GENDER DIFFERENCES IN HEALTH STATUS AND HEALTH SERVICES UTILIZATION OF MIGRANTS, SEEKING INTERNATIONAL PROTECTION IN BULGARIA

Momchil Kostov Baev, MPH* and Emilia Krasimirova Naseva, MD

Faculty of Public Health, Medical University of Sofia,

DOI: http://dx.doi.org/10.24327/ijrsr.2020.1102.5097

ABSTRACT

Global and regional processes of social and economic development brought an unprecedented, difficult to control migration. The flow of migrants, seeking international protection in Bulgaria has critically increased since 2013 and challenged the health system. An insignificant number of studies explore the health status of migrants in Bulgaria. The present study aims to determine the gender differences in health and health services usage of asylum seekers in the country.

In the period January-March 2018 an interpreter-assisted structured interview was carried out with 145 persons (93 men and 52 women), accommodated in the three Registration and Reception centers in Sofia. Information about health, utilization of primary and specialized health care and the opinion on quality of healthcare was collected.

About a quarter of the interviewed men and women assessed their health as fair and poor at present. Significantly more frequently women reported worsening of health as a result of migration (31.0%) and presence of chronic diseases (29%). Special attention is needed to the health of female migrants, seeking an international protection due to the higher frequency of chronic diseases among them, the worse subjective health and quality of life. Provision of interpreters and cultural mediators during the process of health care will improve its quality and effectiveness, as well as the health outcomes of migrants.

INTRODUCTION

The beginning of the civil war in Syria led to a prolonged humanitarian crisis that drove hundreds of thousands of people away from their homes. The European continent was the natural direction for all migrants and refugees. The uncontrolled human flow from the Middle East brought not only the refugees fleeing the war conflict but also a high number of economic migrants searching for better life in Europe. What turned out to be the European Migrant Crisis, raised number of ethical issues and debates all over the continent and the EU member states’ parliaments. The public voices stretched from sincere acceptance to complete hate. The issue divided Europe. The major argument for letting in all migrants was related to ethics, compassion and unity. But this initially humanitarian matter turned into a largely political one that drove numerous processes in the European Union.

Together with all challenges that the migrant crisis brought, the European states face number of difficulties in terms of healthcare that is a two-fold problem. First, in protecting the public health from new-coming threats in the host country, and second, in providing the necessary medical coverage for the migrating population. The states struggle in balancing between ethics and national security – where is the thin red line between building walls on the borders and giving shelter and freedom to the foreign citizens?

Migration has become one of the key components of population change in Europe. Migration flows over past decades among EU Member States and in- and outside of the EU has had a significant impact on the current population size in most Member States. Data is available on the number of foreign population residing in the countries (see Population heading in the Eurostat database), and the number of people arriving to and leaving each EU Member State every year can also be followed in Eurostat (immigration and emigration flows).

Migrating persons have no general recognized right to enter a country. However, states must exercise their sovereign powers...
to deny entry to or exclude migrating persons in a manner consistent with international law and human rights, implementing the principle of non-discrimination. This principle requires states not to treat persons intending to enter or reside on their territory differently solely due to their health status unless there is an objective and reasonable basis for doing so. Many countries justify such a differentiation on the grounds of protecting public health and avoiding excessive pressure on national health care resources. Even developed countries like USA for instance performed such policy until very recently. Indeed, various regulations are imposed with the purpose of preventing the entry or residence of migrating persons with certain diseases or conditions (such as HIV infection/AIDS or physical or intellectual, psycho-social or cognitive impairments). These range from health-related questions in visa application forms, to medical examinations by immigration officers at the border and mandatory HIV tests before departure or upon arrival.

The number of first time asylum applicants in the EU-28 in 2017 was 650 000, which was 55 thousand (about 8.0%) less than the total number of applicants. A first-time applicant for international protection is a person who lodged an application for asylum for the first time in a given EU Member State and therefore excludes repeat applicants (in that Member State) and so more accurately reflects the number of newly arrived persons applying for international protection in the reporting Member State.

This latest figure for 2017 marked a decrease of 560 000 first-time applicants across the EU-28 in comparison with the year before, as the number of first-time applicants fell from 1.2 million in 2016 to 650 000 in 2017. This followed on from a slight decrease of 50 000 first-time applicants between 2015 and 2016. The main contributions to the decrease were lower numbers of applicants from Syria, Afghanistan and Iraq. Developing countries hosted the largest share of refugees (86% by the end of 2014, the highest figure in more than two decades); the least developed countries alone provided asylum to 25.0% of refugees worldwide. Even though most Syrian refugees were hosted by neighboring countries such as Turkey, Lebanon and Jordan, the number of asylum applications lodged by Syrian refugees in Europe steadily increased between 2011 and 2015, totaling 813 599 in 37 European countries (including both EU members and non-members) as of November 2015; Some 57.0% of them applied for asylum in Germany or Serbia. The largest single recipient of new asylum seekers in the European Union was Germany, with 202 645 asylum requests, 20.0% of them from Syria. Initially, the health of the migrants has not been studied in-depth as the immigration flows occurred in a state of emergency. However, after the EU managed to control the situation number of research initiatives looked into the most prevailing conditions among the migrants. Chronic non-communicable diseases are an important factor for the general health of those running from wars and civic conflicts. The presented here research shows that prevailing are Cardiovascular Diseases, Diabetes, Hypertension, diseases of the musculoskeletal system, Neurological and Endocrine Diseases. The same disease are also shown as prevailing in other research (Alawa et al.).

The member states in the European Union were not well prepared to meet the huge influx of migrants and to manage the large pressure on the public systems, including healthcare. The flow of migrants, seeking international protection in Bulgaria has critically increased since 2013 and challenged the health system. Bulgaria, although a transit country on the way of the refugees towards Western Europe, was also affected by the critically high number seeking international protection in the country since 2013 until 2015-2016. The healthcare system of the country was struggling to solve the immediate problems of the migrants’ health, to develop a better response system, to allocate additional resources and to control the public health risks related to the influx of migrants. The refugees, seeking international protection in Bulgaria since 2013 until April 2018 is 62 045 persons. 11 690 of them were granted a refugee status and 6 619 were granted humanitarian status.

MATERIALS AND METHODS

The research was carried at the Reception and Registration Centers (RRC) of the State Agency for Refugees SAR) with the Council of Ministers, using an interpreter-assisted structured interview with 93 men and 52 women, accommodated in the three RRCs in Sofia. The standardized questionnaires included both open and closed questions, where the closed ones prevailed. This interview in 26 questions included information about health, utilization of primary and specialized health care, the opinion on quality of healthcare. A statistical analysis was carried with descriptive characteristics, comparisons with classical statistical methods – t-test of

1Medical Examination of Aliens-Removal of Human Immunodeficiency Virus (HIV) Infection From Definition of Communicable Disease of Public Health Significance, CDC-2008-0001-0001, 2009.
2UNAIDS/IOM Statement on HIV/AIDS-related Travel Restrictions, Geneva, UNAIDS/IOM, 2004. See also forthcoming UNAIDS/IOM Best legislative practices regulating the entry and residence of people living with HIV, IOM and UNAIDS.
3The Memorandum by the International Law Commission Secretariat on the expulsion of aliens lists some national laws that enumerate “physical defects, mental illness or handicap or retardation” as grounds for the refusal of entry or the expulsion of those aliens who suffer from the specified health condition or are “disabled or handicapped and thus unable to work” (Document A/CN.4/565, p. 261).
4EUROSTAT – “Countries of citizenship of (non-EU) asylum seekers in the EU-28 Member States, 2016 and 2017”
6UNHCR - "Syria Regional Refugee Response”.
7EUROSTAT - "Asylum statistics”.
have to pay a closer attention to a third of the women (31,0% vs. 26,0% of men) who actually have experienced a worsened health condition. Of those women, 23,0% claim that their health is a little worse and 8,0% - a lot worse. Again, a visible gap between the men and the women is evident here which supports our hypothesis that the health of the women is more vulnerable and needs special attention. Significantly more frequently women reported presence of achronic diseases - 29,0% vs. 17,0% of men.

The research on the health status of persons seeking international protection in Bulgaria is insignificant which shows the need for further investigation to provide evidence for better tailored policies. The following research shows that the women are a particularly vulnerable group in the migration process with a higher risk in terms of diseases, sexual and other types of assaults, mental health risks and others. About a quarter of the interviewed men and women assessed their health as satisfactory and poor at present (Graphic 1). Good health is reported by 57,0% of men and 63,0% of women. In very good health are only 12,0% of the women and 21,0% of the men which shows a significant difference by genders. 21,0% of the women and 14,0% of the men see their health as satisfactory and poor at present (Graphic 1). Good health is reported by 57,0% of men and 63,0% of women. In very good health are only 12,0% of the women and 21,0% of the men which shows a significant difference by genders. 21,0% of the women and 14,0% of the men see their health as satisfactory and poor at present.

The frequency of health-related events observed in both genders shows some significant differences by gender supporting the main hypothesis (Graphic 3). Women more frequently visited a doctor in the past year compared to men (65,0% vs. 59,0%). Almost a quarter of women did that two times in the past 12 months. Much higher is the proportion of women who saw a doctor more than 3 times compared to men (23,0% vs. 15,0%). In recombination of the answers, almost half of the women (48,0%) were seen by a physician more than two times when this is true for only 36,0% of men.

Due to local regulations, all incoming migrants crossing the border must be seen by a healthcare specialist and screened for certain diseases, also regulated in the national legislation. However, finding interpreters for all migrants, especially in the acute phase of the migrant crisis, was difficult for the state institutions. Healthcare providers had to communicate with the migrants either through interpretation or in English whenever
possible. This obstacle was examined in the present research by asking respondents whether their communication with doctors was difficult due to the language barrier. Overall, 60.3% of all respondents report some difficulties in communication with doctors. Majority of the women (65.0%) report difficulties in communication when this is true for 58.0% of men (Graphic 4). Some difficulties are reported by 52.0% of women and 46.0% of men. Very difficult is the communication for 13.0% of women and 12.0% of men.

CONCLUSION

The women seeking international protection in Bulgaria are about one third of all persons. The biggest group of them are the women from Syria, forcefully displaced by war. The female migrants have a higher average age and a lower education level than men. Migration has led to worsening of the health status of one third of the women. Women more frequently than men report the presence of chronic conditions, which might be due to the higher average age of the group. About one fifth of the female migrants are frequently ill, with four or more times being ill in the past year (23.0%).

The usage of healthcare services by women shows a significant difference by doctor’s visits where almost half of the women had 3 or more doctor’s visits, compared to 30.0% of the men. No differences by gender are seen in the personal assessment and satisfaction of the health needs, timely provision of healthcare, attitudes of the healthcare workers and barriers in communication.

Our study shows that special attention is needed to the health of female migrants who seek an international protection due to the higher frequency of chronic diseases among them, the worse subjective health, additional burden due to the care for under-age children and the lack of education. Provision of interpreters and cultural mediators during the process of health care will improve its quality and effectiveness, as well as the health outcomes of migrants.

Reference

2. UNAIDS/IOM Statement on HIV/AIDS-related Travel Restrictions, Geneva, UNAIDS/IOM, 2004. See also forthcoming UNAIDS/IOM Best legislative practices regulating the entry and residence of people living with HIV, IOM and UNAIDS.
3. The Memorandum by the International Law Commission Secretariat on the expulsion of aliens lists some national laws that enumerate “physical defects, mental illness or handicap or retardation” as grounds for the refusal of entry or the expulsion of those aliens who suffer from the specified health condition or are “disabled or handicapped and thus unable to work” (Document A/CN.4/565, p. 261).
4. EUROSTAT – “Countries of citizenship of (non-EU) asylum seekers in the EU-28 Member States, 2016 and 2017”
6. UNHCR - "Syria Regional Refugee Response".
7. EUROSTAT - "Asylum statistics".