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Infectious Disease: Stigmatization of Refugees and Vulnerable Migrants

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There are approximately 250 million migrants in the world today. Twenty-eight million of those are refugees and asylum seekers. In addition, an untold number have been forcibly displaced or are in vulnerable situations yet lack refugee status. This mass movement of people has prompted global public discourse about the rights of people fleeing danger or persecution and the responsibilities (or limits thereof) of countries willing to accept them. Many national governments and international organizations face a complex public health and programmatic quandary of how to meet the health needs of these vulnerable populations and assess the risk to the health of host communities, while not stoking further fear and stigmatization. The situation has been particularly precarious given the growth of stigma and nationalistic responses from politicians and subsets of the public in some host countries.

Recent studies have shown that even though refugees and involuntary migrants may be at increased risk for infectious diseases¹, the rate of transmission from these people to the general population is very low, and is often exaggerated, particularly in quarters promoting a broader anti-migrant agenda. The stigmatization of forcibly displaced persons on the basis of potential risk for infectious disease is one manifestation of a larger backlash against refugees and migrants. There is an urgent need to examine this type of stigma and assess its impact to help highlight areas of programmatic and policy innovation. The soon to be adopted Global Compact for Safe, Orderly and Regular Migration and the Global Compact on Refugees (both based on the 2016 New York Declaration for Refugees and Migrants) create an opportune moment for international organizations to push forward on the development of policies to address this issue.

¹ Infectious diseases refer to any disease caused by a microorganism or pathogen. Communicable diseases refer to infectious diseases that have the capacity for human to human transmission either through direct contact or through the environment.

This paper outlines the real and exaggerated concerns related to communicable diseases among vulnerable migrants, explores the impact of stigma on the opportunities and protections offered to this population, and identifies relevant international law and illustrative practices of governments. Our purpose is to create a common background and basis for discussions on areas for further exploration and policy development by international organizations.

Definitions

Populations of concern

In this paper, we focus on two populations of concern: refugees and vulnerable migrants. The definition of a refugee is well-known: a person who, “owing to a well-founded fear of persecution for reasons of race, religion, nationality, membership of a particular social group or political opinions, is outside the country of his nationality and is unable or, owing to such fear, is unwilling to avail himself of the protection of that country.”² This definition has been expanded in Africa and the Americas to include persons who flee their country because of conflict, other forms of generalized violence, or serious disruptions to public order.³

The definition of a migrant is less clear. The International Organization for Migration defines a migrant as any person who is moving or has moved across an international border or within a state away from his/her habitual place of residence, regardless of legal status, whether the movement is voluntary, the causes for the movement, or the length of the stay.⁴ Our focus is on a subset of that broad categorization – migrants who have crossed a border and are especially vulnerable. These could be forcibly displaced persons who fear for their lives due to widespread violence or state collapse. They could be people who flee from serious social or economic distress, like famine. They could be people driven out of their home countries as a result of natural or environmental disaster. The terms “involuntary migrants” “irregular migrants” and “survival migrants” are

sometimes used. We find “vulnerable migrants” to be the best descriptor, connoting migrants who are at special risk of abuse, discrimination or other human rights violations.⁵

Stigmatization

For the purpose of this analysis, we borrow from existing infectious disease related literature, and adopt the definition of stigma offered by Alonzo and Reynolds, namely that stigma is “a powerful discrediting and tainting social label that radically changes the way individuals view themselves and are viewed as persons.”⁶ Stigma is pervasive and profoundly disrupts individual as well as community health and well-being and can be a determinant factor in health inequalities. Three sources of stigma have been described in public health contexts:

- 1 Public or “social” stigma:** results from attitudes and beliefs of the general public towards the targeted group. Such stigma can be due to careless language and unclear terminology used by the media, social leaders and society in general. Such stigma often arises from misrepresentation of facts regarding the targeted population.
- 2 Institutional stigma:** results when an institution or government policy reflects stereotyped or negative attitudes or beliefs about the targeted group and hence “constrains the opportunities, resources, and wellbeing for stigmatized populations.”⁷ In the health sector, it can manifest in compulsory testing or disclosure, and denial of treatment or access to care. The format and composition of national screenings for infectious diseases can have a stigmatizing impact.
- 3 Personal or self-stigma:** is the internalization of societies’ negative attitudes by the target population leading to avoidance of people, withdrawal and depression. This may be expressed as low self-esteem or even self-hatred. The negative mental state can in turn impact physical health.

2 Art. 1(A)(2), Convention Relating to the Status of Refugees, 1951 (as modified by the 1967 Protocol).

3 1969 Organization of African Unity (OAU) Refugee Convention; 1984 Cartagena Declaration.

4 International Organization of Migration, Key Migration Terms <https://www.iom.int/key-migration-terms>.

5 This corresponds to the definition used in the Global Migration Group *Principles and Guidelines, supported by practical guidance, on the international human rights and protections of migrants in vulnerable situations*. <https://www.ohchr.org/en/issues/migration/pages/vulnerable-situations.aspx>.

6 Alonzo A.A. and Reynolds N.R. (1995). Stigma, HIV and AIDS: an exploration and elaboration of a stigma trajectory. *Social Science and Medicine*, 41 (3), 303–315.

7 Hatzenbuehler ML and Link BG. Introduction to the special issue on structural stigma and health. *Soc Sci Med* 2014; 103: 1–6.

Nature and scope of the problem

Although the risks vary depending on the specific group, there are several factors that place refugees and vulnerable migrants at higher risk for both acquisition of infectious diseases and worse outcomes in their aftermath. First, many refugees and migrants originate from societies where public health (including surveillance and vaccination for infectious diseases) and public works (including water and sanitation) infrastructure are minimal, lacking or destroyed. Further their access to healthcare may be limited due to debilitated health systems. The majority of the asylum seekers from the recent mass flow to Europe come from three conflict-affected states: Syria, Afghanistan and Iraq. Research shows that many of the war affected areas of the eastern Mediterranean region have seen the reemergence of vaccine preventable diseases such as cholera, measles and polio.⁸ A drop of vaccination was noted in many of these areas between 2000 and 2015 in the aftermath of destruction of health facilities and temperature-controlled supply chains for materials, as well as a dearth of health workers.⁹

Additionally, refugees may reside for prolonged periods in crowded conditions during their migration, putting them at higher risk for exposures both from other displaced persons but also due to the poor water and sanitation conditions within their camps. Due to the stress of the migration, poor access to nutrition and poor living conditions may make them less resilient to infections. For example, Médecins Sans Frontières (MSF) discovered that many refugees detained in camps in Greece with serious chronic and communicable diseases, such as tuberculosis, had interrupted their treatment due to lack of access to consistent care. No measures were taken to protect other detainees from possible disease transmission within the crowded conditions.¹⁰

However, studies have repeatedly shown that the risk of infectious diseases to general populations of countries accepting asylum seekers is small.¹¹ For example, a concern that was overlaid in the media during the recent European crisis was the risk of polio transmission from Syrian refugees; yet no cases were identified in Germany from screening of asymptomatic children from this part of the world.¹² Numerous studies have demonstrated that the risk of transmission is greatest within refugee and migrant communities, due to poor living conditions during and after migration, rather than to other communities in host country.¹³ Access to care and reduction of stigma would actually help to address these risks. One recent study showed that the increased risk of drug resistant tuberculosis is highest among members of refugee communities and yet this very same population faces barriers to care and restrictive health systems, potentiating a future larger public health risk.¹⁴

Why then, to the detriment of larger public health goals, are the risks of infectious diseases from refugees and asylum seekers overlaid in the public domain and by whom? Infectious diseases in general provoke public fear of the affected, particularly when those diseases are new.¹⁵ For example, the stigma against patients with SARS continued long after the outbreak ended in Hong Kong in 2001 with the creation of public outpatient clinics that were specially designed for the SARS victims (institutional stigma). The establishment and the design of these clinics were problematic as they reinforced the stigma associated with SARS despite no continued risk to the public. Survivors of SARS in turn continued to wear face masks despite not considering themselves infectious because they were anxious about being perceived as a threat (self-stigma).¹⁶ Media reports often serve to exacerbate prejudice and discrimination against refugees and migrants. Several studies

8 Raslan R, El Sayegh S, Chams S, et al. Re-Emerging Vaccine-Preventable Diseases in War-Affected Peoples of the Eastern Mediterranean Region-An Update. *Front Public Health* 2017; 5: 283.

9 Lam E, McCarthy A and Brennan M. Vaccine-preventable diseases in humanitarian emergencies among refugee and internally-displaced populations. *Hum Vaccin Immunother* 2015; 11: 2627-2636.

10 Médecins Sans Frontières. *Invisible Suffering: Prolonged and systematic detention of migrants and asylum seekers in substandard conditions in Greece*. 2015.

11 Khan MS, Osei-Kofi A, Omar A, et al. Pathogens, prejudice, and politics: the role of the global health community in the European refugee crisis. *Lancet Infect Dis* 2016; 16: e173-177. Mockenhaupt FP, Barbre KA, Jensenius M, et al. Profile of illness in Syrian refugees: A GeoSentinel analysis, 2013 to 2015. *Euro Surveill* 2016; 21: 30160.

12 Gulland A. World has been slow to act on polio outbreak in Syria, charity warns. *BMJ* 2014; 348: g1947.

13 Eiset AH and Wejse C. Review of infectious diseases in refugees and asylum seekers-current status and going forward. *Public Health Rev* 2017; 38: 22.

14 Hargreaves S, Lonroth K, Nellums LB, et al. Multidrug-resistant tuberculosis and migration to Europe. *Clin Microbiol Infect* 2017; 23: 141-146.

15 Des Jarlais DC, Galea S, Tracy M, et al. Stigmatization of newly emerging infectious diseases: AIDS and SARS. *Am J Public Health* 2006; 96: 561-567.

16 Siu JYM. The SARS-associated stigma of SARS victims in the post-SARS era of Hong Kong. *Qual Health Res* 2008; 18: 729-738.

have suggested that representations of migrants in the media reporting of tuberculosis were implicated in the production of stigma.¹⁷ In Belgium, media attention linking HIV with migration, together with changes in migration policies throughout Europe, may have fueled the sense of social exclusion felt by many migrants from sub-Saharan Africa.¹⁸ During the H1N1 epidemic (swine flu), the media's use of the term "Mexican flu" incited stigma directed toward Mexicans.¹⁹ Similarly, research shows how media stories during the 2013-2016 ebola epidemic led to stigmatization of African immigrants in the United States.²⁰

False narratives and fear have been used by politicians and cultural leaders to promote anti-immigration sentiment. In Poland, the leader of the largest conservative opposition party, spread rhetoric about the "diseases and parasites brought by Middle Eastern refugees", and garnered significant support among those in the country who hold a mistrust of foreigners.²¹ During the H1N1 pandemic, anti-migrant groups in the US attempted to link illegal aliens and immigrants to the "rising tide" of infectious disease.²² Government policies, particularly those related to entry of refugees and migrants, may themselves promote stigma, inadvertently or otherwise. Some of these are discussed in the next section of this paper.

Stigmatization based on perceived risk of infectious diseases can result in direct discrimination, exclusion from social programs, and self-inflicted distancing by these groups from beneficial programs out of fear of reproach. Below are some concrete examples:

1 Ability to gain asylum: More than half of EU countries, the United States and Canada have screening policies for infectious diseases applicable to asylum seekers. These policies are meant to protect public health and identify patients who may need access to care, and yet, create anxiety and reluctance to seek care among asylum seekers who fear the results may affect their application.²³ Certain countries go further in their policies by openly declining access to asylum for individuals with certain infectious diseases.

2 Ability to access health and human services: Navigating the healthcare landscape is difficult enough for newcomers due to language and cultural differences and systemic complexities, but stigmatization can reduce healthcare seeking behavior either directly due to delayed or denied care, blame and humiliation, or indirectly due to fear of reproach.²⁴

3 Ability to access broader economic, education and social opportunities: Non-acceptance and lack of integration of migrant populations by host communities can deprive migrant and refugee children of schooling and other basic social services.

4 Indirect impact on wellbeing and mental health: Refugees reporting discrimination experience higher stress levels than those who do not.²⁵

17 Craig GM, Daftary A, Engel N, et al. Tuberculosis stigma as a social determinant of health: a systematic mapping review of research in low incidence countries. *Int J Infect Dis* 2017; 56: 90-100.

18 Arrey AE, Bilsen J, Lacor P, et al. Perceptions of Stigma and Discrimination in Health Care Settings Towards Sub-Saharan African Migrant Women Living with Hiv/Aids in Belgium: A Qualitative Study. *J Biosoc Sci* 2017; 49: 578-596.

19 Williams J, Gonzalez-Medina D and Le Q. Infectious diseases and social stigma. *Applied Technologies and Innovations* 2011; 4.

20 Fuller D. New Research Explores How the Ebola Scare Stigmatized African Immigrants in the United States, <https://www.uc.edu/news/articles/legacy/enews/2015/11/e22410.html> (2015).

21 Seedat F, Hargreaves S and Friedland JS. Engaging new migrants in infectious disease screening: a qualitative semi-structured interview study of UK migrant community health-care leads. *PLoS One* 2014; 9: e108261.

22 Perry P and Donini-Lenhoff F. Stigmatization complicates infectious disease management. *Virtual Mentor* 2010; 12: 225-230.

23 Beeres DT, Cornish D, Vonk M, et al. Screening for infectious diseases of asylum seekers upon arrival: the necessity of the moral principle of reciprocity. *BMC Med Ethics* 2018; 19: 16.

24 Arrey AE, Bilsen J, Lacor P, et al. Perceptions of Stigma and Discrimination in Health Care Settings Towards Sub-Saharan African Migrant Women Living with Hiv/Aids in Belgium: A Qualitative Study. *J Biosoc Sci* 2017; 49: 578-596. Mirza M, Luna R, Mathews B, et al. Barriers to healthcare access among refugees with disabilities and chronic health conditions resettled in the US Midwest. *J Immigr Minor Health* 2014; 16: 733-742.

25 Baranik LE, Hurst CS and Eby LT. The stigma of being a refugee: A mixed-method study of refugees' experiences of vocational stress. *J Vocat Behav* 2018; 105: 116-130.

Policies/practices of host governments

The language and scope of national policies and practices can further stigmatize refugees and asylum seekers. Such stigmatization can hinder both the health of individuals as well as the larger public health goals of the host country. We present illustrative examples of problematic practices below:

a) Detention of refugees and asylum seekers at arrival:

The systematic detention of migrants and asylum seekers is increasingly being used, worldwide, as a migration management tool to restrict the influx of migrants and to pressurize detained migrants into joining voluntary return programs. In Greece for example, migrants whose forced or voluntary return did not take place within the initial detention period could be detained repeatedly, sometimes for as long as 15 months. While policies have evolved since 2015, at the time many people detained in these units had limited or no access to medical care and sometimes did not even go through an initial medical assessment, creating enclosed environments where communicable diseases were not addressed in a timely manner.²⁶

b) Linking of infectious diseases screening results to asylum status causes undue fear among asylum seekers and hurts larger public health goals:

As a recent WHO report states, health care is a right independent of the lawfulness of a person's situation of stay, yet many national policies allow for exclusion of refugees based on whether they have a handful of infectious diseases deemed as undesirable or a public health threat. In United States, these are termed Class A conditions and include numerous sexually transmitted diseases (in which HIV is no longer included), leprosy and active TB. Asylum seekers may further be quarantined for other infectious diseases with the potential to cause outbreaks. The first category of these diseases and their connection to admissibility promotes the idea that it is new arrivals that bring this disease into the country, and that these diseases

can be stopped at the border (rather than through treatment and public health measures), despite the fact that many of the Class A diseases already occur in United States.²⁷

c) Services are sometimes marred by discrimination at the point of access:

The United Kingdom has a number of official resettlement programs including two -- the Syrian Vulnerable Persons Resettlement Scheme (VPRS) and the Vulnerable Children Resettlement Scheme (VCRS) -- that are designed to offer protection during a large scale humanitarian crises. Today, most of the medical screening is performed pre-entry into the country. Refugees are referred by UNCHR for UK consideration and the IOM conducts a health assessment including interview, exam, screening for infectious diseases and immunizations. Prior to moving to the pre-entry model, the UK had port of entry TB screening which was shut down because it was, "poorly run, discriminatory, and not cost-effective."²⁸ The UK's experience highlights that staff training and sensitization for refugee needs is one space for intervention for countries that still perform this type of port of entry testing.

d) The mode of screening for infectious diseases is sometimes not logistically friendly or culturally appropriate:

There are no generally accepted definitions of what infectious diseases screening of refugees and asylum seekers should consist of and hence, national policies vary along a large spectrum. In many of the published studies, interviewed migrants stress their willingness to be screened and yet underscore the practical barriers created by lack of language services or location of services.²⁹

e) Screening programs tend to focus more on perceived needs of the receiving country rather than the needs of the individual:

One of the major reported concerns of refugees and of advocates is that the health examination and screening of arriving populations tends to be infectious-disease focused rather than looking at all the health needs of

26 Médecins Sans Frontières. *Invisible Suffering: Prolonged and systematic detention of migrants and asylum seekers in substandard conditions in Greece* (2015).

27 Hong MK, Varghese RE, Jindal C, et al. Refugee Policy Implications of U.S. Immigration Medical Screenings: A New Era of Inadmissibility on Health-Related Grounds. *Int J Environ Res Public Health* 2017; 14.

28 Seedat F, Hargreaves S and Friedland JS. Engaging new migrants in infectious disease screening: a qualitative semi-structured interview study of UK migrant community health-care leads. *PLoS One* 2014; 9: e108261.

29 Cheng I, Advocat J, Vasi S, et al. *A Rapid Review of Evidence-Based Information, Best Practices and Lessons Learned in Addressing the Health Needs of Refugees and Migrants*. (World Health Organization, 2018).

the arriving person, including chronic diseases.³⁰ The focus on only the communicable diseases has the result of portraying refugees as threats to the general population.

Relevant international law

While there is no comprehensive treaty on migration, there is a substantial body of international law that bears on the situation of refugees and vulnerable migrants. In this section, we provide a snapshot of the key instruments.

Human rights law

Article 12 of the International Covenant on Economic, Social and Cultural Rights (ICESCR) recognizes “the right of everyone to the enjoyment of the highest attainable standard of physical and mental health”. The ICESCR was preceded by the Constitution of the World Health Organization, whose preamble defines health as “a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity” and declares that “the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition.”

The right to health is understood to include the prevention, treatment and control of diseases, as well as access to essential medicines, to basic health services and to health-related education and information. In addition, a number of rights, freedoms and entitlements relating to health are enshrined in international law. The Committee on Economic, Social and Cultural Rights lists safe water, sanitation, food, adequate nutrition and housing, a healthy workplace, health-related information and gender equality as being among the determinants of health.³¹

Of particular importance to vulnerable migrants, health and health-related rights are subject to the prohibition against discrimination. Article 2(2) of

the ICESCR states “the rights enunciated in the present Covenant will be exercised without discrimination of any kind as to race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status”. Refugees and migrants are not explicitly protected, but arguably fall within one of the protected categories or “other status”.³²

Some human rights cannot be derogated from on grounds of public health (or national security and public order). Principle 25 of the Siracusa Principles, a non-binding instrument that has been accepted as an authoritative standard for limiting civil and political rights, stipulates that rights-limiting measures taken to deal with health threats “must be specifically aimed at preventing disease or injury or providing care for the sick and injured”. Whether the Principles apply to the right to health and rights relating to health is an open question, but arguably entry and residence restrictions based on health status must be “objective and reasonable” and must not be “disproportionate and arbitrary.”³³

Other “hard law”

The Convention and Protocol Relating to the Status of Refugees do not enshrine a right to health, but Article 23 stipulates that refugees lawfully staying in the territory of a party to the Convention are entitled to “the same treatment with respect to public relief and assistance as is accorded to their nationals.” This includes health care.

Various International Labour Organization Conventions also include health-related protections: the 1949 (Revised) Convention Concerning Migration for Employment; the 1975 Convention on Migrations in Abusive Conditions and the Promotion of Equality of Opportunity and Treatment of Migrant Workers; and the 1990 International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families.

30 International Federation of Red Cross and Red Crescent Societies, *When Stigma Kills*. *Reliefwebnet.*, 2016.

31 Other treaties that recognize the right to health are: the 1965 International Convention on the Elimination of All Forms of Racial Discrimination (Article 5 (e) (iv)); the 1979 Convention on the Elimination of All Forms of Discrimination against Women (Articles 11, 12 and 14); and the 1989 Convention on the Rights of the Child (Article 24); the 2006 Convention on the Rights of Persons with Disabilities (Article 25)

32 Pace, Paola ed., *Migration and the Right to Health*, IOM Paper in International Migration Law No. 19 (2009).

33 Pace, id at 17. UN, Economic and Social Council, *Siracusa Principles on the Limitation and Derogation Provisions in the International Covenant on Civil and Political Rights*, U.N. Doc. E/CN.4/1985/4, Annex (1985).

Non-binding instruments

In addition to treaty law, there are many formally non-binding instruments that nevertheless have legal significance either because they carry some legal weight or are intended to have legal effect in the future. Among those that are of relevance to refugees and vulnerable migrants are:

- The New York Declaration for Refugees and Migrants
- The Global Compact for Safe, Orderly and Regular Migration (Objective 15 in particular)
- The Global Compact on Refugees
- The Principles and Guidelines, supported by practical guidance, on the human rights protection of migrant in vulnerable situations (Principle 12 in particular)
- The UN General Assembly Declaration on Rights of Individuals Who are not Nationals

These instruments in turn include references to other documents adopted by international organizations that set out goals, frameworks and action plans. Thus, the Global Compact for Refugees and the Global Compact for Migration reference the Agenda for Sustainable Development 2030 (SDGs), which has numerous health-related goals. The Global Compact for Migration also references the WHO Framework of Priorities and Guiding Principles to Promote the Health of Refugees and Migrants (para. 31(e)).

The New York Declaration makes direct reference to the problem of stigmatization by calling for steps to reduce the stigma of people with HIV (para. 30) and to combat xenophobia against refugees and migrants that may restrict access to healthcare (para. 39). The Principles and Guidelines on the protection of migrants provide a definition of xenophobia (p. 18) and call for measures against acts and expressions that stereotype migrants (Principle 2(2)).

Looking ahead

The IOM, WHO, UNHCR and other organizations have developed policies and practices that relate to the problem of stigmatization, either directly or indirectly. For example, the IOM hosts regional conferences on stigma against refugees and migrants, and conducts community focused projects to train health workers on how to address stigma and dispel myths. The WHO recommends against compulsory mass screening and has produced two recent documents that consider the legal, social, and programmatic barriers (including stigmatization) to providing meaningful healthcare to refugees and migrants.³⁴

At the Geneva workshop in November 2018 we look forward to exploring these and other initiatives. Among the questions that could be considered:

1. What additional research is needed on the type and forms of stigma and discrimination faced by refugees and vulnerable migrants?
2. How can the imminent adoption of the Global Compact for Migration and the Global Compact on Refugees be leveraged to advance this agenda.
3. How can inter-governmental organizations work with states to ensure screening and health programs that meet the needs of refugees and vulnerable migrants while respecting their rights, as well as serving public health goals? Are new legal frameworks or non-binding guidelines needed?
4. What programs can be instituted that help identify and support populations vulnerable to stigmatization and discrimination related to infectious diseases (both soon after migration and after a period of residency in host country)?
5. How can risk communication and education be used to reduce public stigma against refugees and vulnerable migrants?

34 Cheng I, Advocat J, Vasi S, et al. *A Rapid Review of Evidence-Based Information, Best Practices and Lessons Learned in Addressing the Health Needs of Refugees and Migrants*. (World Health Organization, 2018); Bradby H, Humphris R, Newall D, et al. Public health aspects of migrant health: a review of the evidence on health status for refugees and asylum seekers in the European Region. (World Health Organization, 2017).