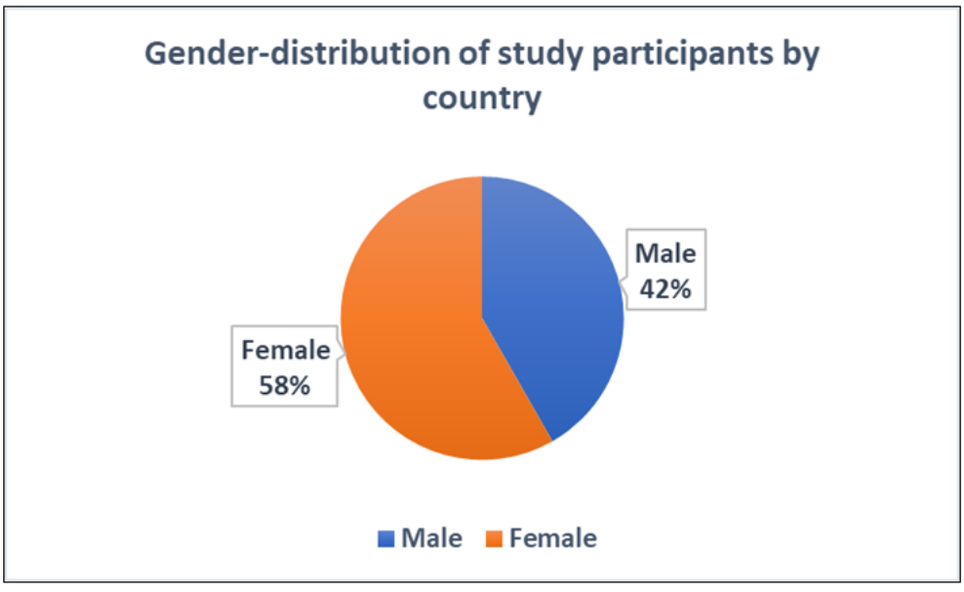

Figure 23.

Age-distribution of study participants by country

Age/Country	Between 18-29 years	Between 30-39 years	Between 40-49 years	Above 50 years
Bosnia-Herzegovina	17	4	4	0
Montenegro	7	10	9	4
North-Macedonia	5	16	8	4
Serbia	5	6	3	1
Total	**34**	**36**	**24**	**9**

Table 23.

	Mean age	Lowest	Highest
Bosnia-Herzegovina	29,1	19	48
Montenegro	38,7	22	62
North-Macedonia	35,8	25	61
Serbia	37,8	24	64
Total	**35,7**	**19**	**64**

Table 24.

Mean age of study participants was 35,7 years with the highest age of 64 years and with the lowest age of 19 years. 36 (34,9%) respondents were between the age of 18 and 29 years. 70% of the study population was under the age of 40 years. Only 9 (8,7%) people were older than the age of 50 years. Study population of Bosnia-Herzegovina was the youngest, since both mean, lowest and highest age were the lowest among Balkan countries.

Distribution of study participants by country of origin

Country of origin	Number of responders
Bosnia-Herzegovina	24
North Macedonia	32
Serbia	15
Montenegro	28
Croatia	1
Iraq	1
Libya	1
Afghanistan	1

Table 25.

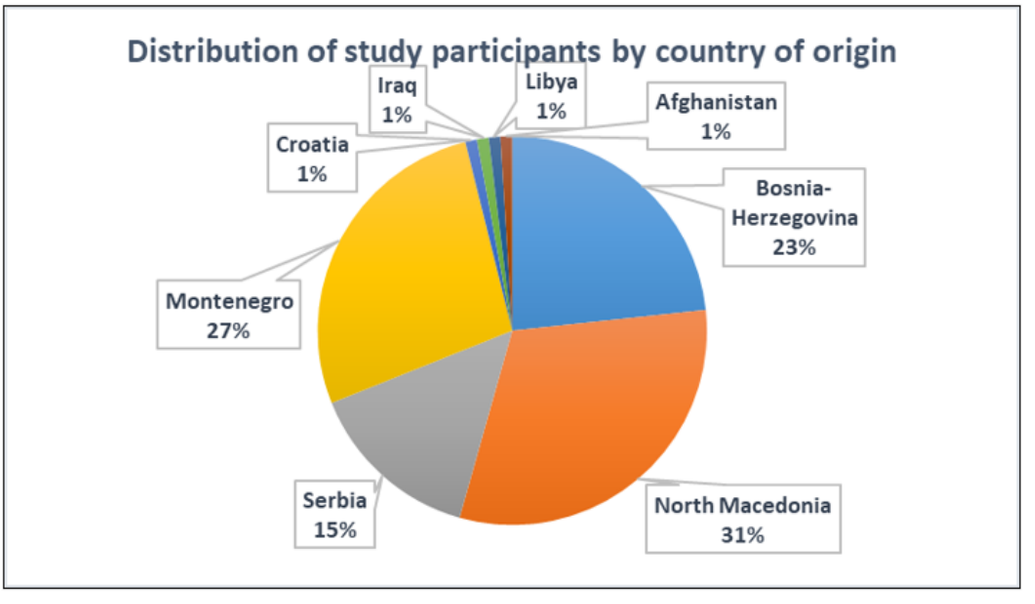

Figure 24.

There were 4 participants whose countries of origin were out of selected Balkan countries. Two participants (1 from Iraq, 1 from Libya) are employees of International Organization for Migration (IOM).

Absolute majority of respondents, altogether 76 (73,8%) people have at least Bachelor's degree. 7 participants preferred not to answer this question.

Family background of study participants

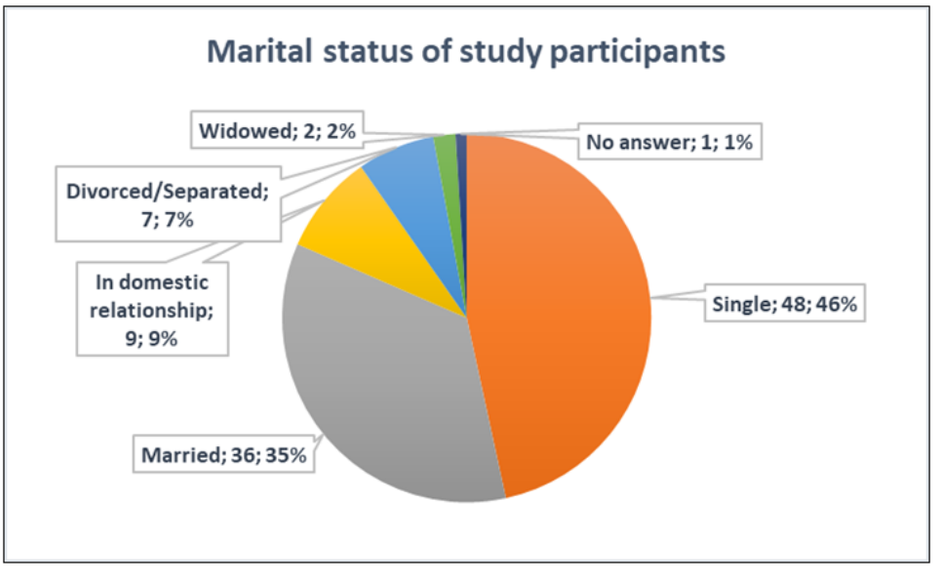

Figure 25.

Almost half of study population (48 people, 46%) is single and 36 people are married. One person did not answer this question, 2 respondents were widowed, 7 participants live as divorced or separated and 9 people live in domestic relationship.

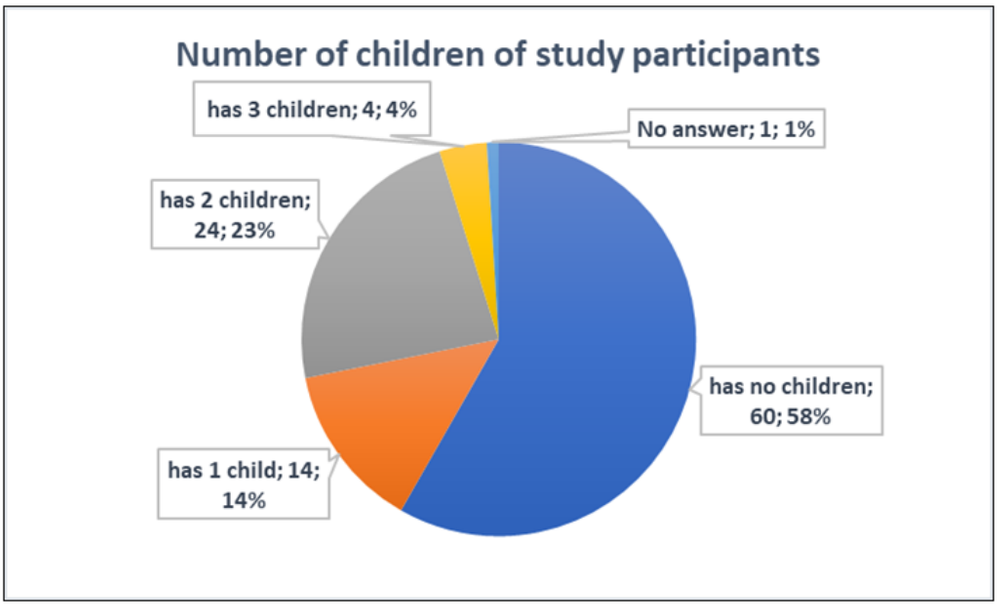

Figure 26.

Participants were asked to report the number of children. 58% of respondents have no children. This result is in line with high percentage of single agents and with low mean age of study population. Nobody reported 4 or more children.

Education level and knowledge of foreign language of study participants

Almost everyone, 94 participants have English language knowledge. 99 respondents speak

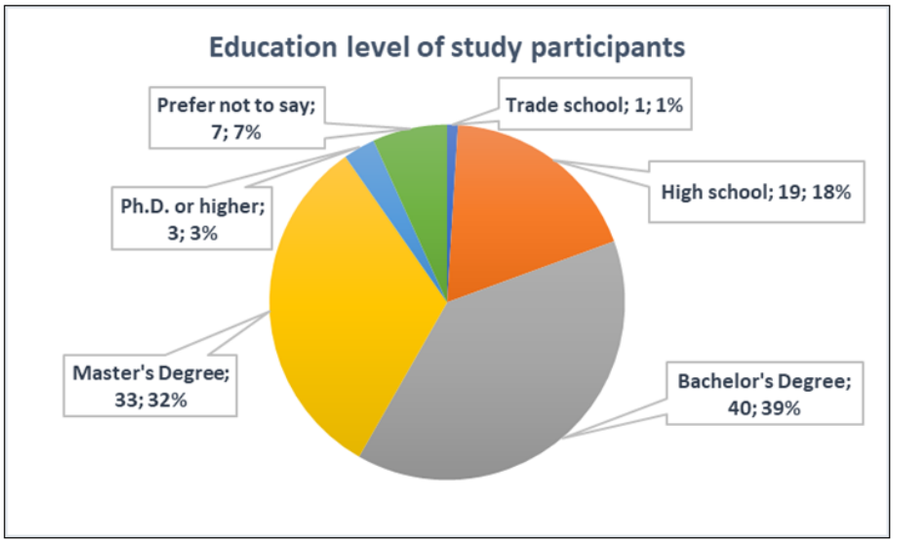

Figure 27.

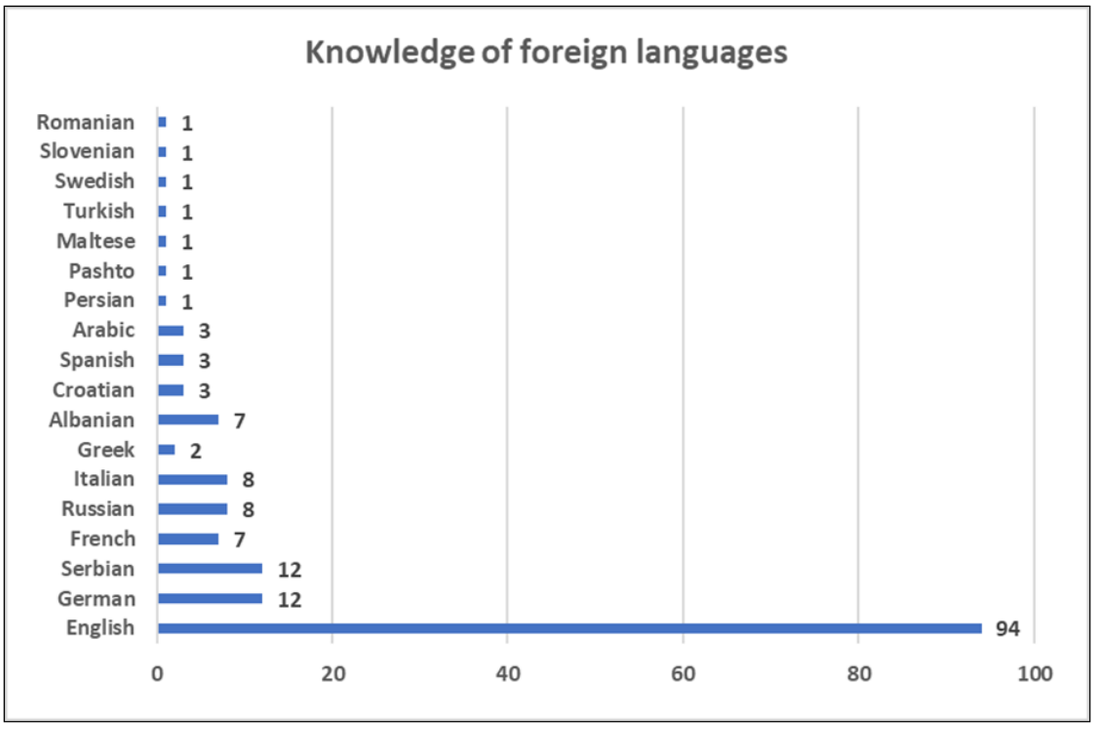

Figure 28.

at least one foreign language. Four people does not speak any foreign language, 44 participants reported to speak one foreign language and one third (35) speaks 2 foreign languages. 17 people speak 3 and 3 respondents 4 foreign languages.

	Does not speak any foreign languages	Speaks 1 foreign language	Speaks 2 foreign languages	Speaks 3 foreign languages	Speaks 4 or more foreign languages
Bosnia-Herzegovina	0	12	4	6	3
Montenegro	1	13	10	6	0
North-Macedonia	3	12	14	4	0
Serbia	0	7	7	1	0
Total	**4**	**44**	**35**	**17**	**3**

Table 26.

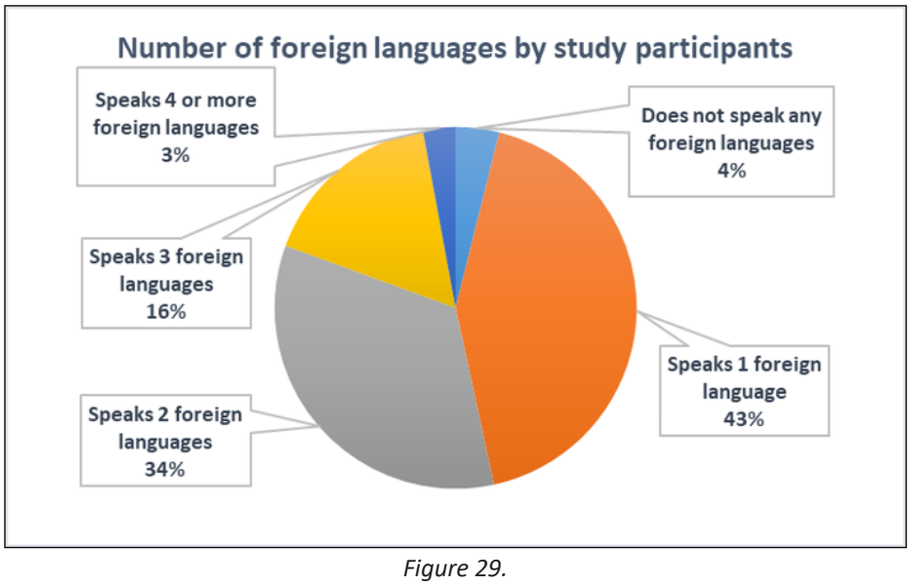

Figure 29.

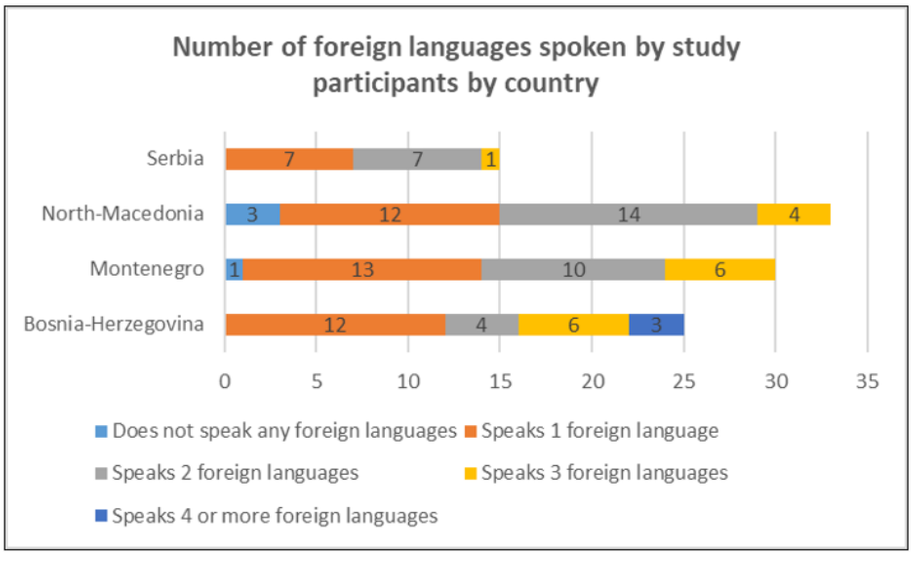

Figure 30.

More than one third (36%) of the study population in Bosnia-Herzegovina speaks 3 or more foreign languages. The percentage of presented foreign language (3 or more (36%)) knowledge is significantly higher than in other selected Balkan countries.

Working conditions, workplace related aspects

Majority of the respondents (64 (62%)) are working at Intergovernmental Organizations or at Non-Governmental Organizations.

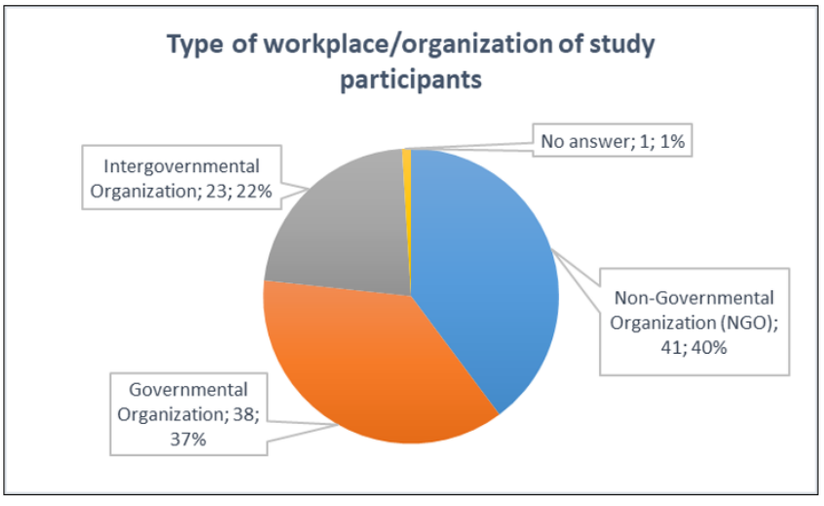

Figure 31.

92 (89,3%) participants are full-time employees, 1 person did not answer and 10 (9,7%) respondents are working with part-time contract.
The study population started to work on average 6,5 years ago in this field. The longest reported employment relationship is 38 years and the shortest is 6 weeks.

Access to health services

Respondents stated that psychological counselling (74), medical aid in emergency (73) and social work services (61) provided by humanitarian organizations most frequently for migrants in the selected Balkan countries.

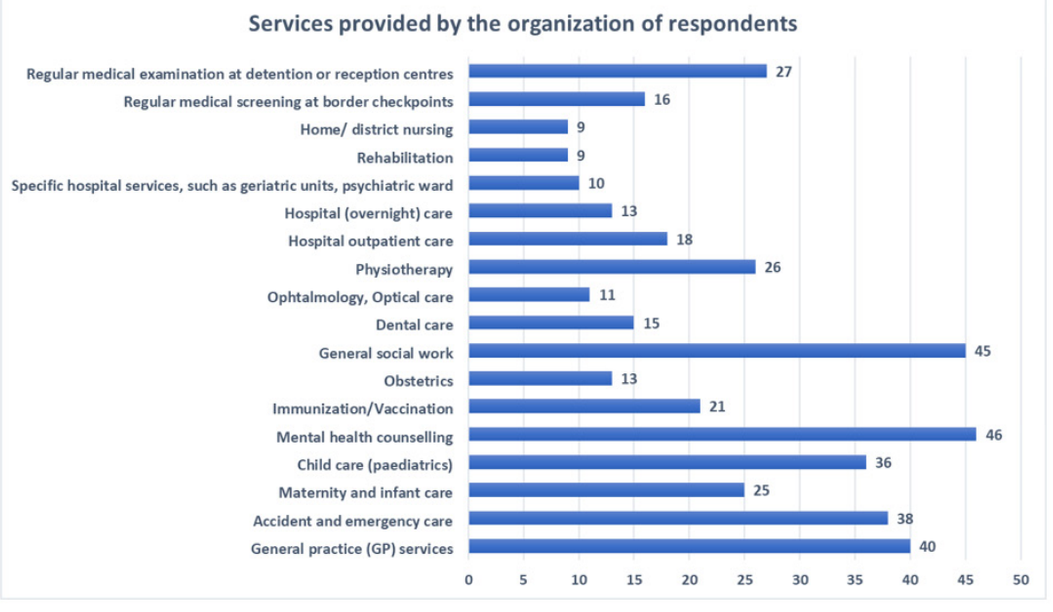

Figure 32.

The health services, provided by organizations employing the respondents, cover broad spectrum of professional fields. Mental health counselling (46), general social work (45), general practice (GP) services (40), accident and emergency care (38) and paediatrics (36) received the highest scores. General social work and mental health counselling outstand from the field.

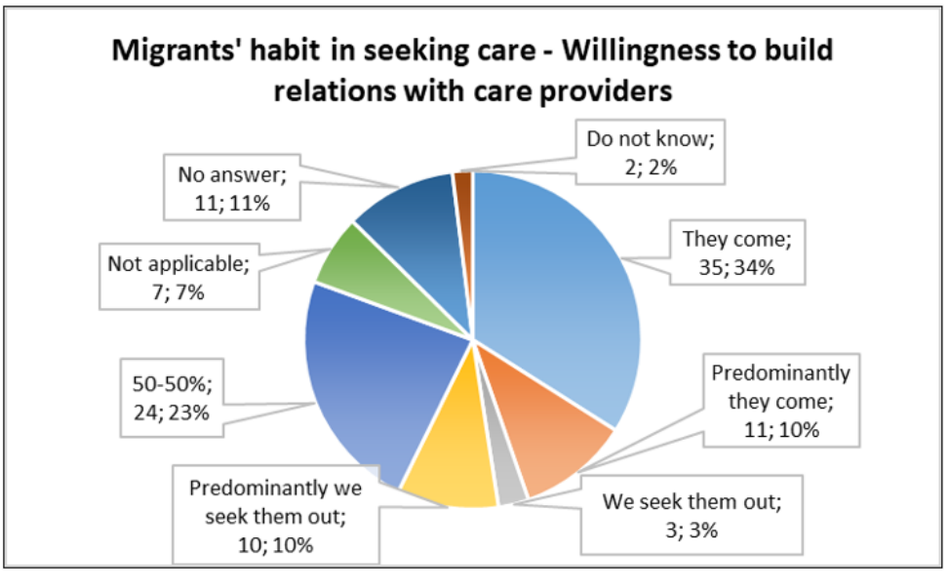

Figure 33.

According to one third of the study population (35 (34%)), migrants seek care by themselves and not necessary to seek them out. 11 (11%) respondents stated that migrants predominantly come by themselves to claim care/service. Only 3 (3%) respondents stated that they need to seek migrants out and 10% (10) of the study population figured that service providers need to seek migrants predominantly out. 11 participants did not answer and in case of 9 people this question was not applicable or they had no information.

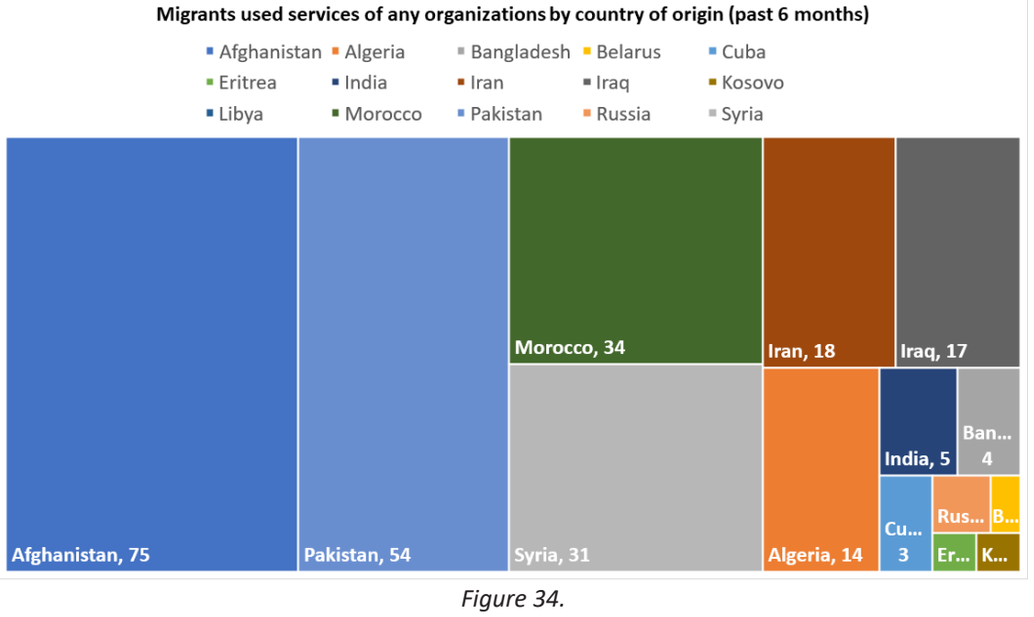

Figure 34.

Study participants were asked to list those three countries of origin registered most frequently among migrants, who used the services of their organization during past 6 months. The result reflects the migration statistics. Afghanistan was mentioned 75 times, the second country was Pakistan (54) and Morocco (34) the third. The next three countries (Syria (31), Iran (18), Iraq (17)) are Western Asian countries, known also as important sending countries of refugees and irregular migrant. Comparing these findings with the statistics of the United Nations High Commissioner for Refugees (UNHCR) on asylum seekers, refugees and other mixed movements,[14] a very similar picture can be seen about the ranking of countries of origin.

	Financial unavailability	Shortage in labour force	Language barriers	Administration processes	Entitlement restrictions	Discrimination
Not at all	29	26	17	21	31	**50**
A little bit	16	24	20	17	18	12
Somewhat	26	12	18	25	28	10
Quite a bit	9	19	**27**	16	7	13
A lot	6	7	**11**	9	5	4
No answer	17	15	10	15	14	14

Table 27.

Figure 35. gives general overview of the importance of six obstacles setting the daily work back. Discrimination was the less important and language barriers seem to be the most relevant hindering factor. This tendency reflects both in scores and in distribution of answers. Visibly, financial unavailability and restrictions in entitlements were less significant than shortage in labour force and administration processes.

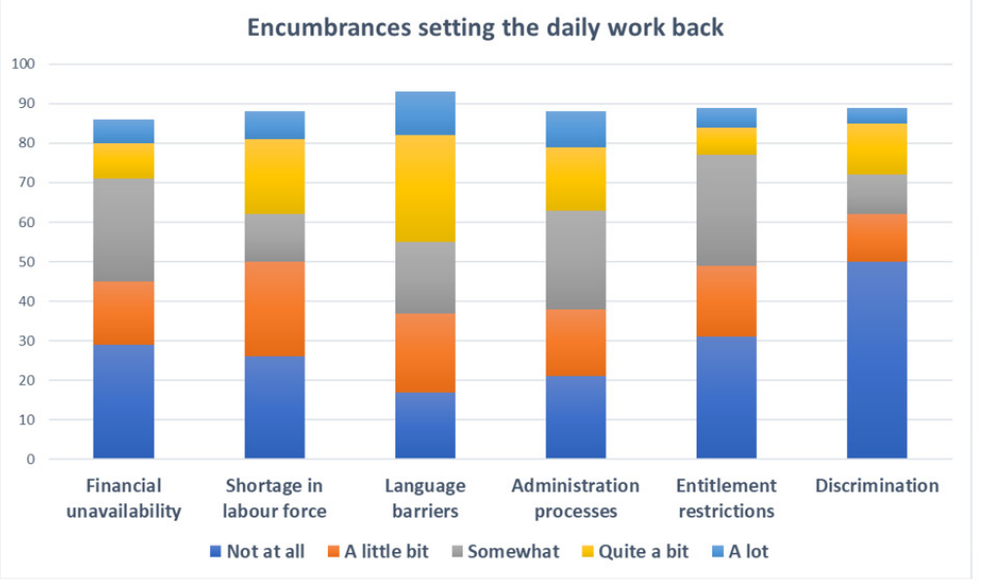

Figure 35.

14 UNHCR - RBE - Western Balkans - Refugees, asylum-seekers and other mixed movements - April 2020; https://data2.unhcr.org/en/documents/details/76283 (accessed on 28th Sept, 2020.)

Access to information use of health services

Awareness of entitlements for healthcare services may considerably influence the accessibility of services.

The spectrum of entitlements depends on the legal status of migrants substantially. For instance, an asylum seeker has broader access to free of charge healthcare services provided by governmental institutes than an unregistered irregular migrant. Sharing reliable information about entitlements, with both migrants and staff members, may contribute to the adequate therapy of migrants in time and help to prevent possible adverse health outcomes.

Altogether 56 (54%) participants take part in information sharing practice. 38 (37%) respondents are engaged in providing information for migrants. 47 participants gave no answer or esteemed this question as not relevant.

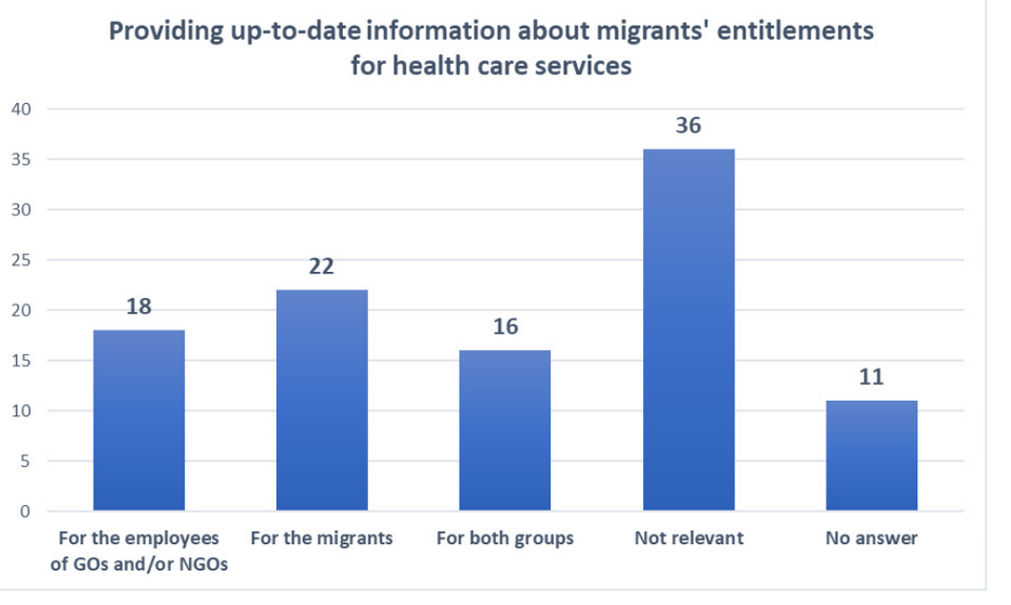

Figure 36.

A multiple-choice question inquired about the methods and tools used for the dissemination of entitlements related information. The question did not make any difference on the level of target groups of the information sharing practice. It referred to the used methods for information sharing in general.

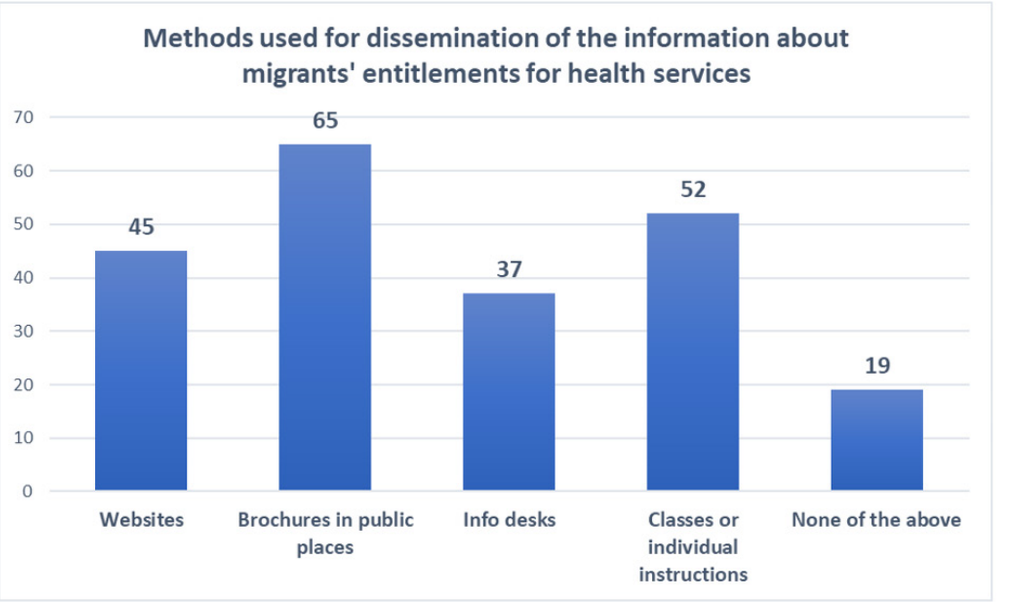

Figure 37.

19 (18%) participants stated that they do not use any of the listed methods for dissemination of entitlements related information. However, printed brochures are still the most important (n=65) and easiest way for information sharing, but both personal and virtual options are available. Both migrants and professionals have the opportunity to gain the necessary information.

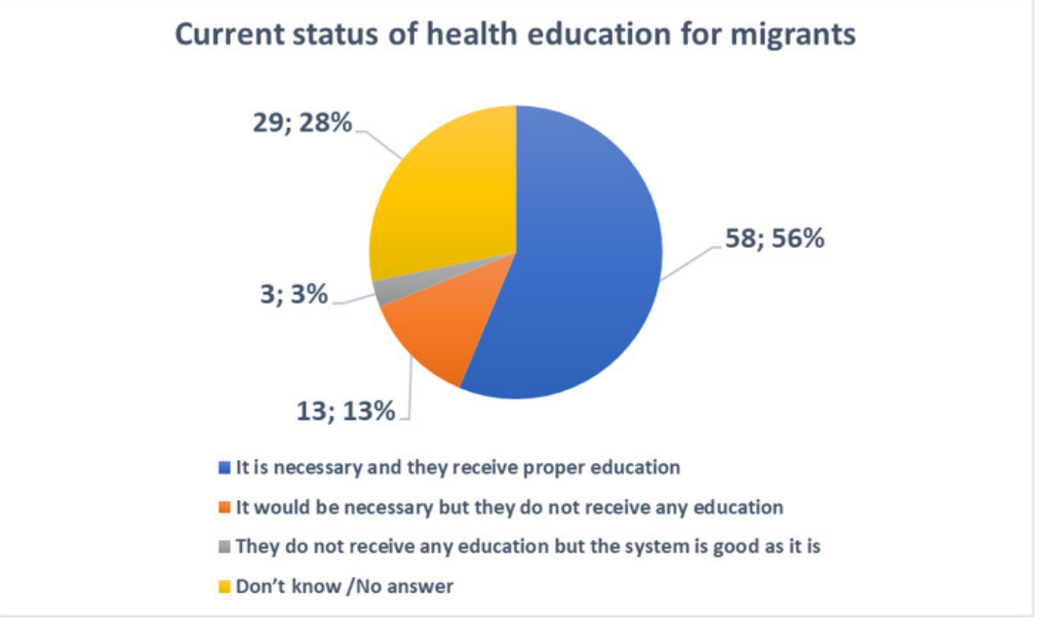

Figure 38.

More than 50 % (n=58, 56%) of the study population recognized that health education is necessary and migrants receive the proper education. According to 16 (16%) respondents, migrants do not receive any health education. 13 representatives agreed that health education would be necessary, but migrants do not receive any education. Unfortunately, 29 participants had no information or gave no answer to this question.

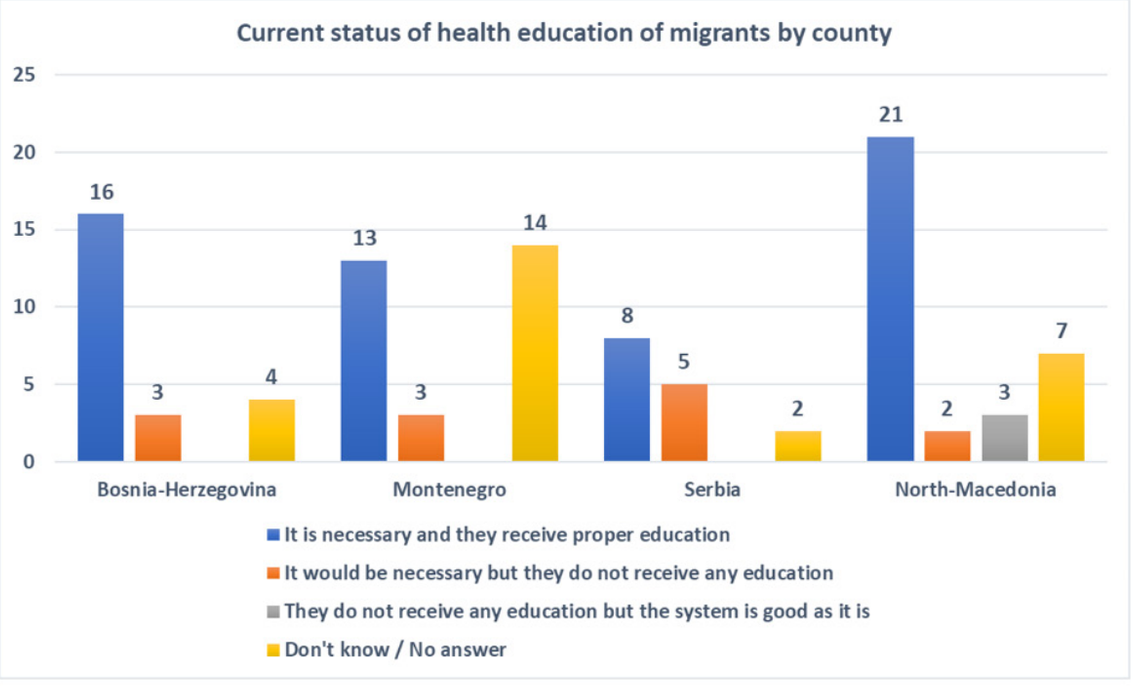

Figure 39.

Respondents from Bosnia-Herzegovina (16/23, 70%) said in highest percentage that health education is necessary and migrants receive proper education. The lowest rate was registered in Montenegro (13/30, 43%).

Serbian participants stated in the highest rate (5/15, 33,3%) that education of migrants is still missing. However, this rate was the lowest in Montenegro (3/30, 10%), but the highest was the percentage of those who did not give answer or had no information (14/30, 47%). In 2015, the migration crisis exceeded the capacity of both governmental and non-governmental organizations. The enormously high number and rapid movement of migrants seriously overloaded the system. Participants were asked to share their opinion about how did the policies **affect the healthcare of migrants** in general since 2015.

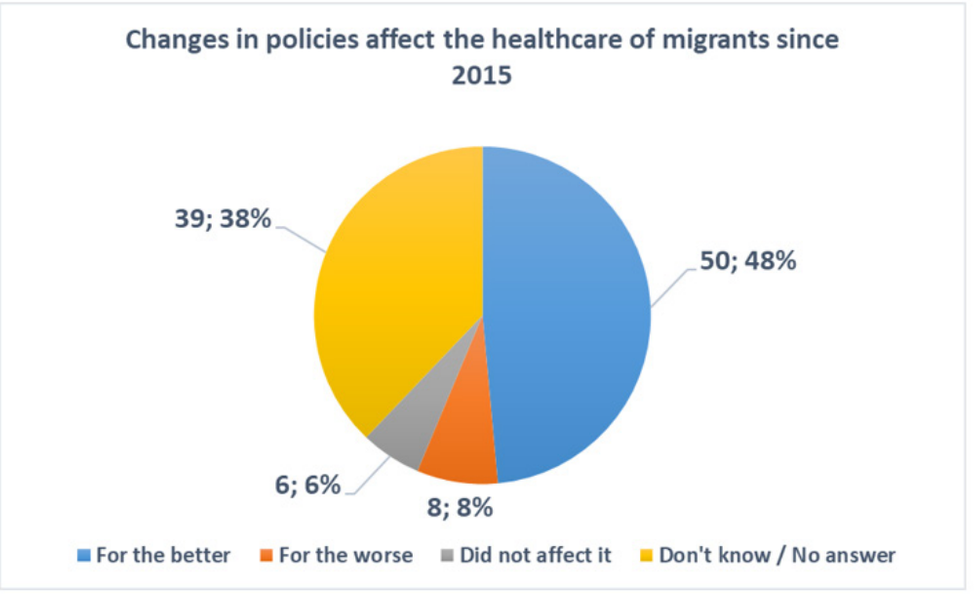

Figure 40.

Almost half of the study population (50, (48%)) assessed that changes in policies affect migrants' healthcare in a positive way. According to 6 persons, there is no change in this field and 8 participants observed that changing policies had negative effect. 39 (38%) respondents had no information and/or gave no answer. Overall, according to the majority of study population, the changes in policies have positive effect on healthcare of migrants.

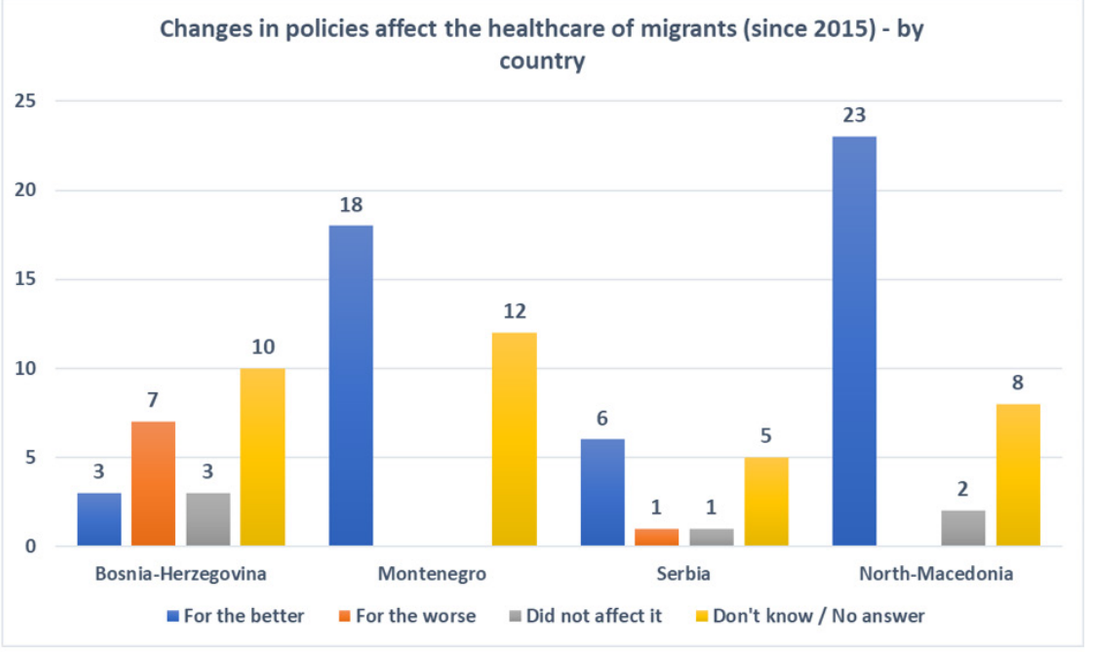

Figure 41.

The results by country are very similar, except for Bosnia-Herzegovina. In Montenegro, Serbia and North-Macedonia, the absolute majority of participants specified their answer, assessed for better the healthcare of migrants than before 2015. In Bosnia-Herzegovina, only 13% of study population esteemed the situation better.

Health and well-being of vulnerable groups

Study participants were asked about the vulnerability of migrants in general. They were asked to give three vulnerable groups of migrants assessed with high relevance. Six typical vulnerable migrant groups were listed to help answering. 57 respondents stated that they provided any services during the last 6 months for unaccompanied minors. Women were mentioned by 56 people. Victims of trafficking belong to the less frequently contacted vulnerable group of migrants, only 14 participants provided services for victims of trafficking. 42 respondents provided any services for elderly during the last 6 months.

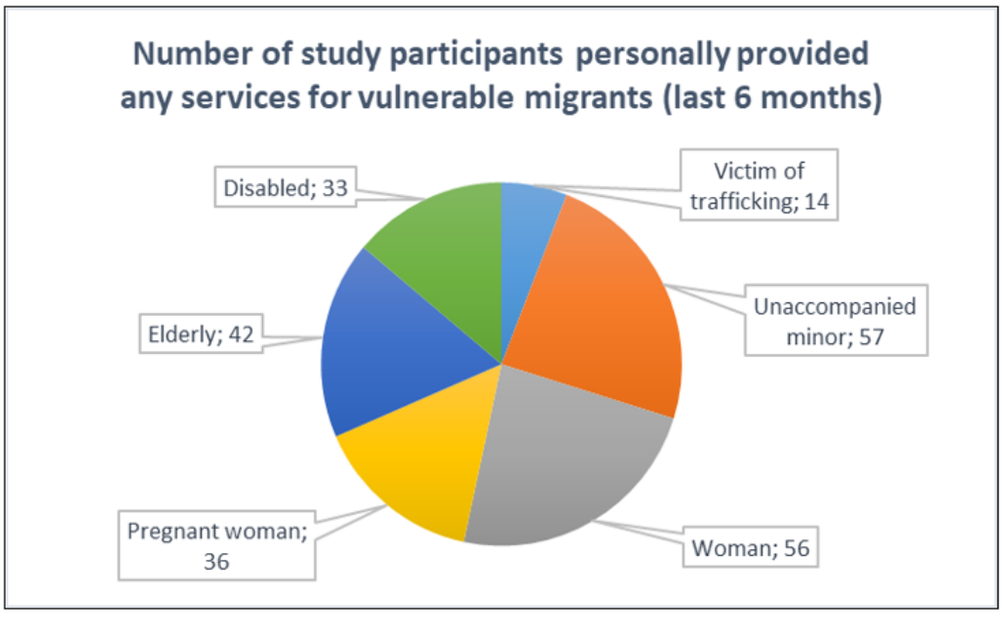

Figure 42.

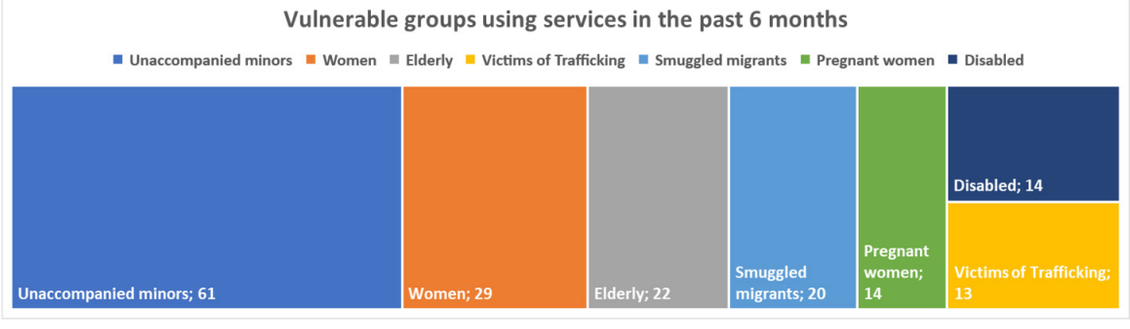

Figure 43.

According to *Figure 44.*, Afghanistan (35%), Pakistan (25%) and Syria (15%) were esteemed by respondents as the most frequent **country of origin of vulnerable migrants.** This estimation correlates with the distribution of country of origin of those migrants who were treated during the past 6 months.

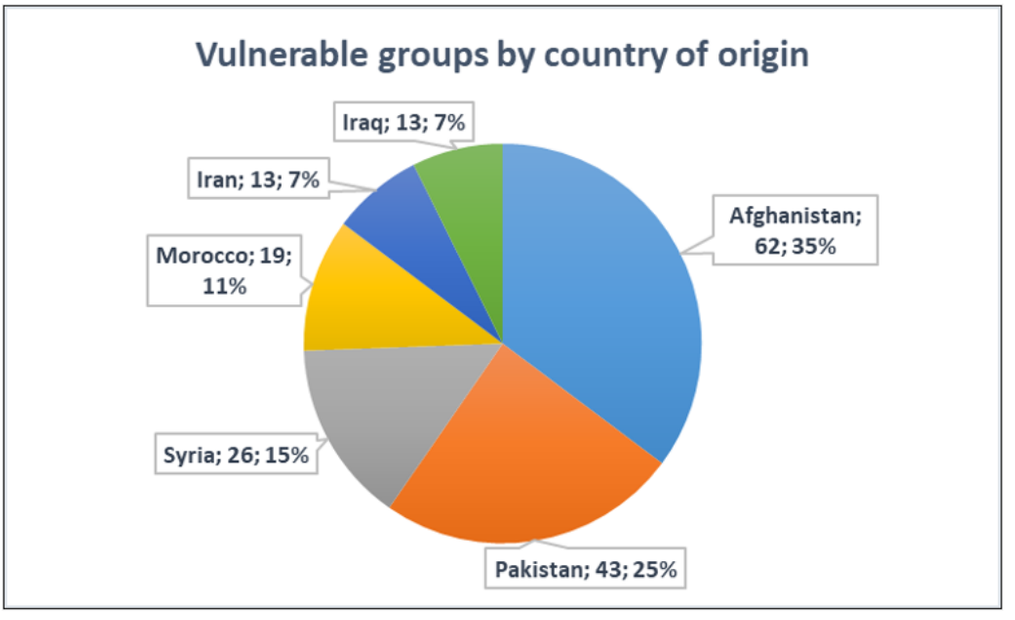

Figure 44.

The majority of study participants, at least 50%, stated that there is no special attending or resident department for trafficked persons or minors separated from other departments. About 5% of the workplaces have regular departments preserved for victims of trafficking.

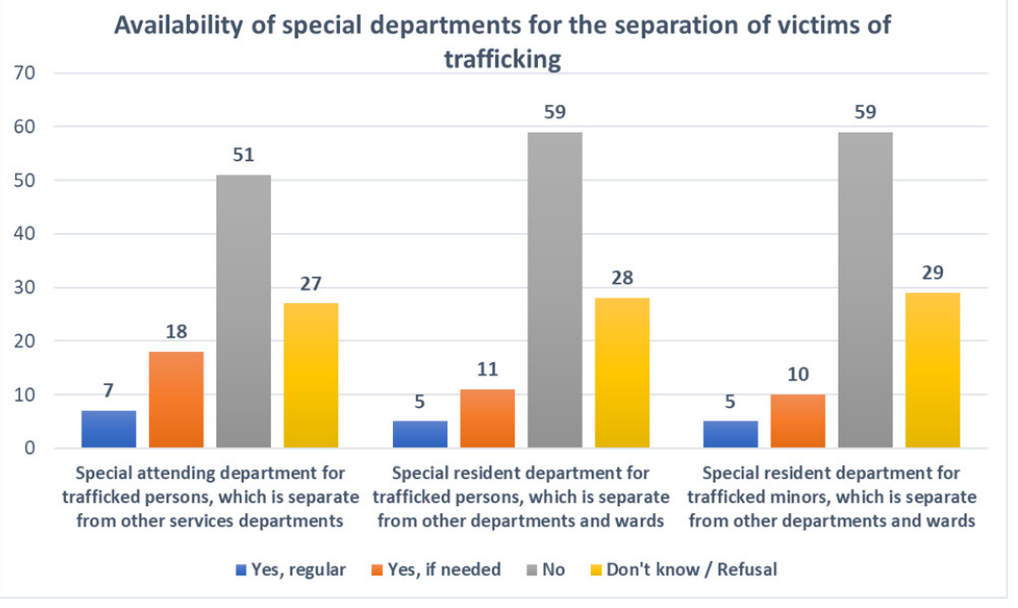

Figure 45.

Communicable disease related aspects

Asylum seekers, refugees and other subgroups of irregular migrants may be subjects to risks of infectious diseases. This burden of communicable diseases depends on migrants' country of origin, countries visited during their journey as migrants and the conditions they experienced during migration. They may present not only the health characteristics of the country of origin, but also may suffer from other infectious diseases acquired during their travel. The communicable disease related health risks are important from occupational health point of view as well.

Communicable diseases may pose the major health threat for people working with newly-arrived migrants.

Screening practice – Vaccine-preventable diseases

Migrants may be more susceptible for vaccine preventable diseases than the indigenous population of the given host country. Screening tests contribute to the recognition and treatment of infectious diseases in a timely manner. Vaccination and screening measures provide together the highest level of protection. Both screening and vaccination protocols differ country by country.

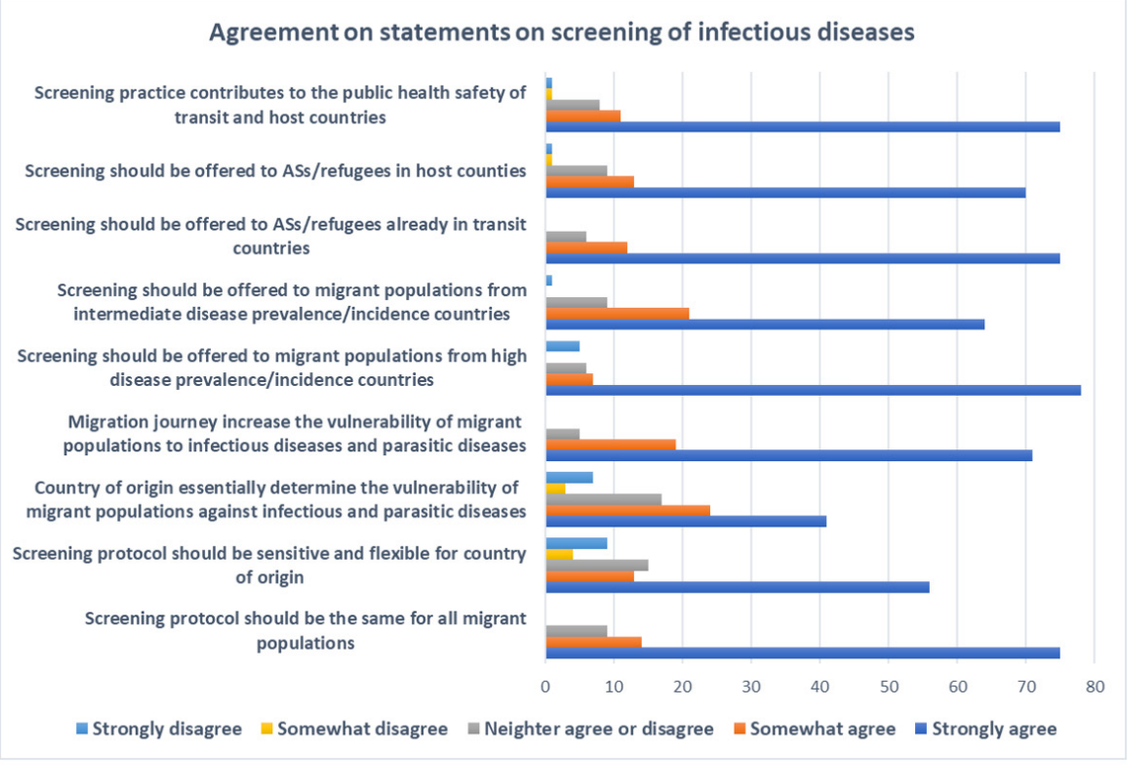

Figure 46.

Figure 46. lists statements in relation to screening practice among migrants. Respondents needed to assess the level of their agreement or disagreement on a five-point Likert scale. The majority of study population strongly agrees and somewhat agrees with the listed statements. Practically, they can accept these establishments. In two cases, respondents somewhat or strongly disagreed the statements. Interesting, that even these statements refer to the determining effect of country of origin and underline the importance of flexible screening protocols depending on such influencing factors like disease profile of the country of origin.

The prejudice against migrants, they are infected with varieties of infectious diseases is critical in the host population. *Figure 47. and 48.* reflect the opinion of the study population. Respondents have the opportunity to give further examples as well. Scabies is a skin infection, caused by mites, mentioned by 16 respondents in the optional section. Coronavirus infection and scabies are considered diseases with very high risk posed by migrants. Ebola also received comparatively higher scores than others.

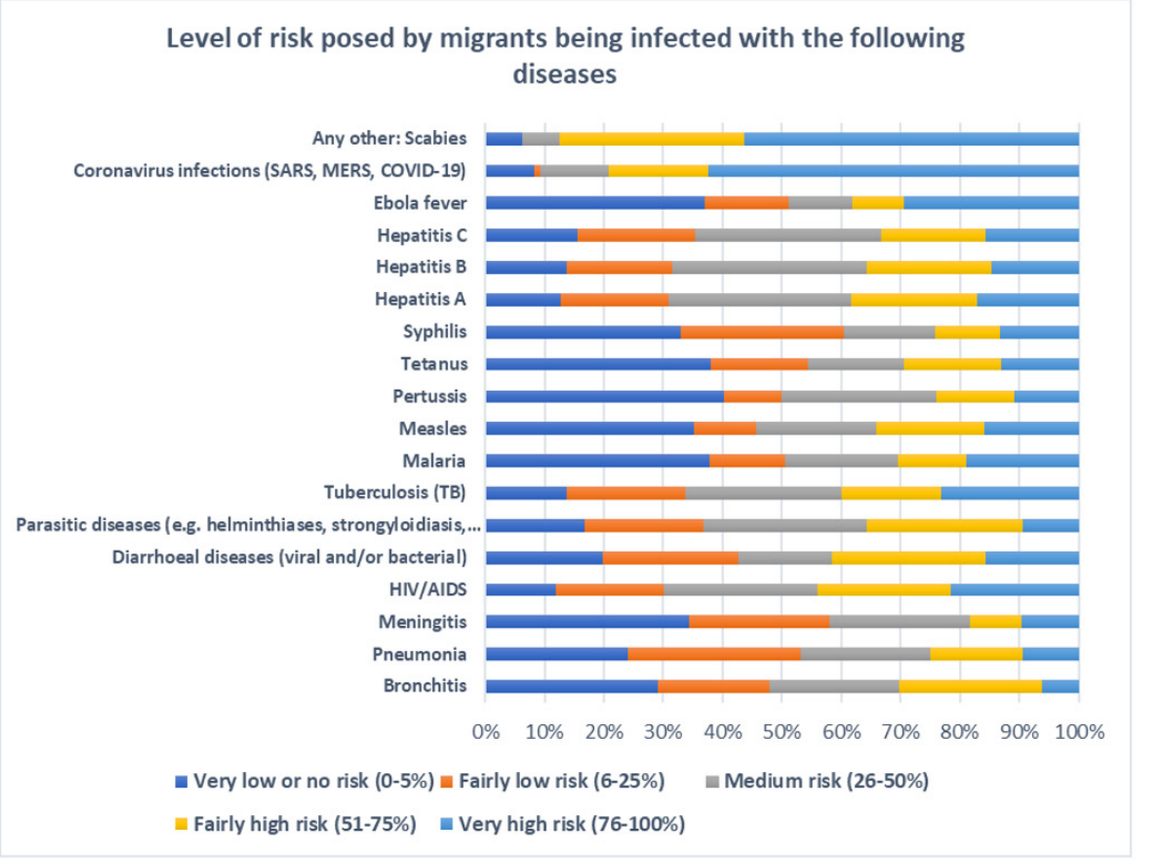

Figure 47.

Figure 48. summarizes the significance of screening of selected infectious diseases among migrants, shows a very similar picture to the level of risk being infected migrants. The significance of Coronavirus infections may be overestimated and in both figures are visible the dominance compared to other infectious diseases.

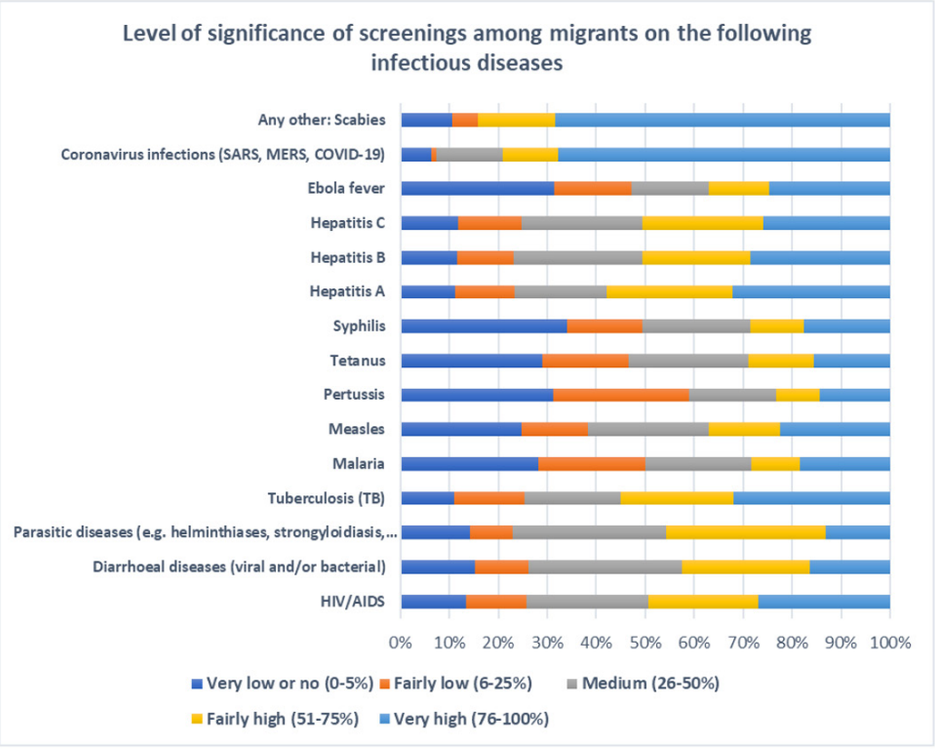

Figure 48.

Figure 48. shows the opinion of respondents about the necessity of screening tests regarding the listed infectious diseases. Practically, both existing screening protocols and official recommendations point out more or less similar list of infectious diseases. Hepatitis A, Hepatitis B, Hepatitis C, Tuberculosis and HIV/AIDS received higher scores on significance and have overlapping with recommendations as well.

Table 28. summarizes the knowledge of participants regarding national screening protocol for infectious diseases in newly-arrived migrants, the phase of migration process in which screenings are implemented, and the average timeframe between reception and screening. 64 persons stated that there is a national level screening protocol for infectious diseases in newly-arrived migrants. 54 % (35/64) of positive answer given respondents mentioned that screening tests are performed during the first 24 hours on entry level.

National level screening protocol for infectious diseases in newly-arrived migrants		**Screening protocol implemented in migration process**		**Average timeframe between reception and screening**	
Yes	64	Entry level	36	24 h	35
No	33	Holding level	16	1-7 days	8
No answer	6	Community centre	4	over 7 day	2
		Unclear	8	changing	11

Table 28.

However, study participants figured that the majority of migrants undergo entry level screening tests, but time-delay may vary and exceed even a week. *Figure 49.* summarizes the scores on possible obstacles in the implementation of screening tests. Participants had to assess the risk of listed factors being obstacles. Financial unavailability, shortage in labour force and language barriers were assessed as hindering factors.

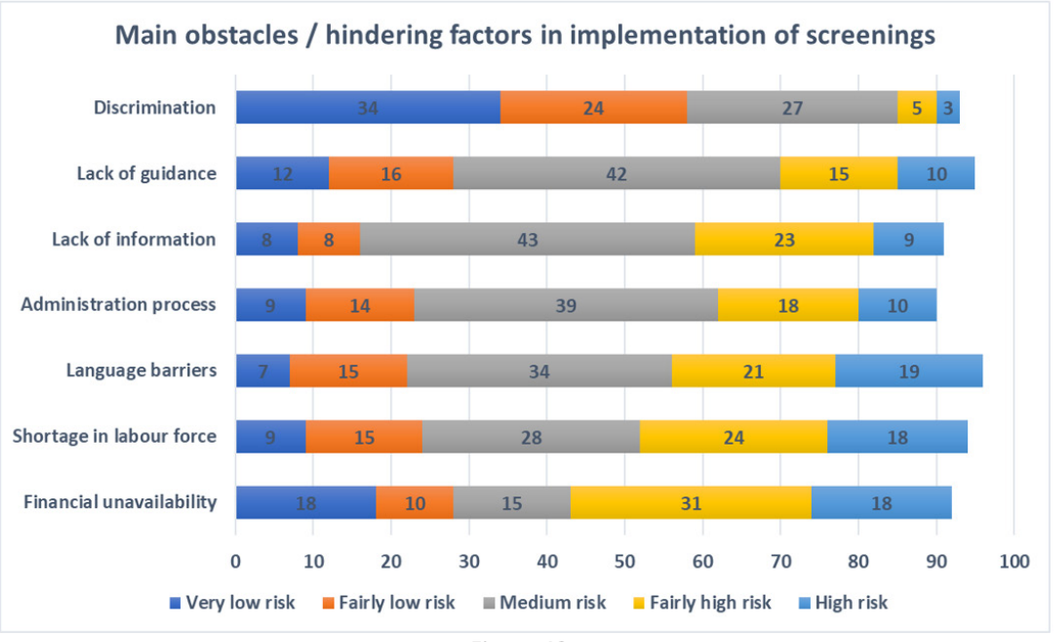

Figure 49.

The level of agreement with evidence-based statements was measured by using five-point Likert scale. VPDs related statements were listed and study participants marked their level of agreement. *Figure 50.* and *51*. represent the listed statements and distribution of answers.

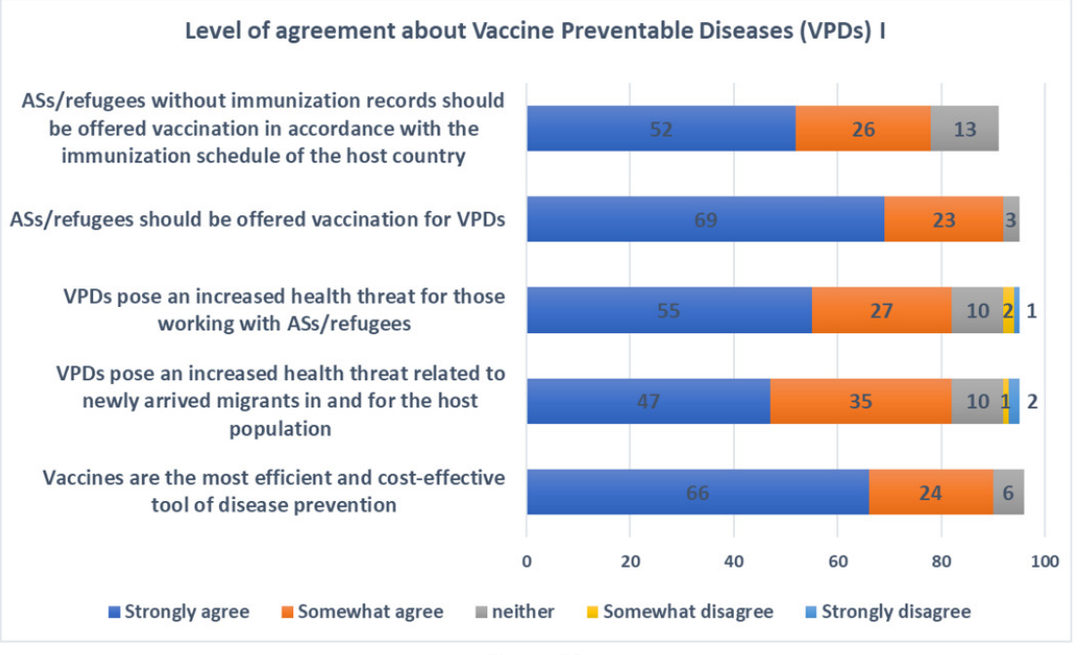

Figure 50.

Overall, study participants agree with the importance, efficiency and cost-effectiveness of vaccination and the fact that working with migrants poses increased health threat in general.

The strongest agreements were registered about the contribution of immunization practice to the public health safety of transit and host countries furthermore, about the immunization practice should cover both children, adolescents and adults. Study population was unanimously supportive regarding immunization practice should be mandatory for migrants.

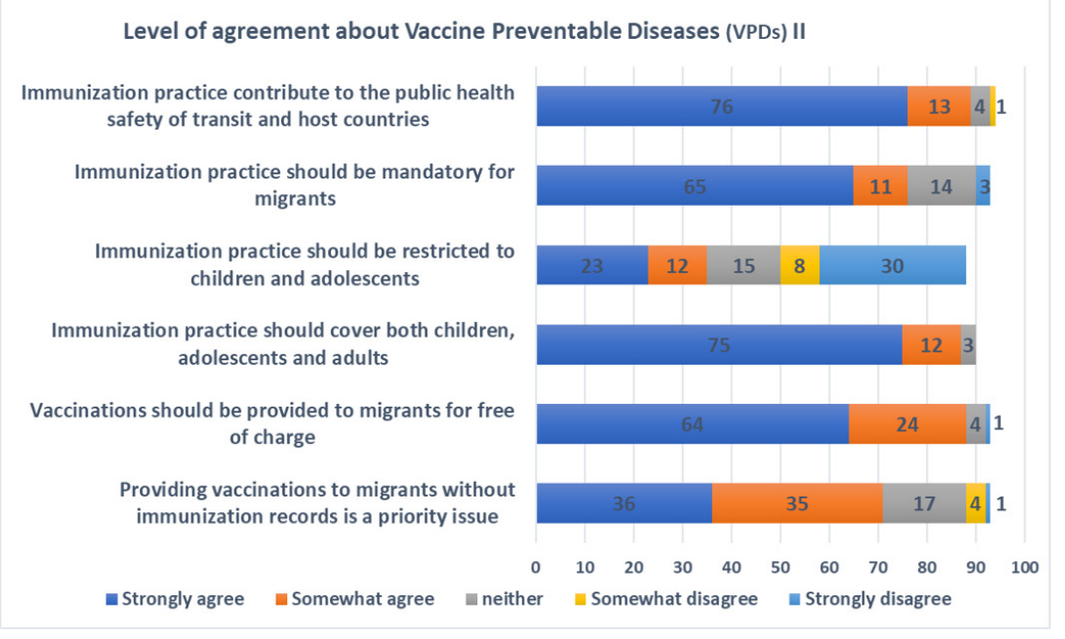

Figure 51.

Providing vaccinations to migrants without immunization records is a priority issue. In study population, there is no consonant agreement compared to other cases. Only 36 persons agreed strongly and 35 were somewhat agreed. Participants' disagreement was higher on restriction of immunization practice to children and adolescents.

Awareness of national immunization protocol for the host population		**Is it free of charge?**		**Is it mandatory?**	
Yes	52	Yes	51	Yes	40
No	35	No	1	No	11
Partly	9				

Table 29.

52 respondents declared the awareness of national immunization protocol and 9 persons have partial awareness. According to the absolute majority of participants, vaccines are free of charge and mandatory.

Recognition of **signs and symptoms of an infectious disease** can be difficult. Many things influence the recognition of communicable diseases, e.g. the general health condition of migrants, health literacy of service providers, etc.

Participants were asked to assess their general knowledge on signs and symptoms, way of transmission and preventive measures against infectious diseases. 86 (84%) respondents assessed their knowledge in hygiene norms for good or excellent. Regarding the knowledge of the way of transmission, the signs and symptoms, and the spreading infectious diseases, there are no significant differences comparing them to each other, but the self-assessed knowledge seems to be worse than the result of hygiene norms.

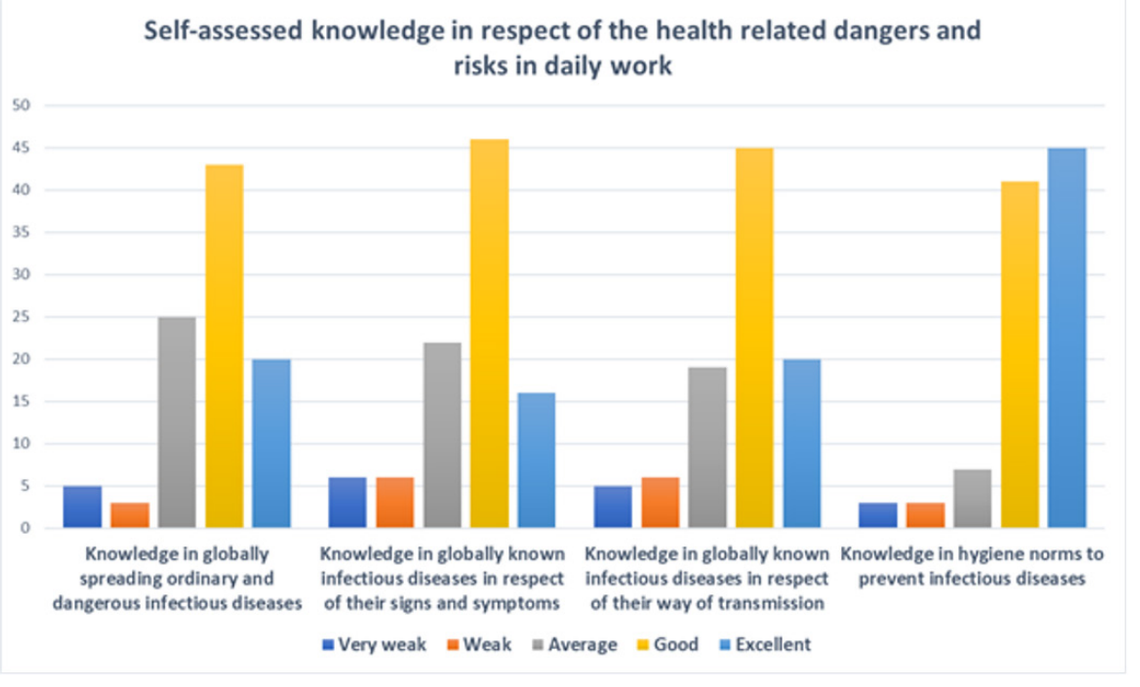

Figure 52.

Since the service provision for refugees and asylum seekers is a really sensitive and complex field, thus numerous factors may have influence on responsiveness of the provided services.

Occupational health – Perceived health risks at work

The recognition of biological and environmental hazards is the first step in building up interventions to improve occupational health and safety.

Participants needed to assess how often they were affected by the listed 26 hazards. Exposure to computers, TV or any other kind of electronic screen work ranked as the most

bothering hazard. Use of latex gloves was also highly, almost on the same level ranked. According to the study population, these two hazards were especially overrepresented in work environment. It means that both office workers and staff members on the field meet risk factors. Only 15 persons stated that they have never using latex gloves, but 56 workers use this protective tool most of the time or always.

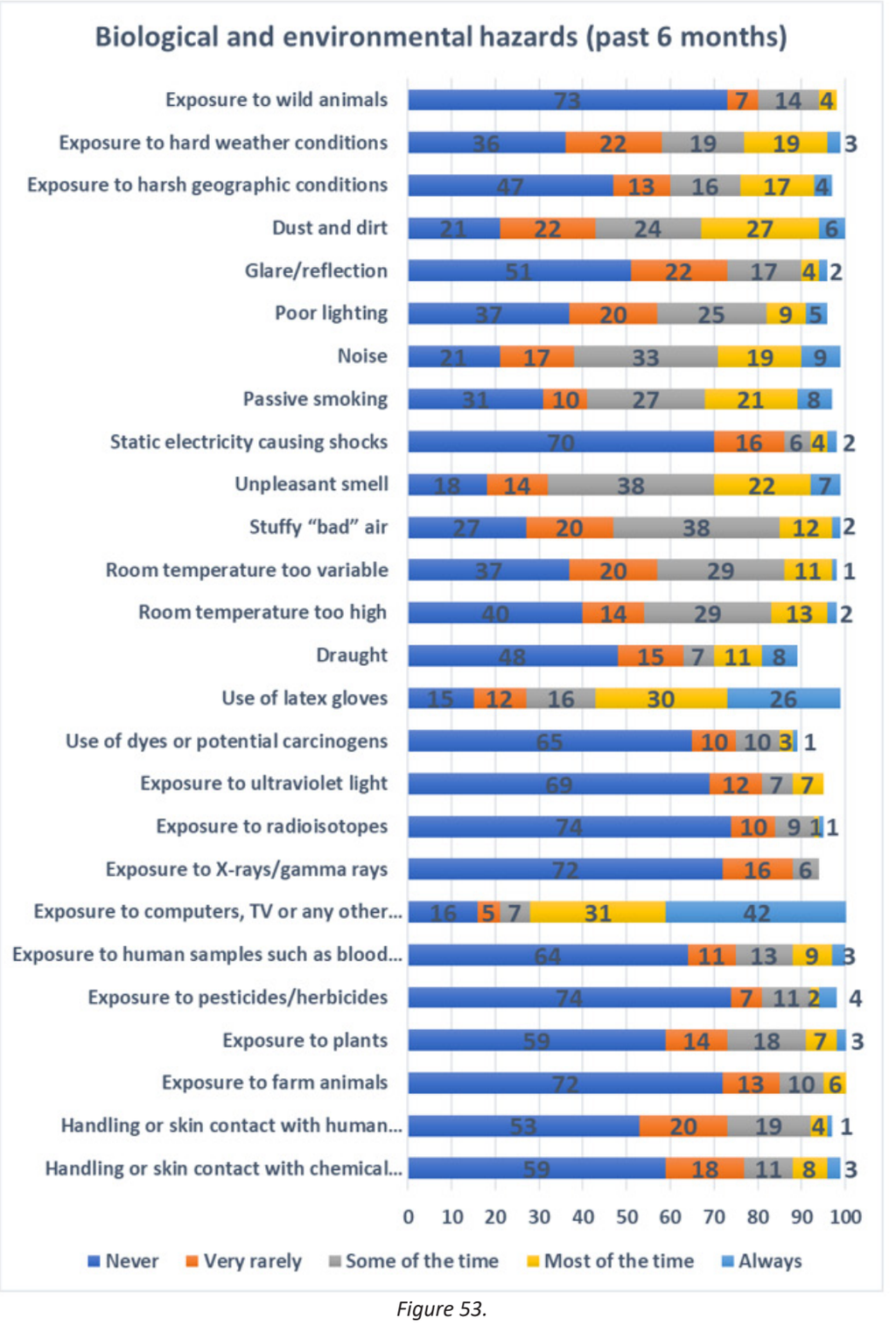

Figure 53.

Staff members reported different workplace or profession related factors with different significance. In case of the following hazards, the cumulative rate of 'always', 'most of the time' and 'some of the time' answers achieved or exceeded the 40% of answers: exposure to hard weather conditions, dust and dirt, noise, passive smoking, unpleasant smell, stuffy "bad" air, room temperature too high, and room temperature is too variable.

The least important factors were: exposure to ultraviolet light, X-ray/gamma rays, radio-isotopes, pesticides/herbicides, farm animals, wild animals, the static electricity causing shocks and use of dyes or potential carcinogens. In case of these hazards, the rate of 'never' answer achieved or exceeded the 60% of responses.

Vaccination and VPDs were also targeted as important occupational health aspects, since service providers working in field of migration may be at special risk being infected with infectious diseases/VPDs. Not only health care workers (HCWs) but other field of proffe-sionnals may also have VPD related occupational safety regulation. For instance, Hepatitis B vaccination is mandatory for HCWs.

Fairly high percentage (67%), the majority of the study population had no information or refused the question on last received vaccination. They have asked to answer when received it. Altogether 34 respondents indicated the year of vaccination. The timeframe is quite long, the earliest indicated vaccination happened in 1975 and two respondents vaccinated in 2020.

Table 30. summarizes the last received vaccine related information. 69 persons did not remember/had no information or refused answering the question. 34 participants referred to any vaccine get in the timeframe between 1975 and 2020. 65% (22/34) of this population was vaccinated since 2012.

However only 34 respondents remembered to the date of last received vaccine, 49 participants named the last received vaccine.

When did you last receive preventive vaccination against any kind of infectious diseases?	
1975	1
1990	1
1993	1
1998	1
2000	1
2002	1
2003	1
2006	2
2008	1
2009	2
2012	1
2013	1
2014	1
2015	1
2016	4
2017	1
2018	7
2019	4
2020	2
Don't know / Refusal	69
Total	**103**

Table 29.

What vaccination did you get?	
Tetanus	25
Hepatitis B	7
BCG	6
DTP	3
MMR	3
Polio	2
Yellow fever	1
HPV	1
Seasonal influenza	1
Total	**49**

Table 30.

In 25 (51%) cases, Tetanus vaccine has mentioned. The list covers, from occupational health point of view, a number of recommended and required booster vaccinations: Hepatitis B, BCG, DTP, MMR.
Majority of respondents do not possess any records about their vaccinations, and only 23 persons (22%) reported any supervisions regarding their vaccination status by local health professionals.

Do you possess a record of your vaccinations related to your job?		Do any of your superiors or local health professionals monitor your vaccinations against infectious diseases?	
Yes	35	Yes	23
No	43	No	50
Don't know	23	Don't know	26
Refusal	2	Refusal	4

Table 31.

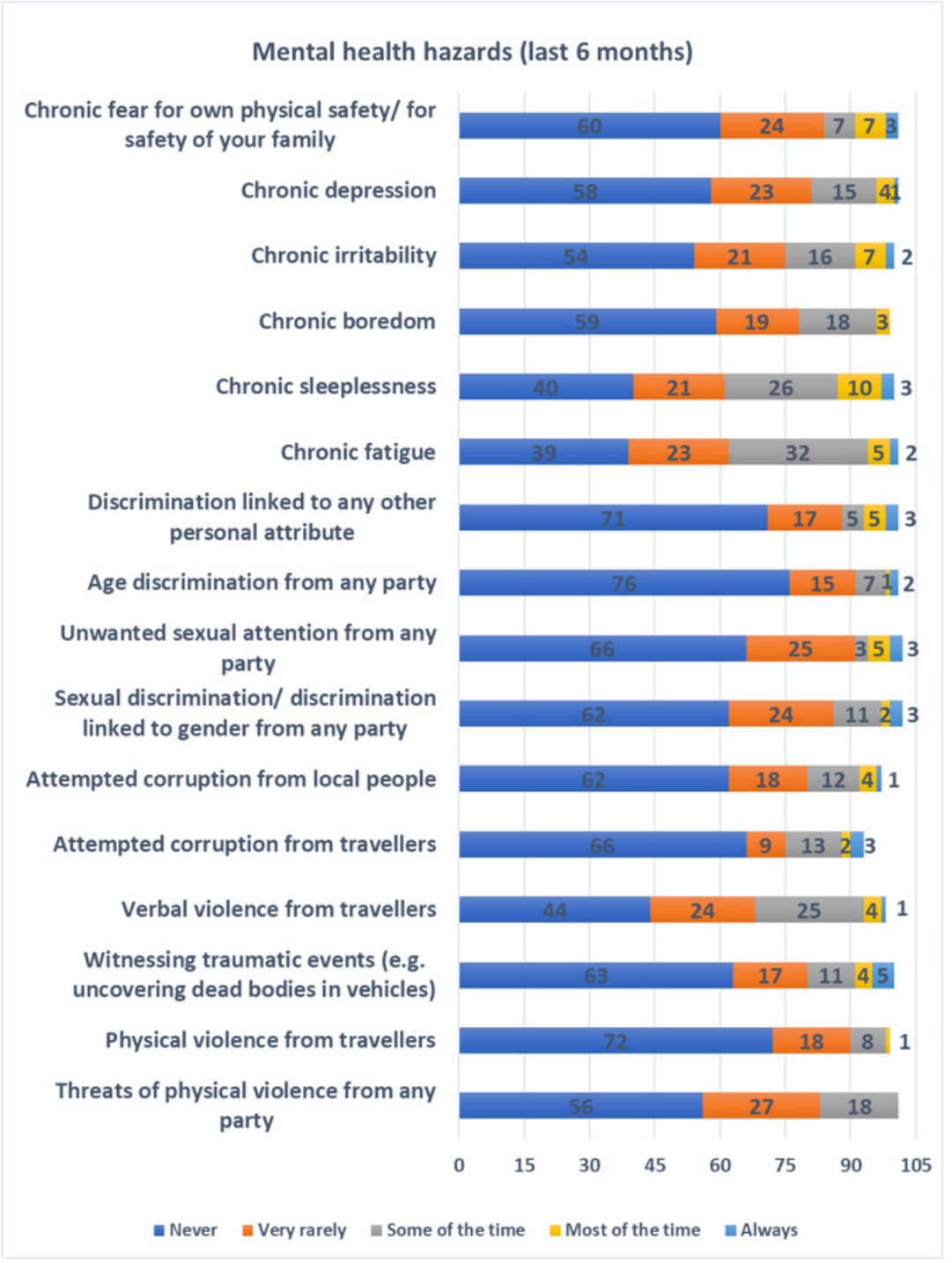
Mental health hazards (last 6 months)
Chronic fear for own physical safety/ for safety of your family
60 24 7 7 3
Chronic depression
58 23 15 4 1
Chronic irritability
54 21 16 7 2
Chronic boredom
59 19 18 3
Chronic sleeplessness
40 21 26 10 3
Chronic fatigue
39 23 32 5 2
Discrimination linked to any other personal attribute
71 17 5 5 3
Age discrimination from any party
76 15 7 1 2
Unwanted sexual attention from any party
66 25 3 5 3
Sexual discrimination/ discrimination linked to gender from any party
62 24 11 2 3
Attempted corruption from local people
62 18 12 4 1
Attempted corruption from travellers
66 9 13 2 3
Verbal violence from travellers
44 24 25 4 1
Witnessing traumatic events (e.g. uncovering dead bodies in vehicles)
63 17 11 4 5
Physical violence from travellers
72 18 8 1
Threats of physical violence from any party
56 27 18
0 15 30 45 60 75 90 105
Never
Very rarely
Some of the time
Most of the time
Always

Figure 54.

Figure 54 cover the list of mental health hazards were assessed by participants. They were asked whether they have been bothered by these hazards during the last 6 months and if yes, how often.

The visualization helps to see the overestimated mental health hazards. As expected, verbal violence from travellers received high scores. Chronic sleeplessness and chronic fatigue assessed as most important hazards. Chronic fear for own physical safety, chronic depression, chronic irritability and chronic boredom have similar presence on the list. Age discrimination from any party seems to be the less relevant factor. Another extremity the everyday presence of sexual discrimination (3 persons) and unwanted sexual attention (3 persons).

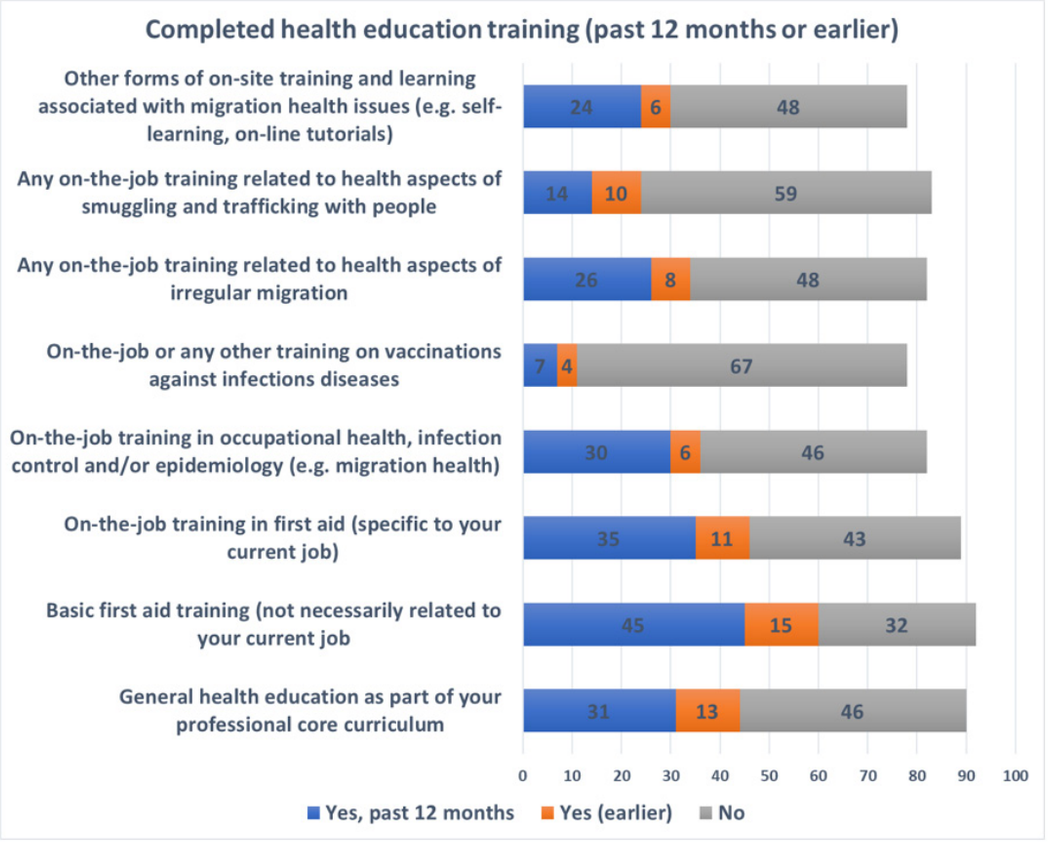

Figure 55.

Figure 55. give a general picture about completed health education training of study participants. Basic first aid training was the most significant compared to other training opportunities. 45 respondents completed it within the past year and 15 persons earlier. Training on vaccinations against infectious diseases received the lowest scores. Only 11 persons completed such training during past 12 months or earlier. Another important, but underestimated training topic was smuggling and victims of trafficking.

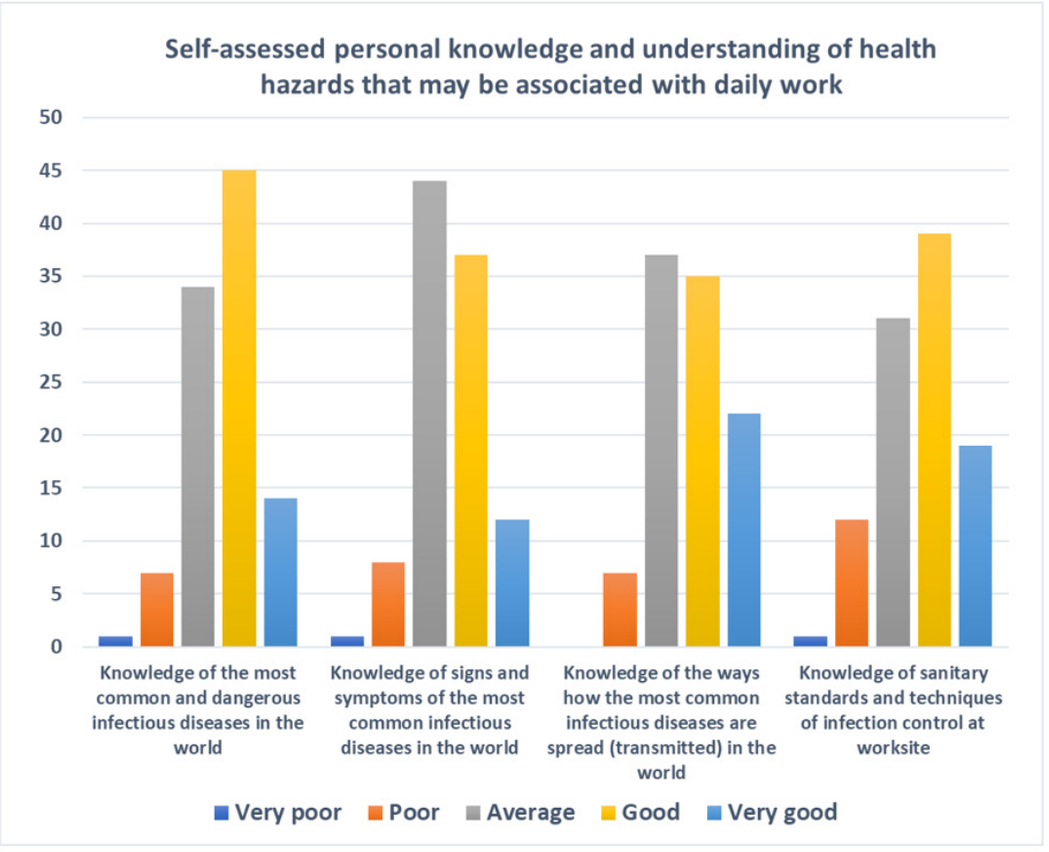

Figure 56.

In light of the performed training programs, participants were asked to assess their own knowledge on four infectious diseases related statements. *'The knowledge of the most common and dangerous infectious diseases in the world'* received higher ranks than 'the knowledge of signs and symptoms of the most common infectious diseases in the world'. Knowledge on the way of spread/transmission of the most common infectious diseases was the most significant. Sanitary standards and techniques of infection control at worksite shows very similar picture comparing to disease transmission and spread. Results can be interpreted by commonly referred training topics: infection control, first aid, general health education.

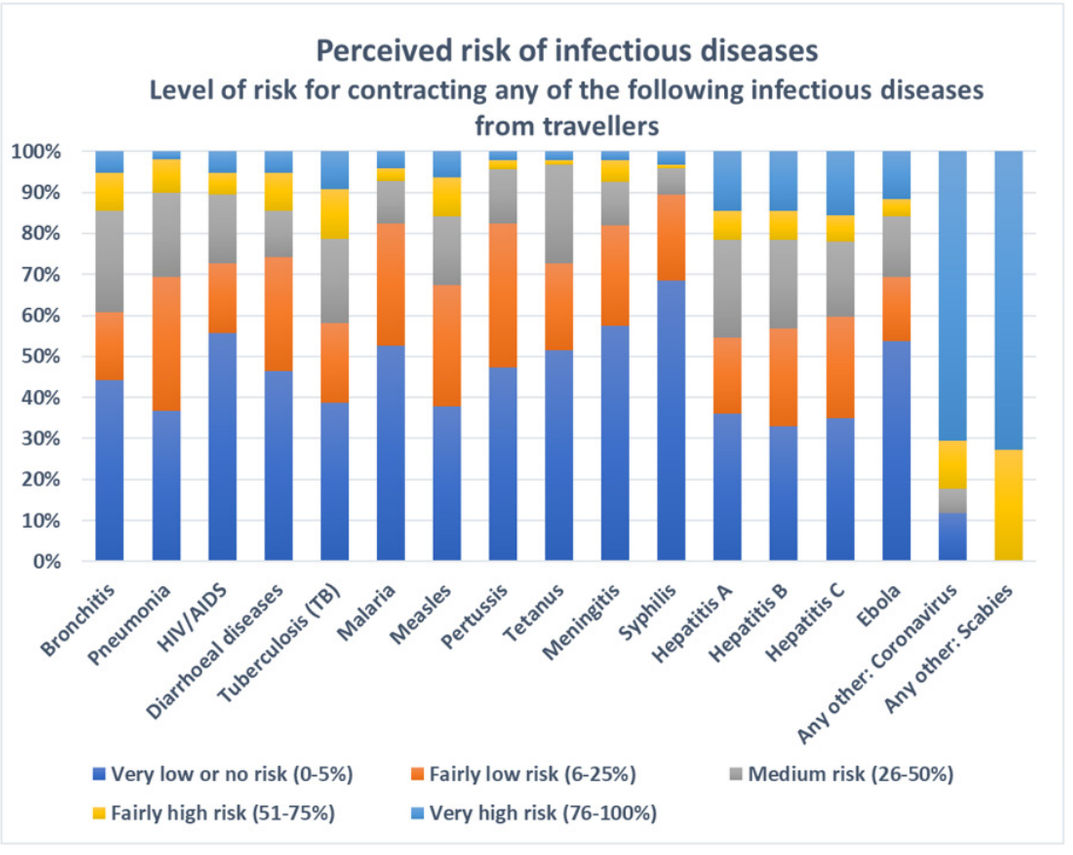

Figure 57.

Figure 57. summarizes the self-assessed risk for contracting any of the listed infectious diseases from travellers. Coronavirus (n=17) and Scabies (n=11) were given by respondents as optional/additional diseases. However, scabies, skin infection caused by mites, is not an infectious disease, but study participants assessed as a mentionable contagious disease.

Based on figures, shortage in infectious disease related knowledge can be concluded. The risk of contracting the following infectious diseases can be minimized with compliance of adequate hygiene rules. However, syphilis was referred as the least contagious disease on the list. In case of this sexually transmitted disease, 10% of respondents attributed medium or higher risk for contracting syphilis from travellers. Malaria is also a good example to highlight the low awareness of infectious diseases among study participants, since malaria is a vector-borne disease meaning that human to human transmission is impossible without the vector of the disease. Ebola was assessed with higher relevance for contracting from travellers than many others. The incubation period is much shorter than the average time of migration. The severity of symptoms, progress of disease results high (varies between 50-90%) lethality. Since Coronavirus epidemic appeared in Europe in the beginning of 2020, the fear from this unknown disease was enormously high. The Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) responsible for coronavirus disease 2019 (COVID-2019) and has severe effects on our everyday life, therefore of the risk of infection with SARS-CoV-2 is overestimated.

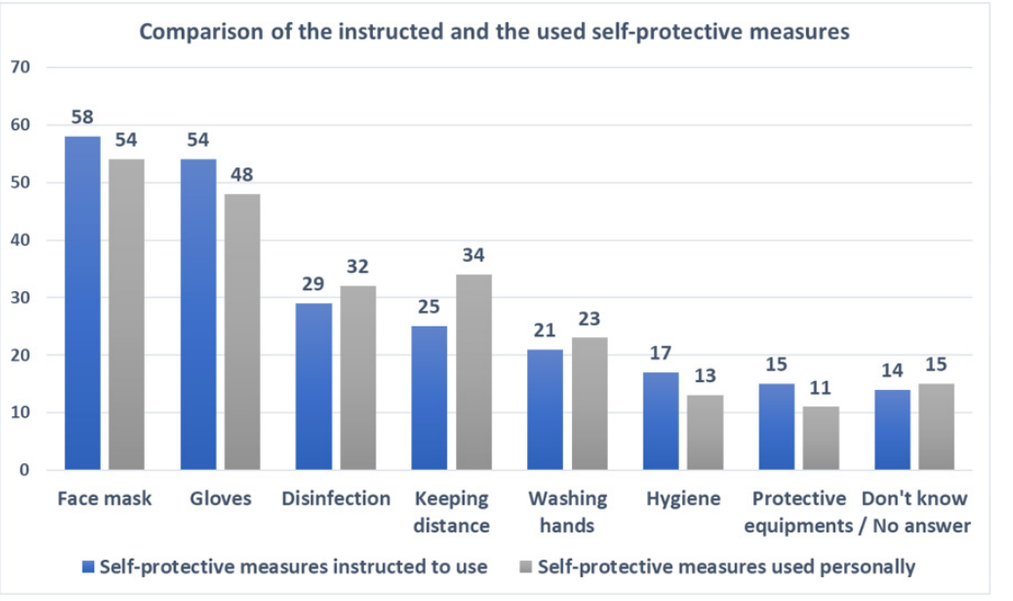

Figure 58.

Respondents were asked to set out three self-protective measures instructed to use at work. Next task was to list three measures have been already used at work. After the categorization of answers and counting the scores, pairs of data were created by the categorized measures. The results are presented in *Figure 58*. Wearing face mask and gloves became the two most frequently used self-protective measures. Overall, no significant differences were recognized between data pairs of the instructed and the personally already used measures. Only the measure of keeping distance shows difference. 34 persons stated that they use it, however 25 respondents scored as instructed measure. This difference was the most mentionable.

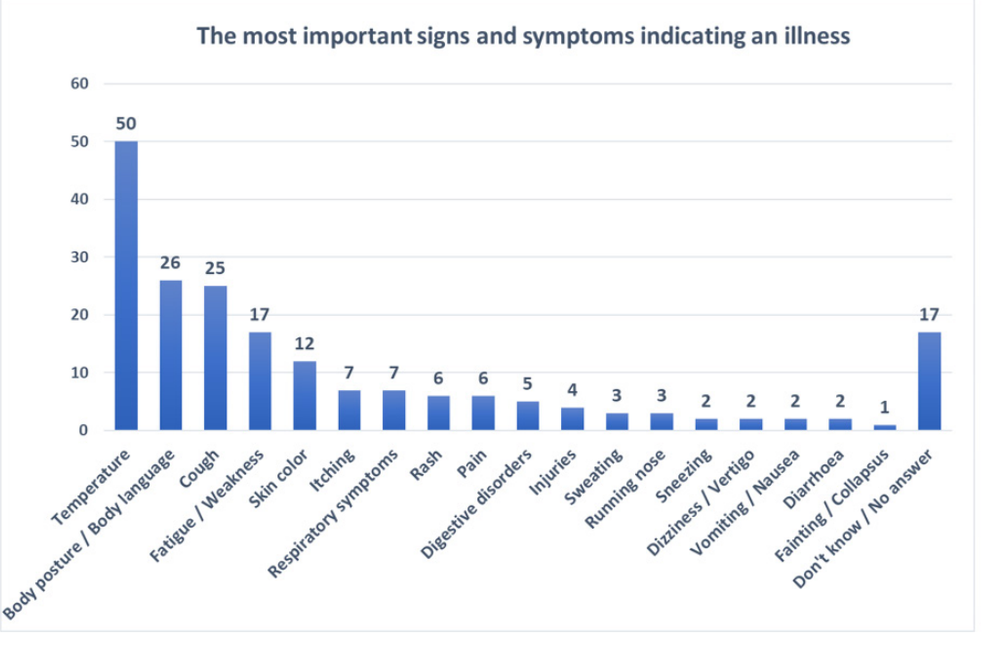

Figure 59.

Respondents were also asked to give three answers on the most important signs and symptoms indicating an illness. *Figure 59.* summarizes the given symptoms with ranking. According to the study population, body temperature was the most significant (n=50) symptom and received twofold higher scores, than body posture/body language (n=26) and cough (n=25). Fatigue/weakness (n=17) and skin colour (n=12) received more than 10 scores. Other 13 signs have less than 10 scores.

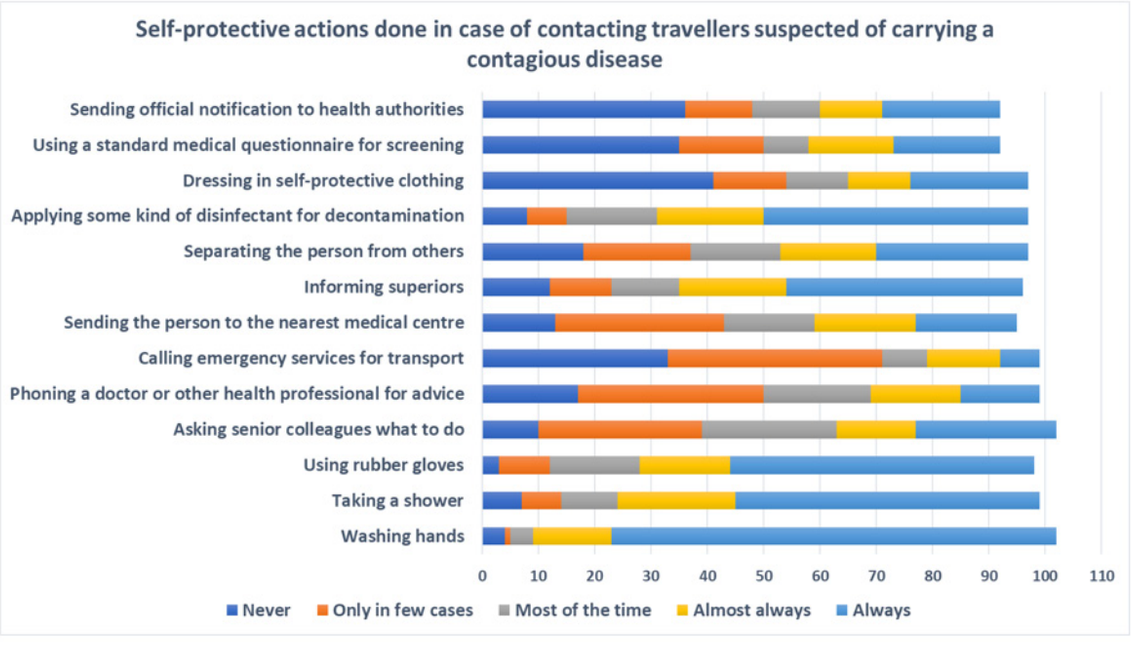

Figure 60.

Self-protective actions were assessed by participants on a five-point Likert scale by indicating the prevalence/relevance of the given action done in case of contacting travellers suspected of carrying a contagious disease. The 76,7% (79) of study population referred to washing hands as done always, 4 persons stated that they never washing hands in such cases. The least relevant action is calling emergency services. Other hygiene measures were also listed with comparatively higher relevance than the average: taking a shower, using rubber gloves, disinfection for decontamination.

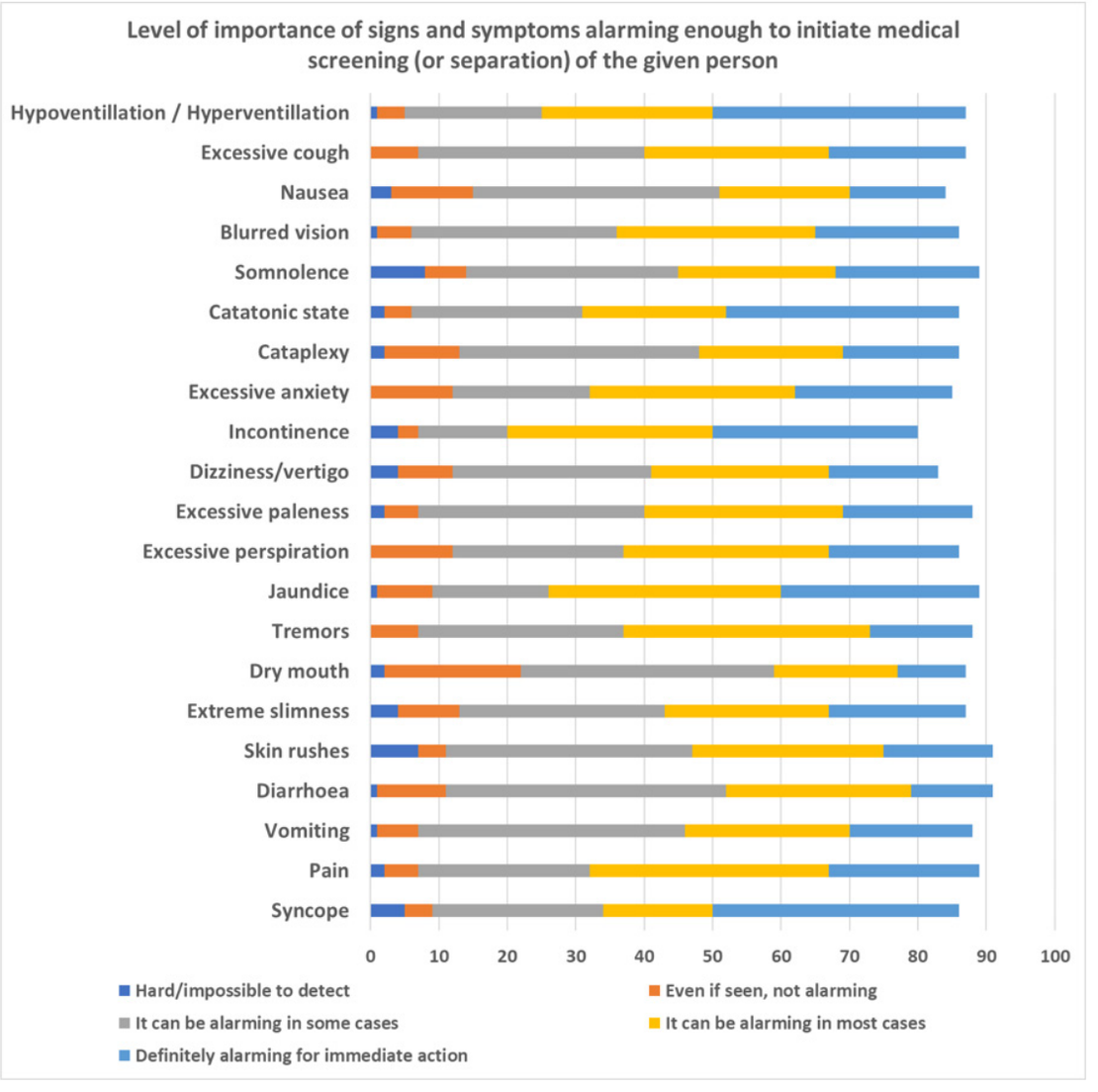

Figure 61.

Hypoventilation/hyperventilation, incontinence, jaundice, catatonic state, syncope and pain received definitely higher scores than others. Scores of 'definitely alarming' and 'it can be alarming in most cases' answer options were summarized. Dry mouth was esteemed as the least important sign.

Instructive could be the fact that respondents overestimated a few signs relevant from provision of first aid point of view and underestimated typical infectious disease related symptoms, like vomiting, diarrhoea, skin rush and nausea. These symptoms could be alarming enough referring to an infectious disease. At least separation of patients should be made until the examination be medical doctor and/or other health care professionals. Infectious diseases pose high risk of spreading easily in communities, even in refugee reception centres. Health education, regular training would be important to maintain and improve their preparedness on infectious disease related knowledge of staff members in order to prevent the outbreak of epidemic among migrants.

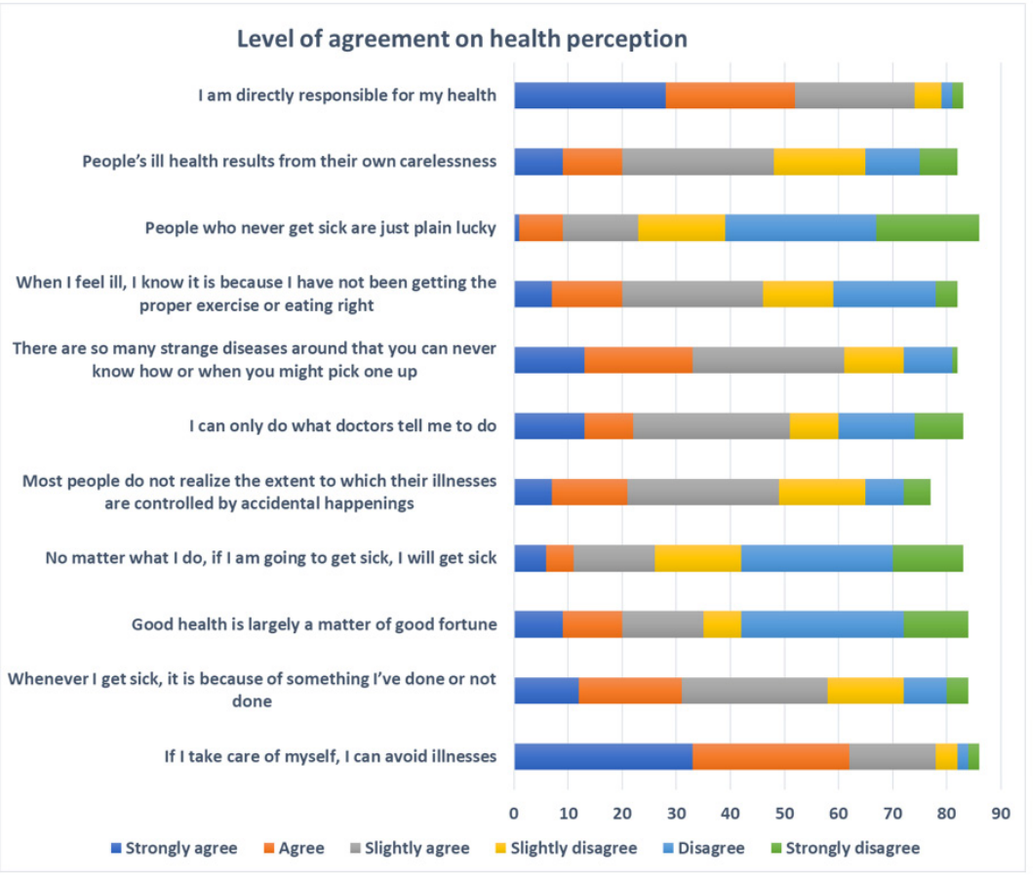

Figure 62.

Participants needed to make a decision on statements to what extent they personally agree or disagree with it. As expected, the majority of respondents disagreed with statements declare that people with good health are just plain lucky. They agreed with the importance of taking responsibility of their own health. The answers and the distribution of agreement levels were shared and not so evident in many cases: 'I can only do what doctors tell me to do'; 'whenever I get sick, it is because of something I've done or not done'; 'When I feel ill, I know it is because I have not been getting the proper exercise or eating right'.

General conclusions and recommendations from the perspectives of health and humanitarian care providers

Brief characteristics of service providers: demographic, country of origin, etc.

- The average number of working years, has been already spent in the field of migration, was 6,5 years what implies broad experiences. This tendency means that the majority of the study population started to work before the migration crisis evolved in 2015.

Education level and knowledge of foreign language of study participants

- The study population of Bosnia-Herzegovina was comparatively younger and had higher foreign language knowledge compared to other Balkan countries.

Migrants access to health services – Difficulties in accessing healthcare

- According to study population, almost half (46, 45%) of migrants seek service providers out for assistance and care. In other words, the willingness of migrant population to build relations with caregivers, ensures good base for increasing the access to healthcare services.
- Not only the scale of the provided services or migrant patients' habit in seeking care have influential effect on access of health services. Hindering factors at workplace may have also disadvantageous effect from patient point of view.
- IBetter awareness may result better health outcomes among migrants by contribution to avoid unnecessary difficulties in seeking care resulting possible time-lag between developing symptoms and receiving adequate care. A well-informed staff member can also contribute to help getting necessary interventions in time.
- Improving health literacy by health education is also essential. Information sharing on entitlements and health education together can contribute not only to an improved access to healthcare services but can result increased compliance as well.

Working conditions, workplace related aspects

- In workplaces of respondents, there is no financial unavailability, discrimination or restrictions in entitlements may influence negatively and significantly the daily work. As an expected outcome, labour force shortage and administrative issues received higher scores and language barriers seem to the most relevant problem.
- Biological and environmental hazards: Desk-bound work-related hazards were ranked with higher relevance. This point to the fact that the majority of the study population is office worker, or they have been spent the majority of daily working hours in office environment.
- Mental health hazards: Working with refugees and asylum seekers is emotionally demanding and exhausting. Both employees, voluntaries and all staff members should be psychologically trained and prepared. In order to protect and maintain mental health, permanent psychological examinations and training would be needed. They are exposed to 'burn out' syndrome as well, in their occupational health care provision this should be reflected as well.

- Health education: Providing regular health education for staff members is necessary to improve their health literacy. Improved knowledge contributes to recognize and to prevent avoidable health hazards. As expected, first aid trainings were overestimated, but vaccination, infectious diseases and victims of trafficking were a bit underrepresented comparing to other topics.

Health and well-being of vulnerable groups

- Although irregular migrants and refugees form a significantly younger population than host country's society, older migrants are also important vulnerable people.
- Since victims of trafficking, especially trafficked minors, form one of the most vulnerable group, they need special care even in reception settings. They would need special rehabilitation facilities with specially trained care providers. Currently it is not considered at all.

Infectious diseases related aspects

- Migrants entering European countries may be at specific risk of developing infectious diseases compared to the host population. This risk depends on country of origin, the visited countries and the experienced conditions during migration.
- Regular use of interpreters in healthcare service provision is an accepted international guideline, but still neglected or inadequate service even in refugee reception settings. Not only financial and/or Language barriers may set even the implementation of screening tests for infectious diseases, or any other healthcare services back. (Access to healthcare) The majority of study population considers the immunization of adult also important.
- Due to self-protective actions done in case of contacting travellers suspected of carrying a contagious disease, participants would prefer hygienic actions, whilst informing responsible health authorities and putting emergency measures into action were assessed with lower significance. Self-protection appeared for a strong ambition, but protecting others, the public with emergency measures should be strengthened by trainings.

CHAPTER 4.

Online interviews with National Red Cross representatives within the frame of the project

Dr. István Szilárd, Csaba Jaksa

Migrants' health and access to healthcare during transition in selected Balkan countries

Introduction

As a consequence of the COVID-19 pandemic, the originally planned field visits and onsite research in Bosnia and Hercegovina, Montenegro, North Macedonia and Serbia were impossible to perform because of the serious international travel limitations. We were hoping in improvement of the epidemiological conditions and have requested for extension of the project timeframe. Unfortunately, an early second wave (or even the first one has not disappeared) has made it impossible. For example, we have already booked the flight to Montenegro when in the last days in advance to the departure, it has been cancelled. That is the reason why we have to decide to replace the personal visits for online, structured video interviews with the responsible National Red Cross officers.

Herby we provide the essence of the interviews. All of them were voice recorded.

We would like to thank for the kind and perfect cooperation of the representatives of the national Red Cross Societies of Bosnia and Hercegovina, Montenegro, North Macedonia and Serbia.

The structure of the interviews

With the kind and perfect assistance of IFRC Regional Office in Budapest, namely Ms. Aneta Trgachevska, we have contacted the representative officer of the RC country office and performed an approximately on hour Skype interview.

The main topics of it were as follows:

- working conditions/ regulations of the health and medical assistance;
- 'camp entry' health regulations (health screening, vaccination status(?), offer for additional vaccination etc.);
- the system of health assistance provision and registration in the camp's medical unit (paper-pencil, digital etc.)
- availability of specialists/ hospital health consultation/ treatment in case of need (regulation, financial conditions etc.);

- availability of medicines, coverage of related financial aspects;
- 'most vulnerable groups' related special conditions (women, children, elderly, victims of trafficking);
- sharing of tasks and coordination between national authorities, international organizations in health assistance of migrants;
- the way of mental health assistance of migrants;

Republic of Serbia

Date: 04.08.2020.

National representative: Ms. Natasa Todorovic

Interviewer: Dr. István Szilárd,

HLMDI/WCCUPMS participants: Csaba Jaksa, Dr. Zoltán Katz, Dr. Erika Marek

Topics and answers:

- Working conditions/ regulations of the health and medical assistance:

These are regulated by Serbian Law on Healthcare,[15] and the law on Public Health.[16]

- 'Camp entry' health regulations (health screening, vaccination status(?), offer for additional vaccination etc.):

Each camp has a health-care team (usually MD+ nurse+ psychologist) and they do the basic health screening at the admission (chronic diseases, health status, regular medication needs). The vaccination policies were changing a lot since the majority of refugees have no document or knowledge on their previous vaccinations, so school-aged children were offered vaccination within the same protocol as local children, but other vaccinations were not systemic.

- The system of the registration of the health assistance provision in the camp's medical unit (paper-pencil, digital etc.):

Paper-pencil in the camp but transferred to the digital healthcare system afterward.

- Availability of specialists/ hospital health consultation/ treatment in case of need (regulation, financial conditions etc.):

As explained above the specialist services and treatments are available to the registered asylum seekers and refugees in exactly the same way as to the citizens of Serbia, as provided by the Law on healthcare. The costs of examination and treatment are covered from the Budget of the Republic of Serbia. During the epidemic lockdown the availability of these services was scaled back due to the focus on COVID-19 response.

- Availability of medicines, coverage of related financial aspects:

Same as above. In addition to that specific medicine or specialized healthcare services are

15 https://www.paragraf.rs/propisi/zakon_o_zdravstvenoj_zastiti.html
16 https://www.paragraf.rs/propisi/zakon_o_javnom_zdravlju.html

provided by international or local organizations like the Danish refugee council, MSF etc.

- 'Most vulnerable groups' related special conditions (women, children, elderly):

Same as the above, their access to examination, treatment and therapy is equal to that available to Serbian citizens with the costs covered from the Serbian National Budget.

- Sharing of tasks and coordination between national authorities, international organizations in health assistance of migrants:

There is a Working group (meeting on a monthly bases), chaired by the Ministry of Health and participants include representatives of WHO, Comissariat for Refugees, Ministry of Social Affairs, international organizations working with refugees and migrants (e.g. IOM), local healthcare teams, Red Cross, NGOs working with refugees and migrants. A separate Working group (also meeting monthly) was established last year to tackle the mental health issues.

- The way of mental health assistance of migrants:

Mental health services are provided by psychologists in the camps either working as a part of medical team or NGO. These services are provided in line with guidelines.

Republic of Montenegro

Date: 20.07.2020.

National representative: Ms Milena Scekic

Interviewer: Dr. István Szilárd,

HLMDI/WCCUPMS participants: Csaba Jaksa, Nikolett Arnold

Topics and answers:

- 'Camp entry' health regulations (health screening, vaccination status(?), offer for additional vaccination etc.):

Medical office is not a separate facility from the reception centre. No medical control at the entrance point, unless there is a straight request due to medical condition of the person. During Covid-19 the border guards only asked about the general symptoms. In the reception centre there always should be a doctor, they do basic medical screening, if the patients express their need specific examination or show symptoms (such as of scabies) then further steps are taken. Adults are not asked about their vaccination status, but medical staff ask them if they are with children. Migrants are more open to vaccination and less likely to resist vaccination.

- The system of the registration of health assistance provision in the camp's medical unit (paper-pencil, digital etc.):

All level of health services should be available to migrants same as the citizens. Migrants don't have social security numbers; they are not registered in the national system. Availability of specialists/ hospital health consultation/ treatment in case of need (regulation, financial conditions etc.):

All level of health services should be available to migrants same as the citizens.

- Availability of medicines, coverage of related financial aspects:

Medicines cannot be subsidized because of the lack of social security number.

- 'Most vulnerable groups' related special conditions (women, children, elderly):

3 different wards in the reception centre:

1st floor: families, single mothers with children, elderly, protected and isolated from others; 2nd floor: single men.

No preorganized service structure for every vulnerable groups, but the care is developed through as the issues come up.

Trafficking of human beings: advocating awareness of it. The bigger part of the people remains outside of the oversight of the reception centres, outside there are more people who are unregistered, undocumented, don't like collective accommodation, this renders them to exercise their rights properly.

- Sharing of tasks and coordination between national authorities, international organizations in health assistance of migrants:

UN (UNHCR and UNICEF) is monitoring the situation, IOM is providing help, other than this Red Cross, and organizations for legal help, integration process. IFRC: provision and supervision of the services for the beneficiaries, in reception centres or in their private accommodation. Red Cross is the biggest and most important NGO that provides health services and humanitarian aid to migrants. No national party mentioned.

- The way of mental health assistance of migrants:

Legally one psychologist should be available every day, practically they are not always present, IFRC stepped in to make psychiatric professionals more frequently available.

North-Macedonia

Date: 29. 07. 2020

National representative: Ms Suzana Tuneva Paunovska

Interviewer: Dr. István Szilárd,

HLMDI/WCCUPMS participants: Csaba Jaksa, Nikolett Arnold

Topics and answers:

- 'Camp entry' health regulations (health screening, vaccination status(?), offer for additional vaccination etc.):

At the border red cross is present with medical (first) aid 24/7, during the night paramedics, at the centre 3 times a week. Government gave rights for Red Cross to take patients to hospitals. Psychologists and social workers are present as well. Registered, RC notified to health check-up, if needed medical treatment is immediately organized. Vaccination asked, but no reliable data on it. Vaccination is offered for free but migrants in general refuse it.

- The system of health assistance registration in the camp's medical unit (paper-pencil, digital etc.):

N/A

- availability of specialists/ hospital health consultation/ treatment in case of need (regulation, financial conditions etc.):

Secondary health care is directly provided by domestic hospital, the medical transport is done by Red Cross teams. The invoices for the treatments are covered by IOM and some additional costs from our budget (UNHCR /Red Cross Agreement)

- availability of medicines, coverage of related financial aspects:

The medicines are provided free of charge, through the budget from our Agreement with UNHCR. First aid kits are provided from our budget through IFRC support. Medicine is also subsidized by RC and IOM.

- 'most vulnerable groups' related special conditions (women, children, elderly):

special program activities for vulnerable groups (PSS, special food parcels / dietary requirements, CoA activities)

- sharing of tasks and coordination between national authorities, international organizations in health assistance of migrants:

Coordination regarding health activities are done through regular meetings with Ministry of Health, IOM and Institute for Public Health (regarding COVID 19 activities). Supporters from abroad found bigger medical spending. IOM supported by the government; they employ doctors for 3 days a week.

- the way of mental health assistance of migrants:

Mental health activities for migrants are organized through individual session or group session specially for all those who apply for asylum in our country. We have team who is responsible for SGBV activities. This type of activities are performed by the Chamber of psychologist on National level. Psychologists and social workers are present as well.

Bosnia and Herzegovina

Date: 03. 08. 2020.

National representative: Mr Jasmin Niksic

Interviewer: Dr. István Szilárd,

HLMDI/WCCUPMS participants: Csaba Jaksa, Dr. Zoltán Katz, Dr. Erika Marek

Topics and answers:

- 'Camp entry' health regulations (health screening, vaccination status(?), offer for additional vaccination etc.):

N/A

- The system of health assistance provision in the camp's medical unit (paper-pencil, digital etc.):

N/A

- Availability of specialists/ hospital health consultation/ treatment in case of need (regulation, financial conditions etc.):

DRC has signed agreement with the local hospital, so migrants can visit these hospitals and DRC covers the bill for them. RC focuses on vulnerable groups.

- Availability of medicines, coverage of related financial aspects:

Red Cross provides medical doctors and psychologists who take over the shifts after regular working hours, and sometimes on Sundays, they can prescribe medicine.

- 'Most vulnerable groups' related special conditions (women, children, elderly):

N/A

- Sharing of tasks and coordination between national authorities, international organizations in health assistance of migrants:

Only Danish Refugee Council (DRC). No national authorities mentioned.

- The way of mental health assistance of migrants:

RC's own psychologists who are part of the first aid teams, some others work on special cases. Collaborating with DRC.

Summary of the information gained from the online interviews

Interviews have given important information about the structure, regulation and way of health assistance of the migrants in the given countries, but they have even underlined the need for onsite study of the real conditions.

The analysis of the health records (if they are available at all), screening and vaccination practices of the migrant population would be essential for completing the questionnaire surveys and interviews. Most importantly it would be worth studying whether the guideline of the European Centre of Disease Prevention and Control (ECDC) on migrants' health screening and vaccination have been at least partly implemented? It was issued in 2018 as a recommended guideline on the health screening and vaccination of migrant population arriving in Europe.[17]

17 See recent ECDC guidance on programmatic management of LTBI in the European Union for further guidance on management: https://ecdc.europa.eu/sites/portal/files/documents/LTBI%20cost-effectiveness%20report.pdf

CHAPTER 5.

Conclusions

Dr. István Szilárd, Dr. Erika Marek, Dr. Zoltán Katz, Dr. Davron Mukhamadiev

Specific findings

Migrants' perspective:

- The **length of stay in current recipient country** varies greatly between arriving migrants: altogether 23% reported to arrive within one week (65% of all respondents from North-Macedonia), while 15% reported to arrive 3-6 months ago, and another 36% claimed to stay in the current recipient country for even more than 6 months.
    - These data suggest, that the **migrants in the Balkan countries are really in transition,** a great majority of them aim to move further to other destination countries meanwhile waiting for optimal conditions and opportunities. Data also reflect to the uncertain situation of migrants as the asylum procedure may be lengthy, and may last for even more than half a year.
    - Data also reflect to the **uncertain situation of migrants** as the **asylum procedure may be lengthy,** and **may last for even more than half a year.** To reduce this long-lasting uncertainty (and accompanying vulnerability) the acceleration of the lengthy asylum procedures by immigrant authorities would be beneficial for both migrants as well as for the recipient countries, and involved organizations.

- **Regarding the education level of migrants** our survey underlines that both, **transit and destination countries should be well-prepared to increase the literacy and educational levels of the newly arriving migrants.**
    - It is of crucial importance particularly for n**ewly arriving migrant children to avoid their drop off from continuous education.** Both the transit, but most importantly the destination countries must be prepared to **include also the adult migrants** in their educational system, to „fill in the gaps", and providing various educational programs, which should not be limited to language courses only.

- Participants were asked to assess their familiarity with their **rights-based access to health services,** and their **obligations** according to cooperating with local health authorities in their current country of stay. They highest awareness was reported (79% saying 'yes') from Montenegro, and also study participants from Montenegro reported the most (71%) that they got the necessary information about their access to health services after arrival. The scores were the lowest in Bosnia-Herzegovina, where only 13% of participants said they are familiar with their obligations. In general, 46% of total study population reported to get information about their access to health services after arrival.
    - 42% of the respondents **were informed orally,** through a common language (mainly English) without interpreter, 20% reported to get information orally with the help of interpreter, 9% by written documents.

- **It should be noted** that it is important to inform the newly arrived migrants in all transit countries properly about their right-based entitlements and their obligations, as the provision of necessary information is not just a basic human right, but also may promote their cooperation with local authorities during this critical period. As found, locally acting NGOs in the refugee camps may have a huge role in providing this information, and one in five (19%) study participants referred to them as the major source of information, right following immigrant authorities. Red Cross and Danish Refugee Council was mentioned most frequently.

- **Qualified interpreter** was available at the highest rates in North-Macedonia, both during the administrative procedures at the immigration authorities (38%, and 9% generally) and also during healthcare services at the reception centres (47% always and 29% generally). In Montenegro, 25% and 21% of study participants stated that interpreters are always available during the administrative and healthcare procedures, respectively, while in Bosnia, interpreters were reported to be available in 29% always and 25% generally during administrative procedures, while during healthcare these rates decrease to 13% always and 25% generally.
  - Therefore, increasing employment and involvement of multilingual staff members may be **recommended to overcome language barriers, which is the most commonly reported obstacle in migrants' access to health services,** and as a consequence, may have negative effect on health outcomes as well. Furthermore, the use of multilingual staff members may promote **overcoming cultural barriers as well, particularly when they have migrant background** and a longer history in staying at the recipient country.

- Totally, as reported 57% of study population had already participated at **health screening** at their current country of stay, the highest proportion was observed in Bosnia-Herzegovina and Montenegro, with 71% participation in both countries. Nearly 40% of all cases where the health screening was performed at all, it was performed within 48 hours after migrants' arrival to the camp.

  It was performed by the following organizations:
  - Danish Refugee Council
  - Doctors Without Borders
  - International Organization for Migration (IOM)
  - Local Public health services and in most cases
  - Red Cross (RC),

- **Health screening** in most cases included a general discussion about participants health status (86%), complemented by checking for ectoparasites, such as scabies and lice (53% of all examinations)
  - Based on our study participants' opinions, physical examination is mostly completed in Bosnia-Herzegovina (59%), while only in one-third to one-fifth of examinations include physical examinations at other study sites. Faeces test is not performed at any sites, and blood sample is also taken only in 1-2 cases, maybe not as part of health screening but as diagnostic measure. Chest X-ray was also performed in 1 case only, in Serbia, but not as part of general medical screening. Vaccination status was only asked in Bosnia-Herzegovina (53%) and in 2 cases in Montenegro.

- Seven percent of total study population reported to participate at **age-assessment** procedure, 6 from North-Macedonia and one person from Montenegro.
- Two participants from Montenegro reported to get vaccinations (identified both as tetanus), and one person was vaccinated in Serbia (the type of vaccine was non-specified). Altogether 11 migrants were referred to specialized care.

- A great majority, altogether 82% of all study participants **assessed themselves as healthy,** and scored their own health status either 'very good' or 'good'.

- **Non-communicable diseases** (NCDs) increase the vulnerability of migrants, and may put an avoidable, increased burden on health systems when these patients will need care later, at an advanced stage of their diseases. Therefore, in addition to health screening for infectious disease upon arrival, and providing urgent care for those in emergency situation, health systems in both transit and destination countries shall be alert and precautious in assessing the prevalence of chronic NCDs among migrants with a special focus on high-risk populations (i.e. smokers, obese or older migrants), and providing continuous check-ups, and treatment, including medications.

- **Hindering factors in accessing health care:** The 'lack of health education' and 'lack of migrants' information about the local health system' was mentioned by one quarter of all study participants (25-26%), with the highest proportion (42-46%) by migrants from Bosnia-Herzegovina. Discrimination by health providers was generally not commonly reported (13%), however, this was more commonly mentioned from Serbia (36%).

- Those, who required **antenatal care** were asked to report whether they got the necessary care: only one of them (the one in Montenegro) declared to get the necessary care and also did not indicated any difficulties in accessing care; while the one woman, who required antenatal care in North-Macedonia, claimed that she did not get the necessary care.

- As **educational level,** and consequently the 'health literacy' and health awareness level of newly arriving migrants differ greatly by countries/regions of origin, and additionally, due to their disadvantaged socio-economic status these people shall be considered as particularly vulnerable for infectious diseases (lack of proper nutrition, overcrowded temporary housing conditions, lack of hygiene, etc.). Therefore, in addition to providing migrants with as appropriate conditions as possible, **during this transition period organizing targeted, interpreted health educational programs may be beneficial** in order to increase their health awareness in relation to preventing infectious diseases,[18] thus reducing the risk of spreading infectious diseases within the communities.

- As previously discussed, the **'language barriers'** may be considered as the most significant barrier in accessing care, therefore in addition to improving organized interpretation services, the **involvement of multilingual staff members, and language courses for migrants** may be beneficial. Increasing both the migrants' and also the service providers' awareness of status-dependent, right-based entitlements and migrants' obligations

18 Experiences of a such a program are reported from Hungary in a peer-reviewed scientific article. Available: https://academic.oup.com/heapro/article-abstract/34/5/e36/5090807

according to cooperation with local authorities is of vital importance, and also increasing migrants' health awareness (i.e. how to prevent infectious diseases in communities). **Supervision, and/or organized training programs for service providers may also help to improve their anti-discriminatory attitudes and coping strategies as they may also be barriers.**

Service providers' perspective:

- The **average number of working years,** has been already spent in the field of migration, was 6,5 years what implies **broad experiences.**

- Assistance provided by the respondents:
  - general practice level assistance
  - paediatric care
  - mental health/ psychological counselling
  - medical aid in accidents and emergency and
  - social work services
  - were provided by humanitarian organizations most frequently for migrants in the selected Balkan countries.
  - Migrants mostly were seeking care by themselves and not was necessary to seek them out. 11% of the respondents stated that migrants predominantly come by themselves to claim care/service.
  - Discrimination was the less important and language barriers seem to be the most relevant hindering factor.

- **Sharing reliable information about entitlements,** with both migrants and staff members, may contribute to the adequate therapy of migrants in time and help to prevent possible adverse health outcomes. In spite of this opinion altogether only 54% of the participants take part in information sharing practice.
  - More than 50 % of the study population recognized that **health education** is necessary even for the caring staff.
  - Almost half of the study population (48%)) assessed that recent **changes in policies** affect migrants' healthcare on a positive way.
  - **Vulnerable groups' service:** most: unaccompanied children, less: victims of trafficking. Since victims of trafficking, especially *trafficked minors,* form one of the most vulnerable group, they need special care even in reception settings. They would need special rehabilitation facilities with specially trained care providers. *Currently it is not considered at all.*

- **Health screening:**
  - Financial unavailability,
  - shortage in labour force and
  - language barriers
  - uncertainty about the existence of country level screening protocols were assessed as ***hindering factors.***

- Study population was unanimously supportive regarding **immunization practice** should be mandatory for migrants.

- There was an **uncertainty about their own vaccination** and *it was not requested* by the employers *(!).*

- Regarding their own work-related aspects:
  - relatively high self-esteem on mental health hazard
  - relatively low level of health education
  - based on the responses, there was a shortage in infectious disease related knowledge. (E.g.: miss interpretation for Malaria, Ebola)

- Self-protection appeared for a strong ambition, but protecting others, the public with emergency measures should be strengthened by trainings.
  Consensus approach and c**oordinated actions would be crucial in the provision of medical assessment of newly arriving migrants** starting from the very basis: screening or not, when to screen, what to screen, how to screen, how to document test results and follow-up - along with the **'test and treat'** approach: provision of the continuous, necessary care for all detected health problems. Based on international literature,
  - inclusion of mental health assessment as well as
  - screening for intestinal parasites may be reasonable to include in screening protocols along with
  - testing for certain infectious diseases that has a higher prevalence in countries of origin and
  - may also be considered as public health threat (i.e. HIV, hepatitis B/C, TB, etc.).

- As it was also discussed earlier, **harmonized European-level health screening and vaccination protocols,** as well as traceable **migrant-health database** may avoid complications due to the lack of documentation, and would prevent both migrants and service providers from unnecessary, repeated examinations and interventions.

- Similarly to screening protocols, ***evidence–based, harmonized, European-level vaccination protocols would be required according to newly arrived migrants:***
  - how to check immunization status,
  - how to deal with missing vaccination documents and
  - how to replace missing vaccinations,
  - ***who shall be vaccinated, against what,*** only children ***to vaccinate*** or adults as well, etc. ***(ECDC guidelines are unknown!)***

General conclusions

Addressing urgent needs of the most vulnerable migrants to basic health services in short-mid and long -term perspectives still remain one of the main priorities for Red Cross Red Crescent Societies in the region. These actions include continuation of direct support to the most vulnerable migrants as well as strengthening of advocacy actions for better access of the most vulnerable people to Health and Care services, elimination of existing barriers and achieve the Universal Health Coverage goals. In some countries of Europe region disturbing trends continues: as a result of lack of health and care system as well as several social and legal factors, entire groups of the population -: migrants and other displaced population do not have equal access to life-saving health services. They continue to be stigmatized and discriminated against, both because of the aforementioned legislation and because of the influence of the media, which unreasonably reinforce this trend.

The main objective of this survey was 'the provision of a realistic picture on the health status and health assistance need of the migrants, refugees and asylum seekers stranded in four countries of the Western Balkans, as well as the practice of international, governmental and nongovernmental organizations active in humanitarian assistance provision, and last but not least the activity of national Red Cross organizations in the region.'

In order to realize this aim, on the invitation of IFRC European Office, Healthcare Leadership and Management Development Institute (HLMDI) in cooperation with the WHO Collaboration Centre on Migration Health Training and Research at University of Pécs Medical School (WCC) has designed and launched a research in four countries of the West Balkan in cooperation with national Red Cross offices.

According to the original plan the research had two instruments:

- Questionnaire survey of two target groups: migrants (refugees, asylum seekers) stranded in reception centres and employees of international, governmental and non-governmental organization providing humanitarian and health assistance of migrants staying in the camps.

- Field visits assessing onsite the health assistance procedures focusing on the following items:
    - right based access to health assistance;
    - health and hygienic infrastructure of the camps;
    - implementation of WHO and ECDC recent advises into the health assistance policy and practice;
    - way of collection and availability of health/ disease data of migrants.

As an overall summary, based on the questionnaire surveys we can state that National Red Cross Societies of Bosnia and Hercegovina, Montenegro, North Macedonia and Serbia in cooperation with the governmental authorities and other international humanitarian organizations and NGOs, within the frame of the given legislative, environmental and financial conditions are doing their outmost best in serving the health interest of the migrants.

Access to high quality health care is particularly important for these individuals as they face unequal access to basic health and care, mental health services and psychosocial support. Rising numbers of migrants and refugees in host countries put migrant's and refugee's health on the public health agenda. The vision of the United Nations 2030 Sustainable Development Goals is to leave no one behind and to strive for peace and reduction of inequity. For migrants and refugees, ways to improve health care delivery are detailed by the World Health Organization (WHO) which include the need for patient-centred and intercultural approaches. The health of refugees and migrants should not be considered separately from the health of the overall population. Where appropriate, it should be considered to include refugees and migrants into existing national health systems, plans and policies, with the aim of reducing health inequities and to achieve the Sustainable Development Goals.

However, due to existing legal and social-economic restrictions and other reasons, states are unable to provide migrants with adequate access to national health and care system. In many countries of the region, this is due to documentation processes or legal status, leading them to be exposed to higher health risks and hazards. This situation is undesirable both from the perspective of integration and human rights. The right to basic health, including mental health services obliges governments to ensure that health facilities, goods and services are accessible to all, especially the most vulnerable or marginalized sections of the population in law and in fact, without discrimination on any of the prohibited grounds.

The National Red Cross and Red Crescent Societies of the region, having an auxiliary role to their governments in the humanitarian field, are guided by national health strategies in developing and implementing their health activities to reach the most vulnerable people. In this work National Societies closely collaborate with health authorities in their countries in the field of preparedness and response to the urgent needs of migrants in basic health and care, Mental Health and Psychosocial support.

The main results of conducted research provided evidence-based data on the current level of access of migrants to health and care services.

A great majority, altogether 82% of all study participants assessed themselves as healthy and scored their own health status either 'very good' or 'good'. - At the same time when participants were asked about their existing longstanding chronic conditions [longstanding = which have lasted, or are expected to last, for 6 months or more], the vast majority (78%) reported not to have any. Only 16 participants reported to have chronic complaints, however, in the course of a following question, several chronic conditions were listed:

- High blood pressure,
- Allergy, eczema, rhinitis
- Chronic anxiety and chronic depression
- Low back disorder or other chronic back defect
- Asthma
- Chronic ulcer
- Chronic bronchitis
- Severe headache or migraine

Participants were asked whether they get any kind of treatment to their chronic problems. As reported, 40 chronic conditions are under treatment, in 12 cases participants reported not to get any kind of treatment to their chronic problems, and 21 cases there were no answer to this part of the question. The highest rates of receiving treatment were reported from North-Macedonia and Montenegro, while the lowest rates were reported by migrants from Bosnia-Herzegovina.

Approximately one-third (33%) of study participants estimated that they are familiar with infectious diseases that are common in Europe, and an additional quarter of respondents assessed themselves as 'partly familiar' (25%). The proportion of those who admitted not to be aware was 40%, with the highest proportion among Asian migrants, where 53% of participants answered 'no'.

When talking about **prevention,** generally, the level of self-assessed awareness was a bit lower: 26% of total population estimated their knowledge as 'good' or 'very good', with the highest proportions reported by participants from Middle-Eastern countries (8% as 'very good' and 23% as 'good') and by Cuban participants, as well.

All above mentioned data clearly evidences that migrants have extremally limited access to health and care services, as well as lack of awareness about their health status and preventive measures of communicable and chronic conditions that demanding further continuation of Red Cross support addressing urgent and vital life-saving health needs of the most vulnerable migrants.

When analysing **the role of potential barriers in accessing healthcare** for migrants in countries involved in this study, the most significant barrier reported was 'language barrier', as indicated by 47% of all participants. This was followed by the 'too lengthy asylum procedures' (receiving scores 4 or 5 in 33% of all answers). Personal financial problems, the lack of migrants' personal and vaccination documentation, as well as the lack of both migrants' and providers' information on entitlements were also mentioned by 26-30% of study participants, with different emphasis in different countries of current stay. The 'lack of health education' and 'lack of migrants' information about the local health system' was mentioned by one quarter of all study participants (25-26%), with the highest proportion (42-46%) by migrants from Bosnia-Herzegovina. Discrimination by health providers was generally not commonly reported (13%), however, this was more commonly mentioned from Serbia (36%). The 'lack of proper housing' was mainly reported from North-Macedonia (41%).

These answers may reflect to the complex health needs and most commonly faced difficulties of the newly arriving migrants, and may also provide a feed-back to local authorities in recipient/transit countries. As previously discussed, the 'language barriers' may be considered as the most significant barrier in accessing care, therefore in addition to improving organized interpretation services, the involvement of multilingual staff members, and language courses for migrants may be beneficial. Increasing both the migrants' and also the service providers' awareness of status-dependent, right-based entitlements and migrants' obligations according to cooperation with local authorities is of vital importance, and also increasing migrants' health awareness (i.e. how to prevent infectious diseases in communities).

An important item that we were not able to study because of the COVID-19 pandemic related restrictions, was the analysis of health records, screening and vaccination practices of the migrant population. It would be worth to launch an epidemiological survey on the basis of their analysis. Most importantly it would be worth studying whether the guideline of the European Centre of Disease Prevention and Control (ECDC) have been at least partly implemented? It has issued in 2018 a guideline on the health screening and vaccination of migrant population.[19]

19 See recent ECDC guidance on programmatic management of LTBI in the European Union for further guidance on management: https://ecdc.europa.eu/sites/portal/files/documents/LTBI%20cost-effectiveness%20report.pdf

Recommendations

Addressing the urgent needs of the most vulnerable migrants to basic health services in short-mid and long term perspectives still remains one of the main priority for Red Cross and Red Crescent Societies in the region. These actions include continuation of direct support to the most vulnerable migrants, advocacting actions for better access to Health and Care services for the most vulnerable people, elimination of existing barriers, and achieveing the Universal Health Coverage goals. In some countries of European region, disturbing trends continue: as a result of lack of health and care system as well as several social and legal factors, entire groups of the population — migrants and other displaced population— do not have equal access to life-saving health services. Furthermore, they continously face stigmatization and discrimination, due to the aforementioned legislation and media influence, which unreasonably reinforces the ruling prejudice.

- The current research gives good starting point for completing in region specific perspective UNHCR's Global Compact on Refugees[20] four key objectives:
    - Ease the pressures on host countries;
    - Enhance refugee self-reliance;
    - Expand access to third-country solutions;
    - Support conditions in countries of origin for return in safety and dignity;
    - This would be an essential argument when requesting international programs and actions for the migration related conditions in the region.

- For gaining a more complete picture of the infrastructure and conditions – defining the living conditions of migrants and refugees stranded in the region – after the improvement of the COVID-19 pandemic conditions - completing the planned field visits would be essential. It would also provide possibility for
    - checking the availability and form of health records and analysing them. The objective health status of the migrant population would provide the possibility for developing and argue for evidence-based migrant health programs;
    - investigating the placement within the reception centres and refugee camps, hygienic infrastructure and conditions as well as the health care facilities;
    - Personal meetings, round table discussions with the health care and humanitarian assistance providing personnel would provide important information as well.

- The questionnaire surveys gave important information about the need for additional training for both: the healthcare and humanitarian assistance staff. UPMS WCC staff has good experience in delivering this type of training.

- Language, health education, and health promotion trainings would be important for migrants and refugees as well.

- Harmonize health screenings and vaccination protocols at European level.

20 https://www.unhcr.org/the-global-compact-on-refugees.html

- The results of this research aimed at providing support to the national RCRC societies in strengthening a dialogue with the main stakeholders in decision-making, using received evidence-based data to pursue decision makers to create basic conditions for the most vulnerable displaced people.

- We recommend to use the results of this research during different international events, high-level meetings, conferences, addressing existing challenges to public and state representatives.

Introduction of the research team

Istvan SZILARD completed his medical studies at Pécs Medical University and later on he became Specialist in Internal Medicine as well as in Public Health Medicine. He has a Ph.D. degree in Health Sciences.

Since 2007 he is acting as Professor tit. at University of Pécs, heading its Migration Health programs of the Medical School and starting in 2017, he is the co-director of the WHO Collaborating Centre for Migration Health Training and Research at University of Pécs Medical School. In 2010 he became member/ senior researcher of the Healthcare Leadership and Management Development Institute.

Between 1992-1996 he was acting as Associate Professor at University of Pécs and Postgraduate Medical University of Budapest. In 2010, he was elected for Secretary General of the Hungarian Red Cross. In 1996, during the Yugoslav Wars he joined to the International Organization for Migration (IOM) to plan and coordinate the emergency and post-conflict humanitarian operations in the Balkans. Between 2004 and 2007, he was appointed for IOM Senior Migration Health Adviser for Europe and liaison person to EC/ EU on migration health at the IOM European HQ, Brussels.

In September 2007, he returned to University of Pécs and as Professor titular and Senior Scientific Adviser. He is acting as key coordinator for the migration and ethnic minority

health projects and training programs.

Since 2011 he is working in close cooperation with WHO in running its Public Health Aspects of Migration in Europe (PHAME) project and in 2016 he become member of the core expert group responsible for the implementation of the WHO Migration Health Strategy and Action Plan in Europe program. Since 2014 he is the co-editor of WHO PHAME electronic newsletter.

In 2017 the European Parliament awarded him with the 'European Citizen's Prize'.

He has published a total of 118 scientific articles, essays, and book chapters.

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Lilla HÁRDI is a medical doctor licensed at the Semmelweis Medical University, Hungary, Budapest since 1981. She is a psychiatrist, psychotherapist, psychoanalyst, and a rehabilitation psychiatrist.

She was active as the chair of the section of the World Psychiatric Association Section on Psychological Consequences of Torture and Persecution since 2008 till 2012 and later as the vice-chair and the Board member of the section. She was the Executive Committee member of the International Rehabilitation Council of Torture Victims (IRCT) between 2010-2013. She has been the member of the IFEG (International Forensic Expert Group) of IRCT since 2010 publishing scientific statements against torture.

She has been rewarded with the Inge Genefke prize (for the rehabilitation of torture victims) in 2014 in Copenhagen, Denmark.

She is one of the founders of the Psychotrauma and Migration Section in the Hungarian Association of Psychiatrists since 2018.

She has been working in the field of refugee mental health and clinical treatment of victims of torture since 1993. Having been the medical director of Cordelia Foundation for the Rehabilitation of Torture Victims

since 1996 Budapest, Hungary she has personally examined several hundreds of survivors of torture and human rights abuses, written multiple reports, and treated and/or supervised the treatment of hundreds of torture survivors. She has lectured and taught nationally and internationally on this topic and has published multiple articles, monographs and book chapters relating to the psychological consequences of torture and refugee mental health. She was the Chief Guest Editor of Newspaper Torture between 2015 and 2016.

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Erika MAREK is a senior lecturer at the Department of Operational Medicine (Migration Health Programs), Medical School, University of Pécs (UP-MS), Hungary since 2011. She has her PhD in public health: in the field of health promotion, health education. As a part of her PhD studies she conducted research in relation to sexual health awareness and practices of adolescents, as well as among Hungarian female sex workers (FSWs), analysing their sociodemographic characteristics, sexual behaviour, prevalence of sexually transmitted diseases (STDs). Her research interest includes: migrant and ethnic minority

health (particularly the Romas), health-sociology, community health, with a special focus on vulnerable populations (female sex workers, refugees, adolescents and youth, etc.); their health knowledge and health behaviour, as well as their access to health care services; sexual education of adolescents, health promotion and health education (i.e. for asylum seekers); medical education: improving migration-health awareness and intercultural competence of the medical students. She has experiences in data collection among migrant populations; conducting nationwide questionnaire surveys, focus-group analysis as well as in performing in-depth interviews with FSWs and with Roma populations. She also has experiences in developing and implementing health educational programs for specific target populations, such as asylum seekers or Romas, as well as for medical students and health professionals.

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Zoltán KATZ is an assistant lecturer at the Department of Operational Medicine (Migration Health Programs), Medical School, University of Pécs (UP-MS) since 2012. He graduated as a pharmacist at UP-MS in 2009. His PhD studies deal with the effects of migration on public health safety of the host countries with special focus on the epidemiology of infectious diseases. Immunization, communicable disease screening and the related protocols are in the main focus of his research.

He gained experiences in education and development of gradual and post-gradual training programs in the field of medical and pharmaceutical sciences at UP-MS.

He has experiences in implementation of international training and research programs focusing on migrants and ethnic minorities, vulnerable groups. He gained wide experiences by taking part in field visits and research performed in the Hungarian immigration system: refugee reception system, border crossing points, etc. He has also participated as a group leader of medical students in a humanitarian action (medical screening, health education) in Haitian orphanages and schools (Port-au-Prince, 2014).

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Nikolett ARNOLD is an assistant at the University of Pécs Medical School Department of Operational Medicine. She holds a Master's Degree in English Applied Linguistics and she is a certified translator as well. She took part in field work in the Roma segregate zone in Pécs as an interviewer for an ongoing study about the health status and health literacy of the roma population in the area. She also participated in EU funded projects, out of which was one an ERASMUS LLP coordinated by UPMS Migration Health Team. She is currently a board member in the European Network of Intercultural Elderly Care a Dutch-based network, where she is responsible for communication and its newsletter. She also translates books in health-related areas, her most recent publication is The 28 Day DASH Diet Weight Loss Program: Recipes and Workouts to Lower Blood Pressure and Improve Your Health, and the next book is under editing and will be published in the coming months with the title Alzheimer's through the Stages: a Caregiver's Guide.

Currently she is completing her second, this time in the field of interpreting which is a European Master's in Conference Interpreting at Eötvös Lóránd University in Budapest.

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Appendix

Appendix No. 1.
Sample from the 'QUESTIONNAIRE ON MIGRANTS' HEALTH AND ACCESS TO HEALTHCARE DURING TRANSITION IN SELECTED BALKAN COUNTRIES'*

MIGRANTS' SELF-ASSESSED HEALTH STATUS

31. How is your health in general? Please, estimate your health status!
Is it...
1= very good
2= good
3= fair
4= bad
5= very bad
6= don't know
888= do not want to answer this question

32. Do you have any CHRONIC (longstanding) illness or health problem? [longstanding = which have lasted, or are expected to last, for 6 months or more].
1= yes 2= no 888= do not want to answer this question

33. Do you have (or ever had) any of the following conditions? Was it diagnosed by a medical doctor? Do you get any treatment for it (medication, etc.)? If YES, write an X !

	EVER HAD	WAS DIAG-NOSED BY MD/GP	HAD IN THE LAST 6 MONTHS	GETS ANY TREAT-MENT?
a. Asthma (including allergic asthma)				
b. Chronic bronchitis, Chronic Obstructive Pulmonary Disease, emphysema				
c. Myocardial infarction or its chronic consequences				
d. Coronary heart disease (angina pectoris)				
e. High blood pressure (hypertension, hypertonia)				
f. Stroke (cerebral haemorrhage or thrombosis) or its consequences				
g. Rheumatoid arthritis (inflammation of the joints)				
h. Osteoarthrosis (arthrosis, joint degeneration)				
i. Low back disorder or other chronic back defect				
j. Neck disorder or other chronic neck defect				
k. Diabetes				
l. Allergy i.e. rhinitis, eczema, dermatitis (excluding allergic asthma)				
m. Stomach ulcer (gastric or duodenal)				
n. Cirrhosis of the liver, liver disfunction				
o. Cancer (malignant tumour, including leukaemia and lymphoma)				
p. Severe headache such as migraine				
q. Urinary incontinence, problems in controlling the bladder				

r. Long-term consequences of a previous STI (i.e. syphilis)				
s. Chronic anxiety				
t. Chronic depression				
u. Other mental health problems				
v. Permanent physical injury or defect caused by accident				
w. War injuries, permanent				
x. Any physical disability (blindness, etc.): _____				
y. Any other chronic condition, please specify: _____				

DIFFICULTIES IN ACCESSING HEALTHCARE

47. During your attempts to get sufficient health care in THIS country you may have faced certain difficulties to get the necessary healthcare.
First, please, identify the 3 most significant difficulties you may have faced (starting with the most relevant difficulty)!

1. _____
2. _____
3. _____

48. Below we also listed some potential barriers one may face during accessing health-care. Please, ESTIMATE ON A 1 TO 5 SCALE HOW MUCH THE FOLLOWING DIFFICULTIES MAY IMPEDE YOUR ACCESS TO HEALTHCARE IN THE COUNTRY OF YOUR CURRENT STAY!

	1= Not at all	2= Not really	3= neutral	4= some what	5= Very much	Don't know
48.1. language barriers, lack of qualified interpreters						
48.2. cultural barriers, misunderstandings						
48.3. religious barriers						
48.4. lack of **migrants'** information on entitlements						
48.5. lack of **providers'** information on entitlements						
48.6. lack of migrants' documentation (ID, passport)						
48.7. lack of migrants' health insurance						
48.8. lack of migrants' vaccination documents						
48.9. lack of **migrants'** information on the levels, structure and functioning of health system						
48.10. health workers are not prepared (legal aspects)						
48.11. health workers are not prepared (interculturally)						
48.12. health workers are not prepared (risks, etc.)						
48.13. discrimination from healthcare providers						
48.14. too lengthy asylum procedures						
48.15. lack of cooperation between actors (NGO, etc.)						
48.16. lack of health education for migrants						
48.17. lack of special services for victims of violence						
48.18. lack of special services for females						
48.19. lack of mental health services						
48.20. lack of proper housing, social services						
48.21. lack of translation of documents						
48.22. personal financial problems						
48.23. lack of translated informational materials on access to care and/or disease prevention						

Appendix No. 2.

Sample from the 'QUESTIONNAIRE FOR SERVICE PROVIDERS ON MIGRANTS' HEALTH AND ACCESS TO HEALTHCARE DURING TRANSITION IN SELECTED BALKAN COUNTRIES'*

PERCEIVED HEALTH RISKS AT WORK

Biological and environmental hazards:

50. During the last six months have you been bothered by any or several of the following factors in your work environment?

	Never	Very rarely	Some of the time	Most of the time	Always	Don't Know	Refusal
A. Handling or skin contact with chemical products or substances	1	2	3	4	5	8	9
B. Handling or skin contact with human secretions (e.g. saliva on passports)	1	2	3	4	5	8	9
C. Exposure to farm animals	1	2	3	4	5	8	9
D. Exposure to plants	1	2	3	4	5	8	9
E. Exposure to pesticides/herbicides	1	2	3	4	5	8	9
F. Exposure to human samples such as blood (for clinical testing)	1	2	3	4	5	8	9
G. Exposure to computers, TV or any other kind of electronic screen work	1	2	3	4	5	8	9
H. Exposure to X-rays/gamma rays	1	2	3	4	5	8	9
I. Exposure to radioisotopes	1	2	3	4	5	8	9
J. Exposure to ultraviolet light	1	2	3	4	5	8	9
K. Use of dyes or potential carcinogens	1	2	3	4	5	8	9
L. Use of latex gloves	1	2	3	4	5	8	9
M. Draught	1	2	3	4	5	8	9
N. Room temperature too high	1	2	3	4	5	8	9
O. Room temperature too variable	1	2	3	4	5	8	9
P. Stuffy "bad" air	1	2	3	4	5	8	9
Q. Unpleasant smell	1	2	3	4	5	8	9
R. Static electricity causing shocks	1	2	3	4	5	8	9
S. Passive smoking	1	2	3	4	5	8	9
T. Noise	1	2	3	4	5	8	9
U. Poor lighting	1	2	3	4	5	8	9
V. Glare/reflection	1	2	3	4	5	8	9
W. Dust and dirt	1	2	3	4	5	8	9
X. Exposure to harsh geographic conditions	1	2	3	4	5	8	9

Self-assessment for health literacy

54. How would you assess your personal knowledge and understanding of health hazards that may be associated with your daily work?

	Very poor	Poor	Average	Good	Very good	Don't Know	Refusal
A. Your knowledge of the most common and dangerous infectious diseases in the world?	1	2	3	4	5	8	9
B. Your knowledge of signs and symptoms of the most common infectious diseases in the world?	1	2	3	4	5	8	9
C. Your knowledge of the ways how the most common infectious diseases are spread (transmitted) in the world?	1	2	3	4	5	8	9
D. Your knowledge of sanitary standards and techniques of infection control at your worksite?	1	2	3	4	5	8	9

Health awareness and self-protection

Perceived risk of infectious diseases

55. What do you think is the level of risk that you or any of your co-workers may contract any of the following infectious diseases from travellers?

	Very low or no risk (0-5%)	Fairly low risk (6-25%)	Medium risk (26-50%)	Fairly high risk (51-75%)	Very high risk (76-100%)	Don't Know	Refusal
A. Bronchitis	1	2	3	4	5	8	9
B. Pneumonia	1	2	3	4	5	8	9
C. HIV/AIDS	1	2	3	4	5	8	9
D. Diarrhoeal diseases	1	2	3	4	5	8	9
E. Tuberculosis (TB)	1	2	3	4	5	8	9
F. Malaria	1	2	3	4	5	8	9
G. Measles	1	2	3	4	5	8	9
H. Pertussis	1	2	3	4	5	8	9
I. Tetanus	1	2	3	4	5	8	9
J. Meningitis	1	2	3	4	5	8	9
K. Syphilis	1	2	3	4	5	8	9
L. Hepatitis A	1	2	3	4	5	8	9
M. Hepatitis B	1	2	3	4	5	8	9
N. Hepatitis C							
O. Ebola fever	1	2	3	4	5	8	9
P. Any other infectious disease (specify):	1	2	3	4	5	8	9

**If you have any questions regarding to the questionnaires, please contact the authors above.*