Barriers to Effective Right of Access to Health: A Systematic Review with Metanalysis

REVIEW

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Abstract

Objective: Evaluating evidence involving the assurance of health rights for refugee population throughout the world by systematic revision with metanalysis.

Data Source: the following database was used: MEDLINE, accessed via Virtual Health Library (BVS), and SCOPUS. In order to make more assured and straightforward research, the authors chose to unify all the descriptors (MeSH) using the operator AND on the following form: (Refugees AND Right to health AND Human Rights).

Study Selection: The primary selection occur through triage of titles and abstracts followed by eligibility criteria based on full reading of the articles selected under previously established inclusion criteria.

Data Extraction: Some of the information were extracted from studies enclosing author, year, type of participants and its respective numbers, type of intervention, number of sessions or time of follow-up, and outcomes.

Results: The research strategies resulted in 201 articles. Considering inclusion and exclusion criteria, 10 studies were included in the sample (N). The metanalysis make possible to assess the failure of the effective policy towards the refugee population's welfare, thus there is an effective close proximity with the absence line, I^2 (variation in ES attributable to heterogeneity) = 98.32%; Estimate of between-study variance $\tau^2 = 0.04$; Test of $ES=0$: $z = 1.08$ $p = 0.00$.

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Conclusion: The lack of access to information, the language and cultural issues, and the oddness/estrangement over the hosting country are major factors contributing for the refugee's health precariousness in making it difficult in its access. The report "Global Trends" of the United Nations High Commissioner for Refugees (UNHCR) indicate that such difficulties in the health access may be related to the level of social-economic development of the hosting countries. There are plenty of difficulties on the accessing health services, among then the lack of official documentation and information.

Keywords

Right Assurance, Refugees;
Health, Systematic Review,
Metanalysis.

Introduction

A Refugee is defined as a person moved by concerns of persecution from various reasons, related to ethnicity, nationality, religious beliefs, the belonging to determined social group or political choice/wing, who finds himself or herself away from his or her original country, and not being able to return to his/her homeland, fearing for safety reasons [1]. Leaving home can be a tough decision in some parts of the world, especially because food and shelter can be inadequate. For most part of the refugees, there is not room for choice. Their lives and safety are at stake if they remain in their homeland [2].

The responsibility for refugees protection is from the Government of the hosting countries, and includes many aspects, as such as deportation back to endangering situation that they had already fled; Access to proper and efficient asylum; and measures assuring respect of their basic civil rights, dignified living conditions and the search for long term resolution of their citizenship [3]. In this context, the international/global community has identified the health of migrant population as priority, by recognizing as a human universal right. The disparity among national and international migrants (immigrants, refugees, asylum claimers and undocumented individuals) of low-income industrialized

countries may result from the vulnerability related to the immigrant status, neglected health access and communication barriers [4].

In the two last decades, the global population of forcibly displaced persons increased substantially, rising from 33.9 million in 1997 to 65.6 million in 2016. In the end of 2016 there were 2.8 million people seeking international protection, although whose refugee status was not yet recognized/determined [5]. In the first semester of 2017 it has been verified a rise in the number of refugees and migrant population entering Europe through Central Mediterranean route heading Italy, accounting for 83,752 arrivals. In general terms, the number of refugees e migrants arriving (Italy) through Western Mediterranean route in that period was 92% lesser in comparison to the same period of year 2016. The refugees and migrants are still enduring serious dangers during their voyage towards Europe, as well as during their displacement across this continent [6].

The globalization process limits the access to refugees protection by a selective people circulating process through the political borders of countries, as well as it defies its definition due to the complexity of the existing migratory fluxes. In year 2015, the "refugee crisis" has shown a number of aspects imposing challenges to human rights,

such as the precarious conditions to which such refugees are subjected [7]. All over the world, the majority of refugees find themselves in low or medium income countries, being that 4.9 million people were received in countries with the less development indexes in the world. This enormous imbalance reflects various aspects, including the lack of international consensus over the refugees hosting, and the proximity of poor countries to conflict areas [5].

The purpose of this study is to analyze the right to health in the refugees population through a systematic revision with metanalysis by the PRISMA protocol. The leading question was based on the acronym PICO (P for population; I for Interests; and Co for context): Which practical contribution scientific literature has to offer on the right to the health access issue for refugees population in the context of current conflicts in evidence over the world? The International Rights of Refugees seeks to assure the fundamental rights consecrated in the various international instruments of human rights, concerning life protection, health and dignity of the human being [8].

Therefore, the hypothesis is: Although the advances and agreements signed since Geneva Convention in 1951 until nowadays, seeking for the protection of this group of people, the refugees remain in vulnerability [9] in country such as South Africa, Sweden, Kenya, Italy and Canada, especially concerning to health access.

Methods

The study is a systematic revision with metanalysis over the right of health issue of the refugees population of previously selected indexed database. The research was performed between the months of august and September 2017 throughout the SCOPUS/Elsevier and Virtual Health Library (BVS) database holster of MEDLINE base.

The following Medical Subject Headings (MeSH) descriptors in English were utilized for researching on BVS:

- # 1. "Refugees";
- # 2. "Right to health;
- # 3. "Human rights"

The research strategy utilized for SCOPUS was similar and used the same terms mentioned above.

The articles selection was narrowed by applying the following filters on both BVS and SCOPUS: Full text articles available in English, Spanish or Portuguese presenting as main issues public health, medicine, social science and health services, all of them dated between 2013 and 2017. The reason for limiting the research between these years was to evaluate more recent data over the issue, once the question concerning refugees population is in constant transformation, varying with events, such as conflicts, environmental catastrophes among others.

The critical analysis of the articles followed the legibility criteria previously determined. The initial screening process was made by reading the titles and abstracts. The following inclusion criteria were adopted: (1) Publications in English, Spanish or Portuguese; (2) Articles containing at least one of the combination depicted on search strategy; (3) Studies that relevantly approached the right of health status of the refugee population; (4) Original articles available in full text on the CAPES database. CAPES (Coordenação de Aperfeiçoamento Pessoal de Nível Superior – Coordination for the Improvement of Higher Education Personnel), a virtual library created by the Brazilian Ministry of Health comprising of publication content restricted to authorized personnel.

The discarded texts were: (1) Non original texts, such as letters to the editor, preface texts, brief communications, rectifications/errata, comments, editorials, review texts, monographs or dissertation thesis; (2) Texts approaching the right of health sta-

tus of the refugee population irrelevantly; and (3) Non-available full-text articles on CAPES database. Texts appearing in more than one database were counted only once. In order to avoid any biases on findings evaluation, the data collection was made by three researchers individually, whereas possible discrepancy was made solved by a fourth senior researcher.

Each selected article has been integrally read with the collected data/information fed into table containing author, year of publication, periodical, study sample, description and major findings (**Table 1**). RevMan software was utilized providing key elements of metanalysis, such as the graphic of proportion among studies.

Table 1. Representative matrix chart of data synthesis.

Author	Year	Journal	Sample	Main Findings
Chawla	2017	World J Surg.	Interviews were conducted with 225 Iraqi and 150 Afghans. Interviews were carried between April, 2013 and October, 2013; each session lasted for up to 90 min.	Compared to Iraqi group, Afghan group was significantly younger, had lower schooling, had longer period of displacement and was in Australia longer. Afghans were relatively more likely to believe that "family problems" and "moving to a new country" caused PTSD in detriment of "destiny" compared to Iraqi.
Alfaro-Velcamp,	2017	Internacional Journal of Migration, Health and Social Care	The research involved the jurisprudential analysis of South Africa, the African Charter and United Nations documents on rights for access to health and health care.	Asylum seekers and refugees have the right to health and emergency care. However, care institutions require documentation that many immigrants do not have, so health care providers are often placed in an unsustainable position of not being able to treat patients, including some who face fatal conditions. In conclusion, there is a fundamental divergence between the central idea of the South African bill of rights which confers socio-economic rights for all and access to asylum seekers, refugees and migrants health care in South Africa. On the other hand, international doctrines call each more and more states to recognize the responsibility that extends to all peoples residing in a sovereign state / nation.
Jonzon, Lindkvist, Johansson	2015	Scandinavian Journal of Public Health	Semi-structured interviews were conducted with 11 Eritrean refugees residing mainly in Sweden. Eight people, four women and four men were initially recruited. Three more people (one woman and two men) were theoretically sampled to ensure data saturation. Everyone had a residence permit and resided in Stockholm at the time of the interviews. The age of the participants selected ranged from 27 to 43 years and they lived in Sweden between 2.5 and 5 years.	Difficulties in communicating and overcoming cultural barriers were related to the commitment of access to the health service and the quality of health evaluation. Information related to health problems, such as the right to go through health assessment, should be given to asylum seekers newly arrived by the migration authority, but only a few of the informants in this study were able to remember that this information was provided to them. Instead of demanding information in their own language, information about the purpose of health assessment and the right to articulate their own health-related needs, they have given up and turned to the compatriots who arrived earlier in Sweden for help in interpreting information.

Author	Year	Journal	Sample	Main Findings
Arnold, Theede, Gagnon	2014	Social Science and Medicine	The semi-structured interviews were conducted in English with government representatives (n = 3) and service providers (n = 8). Eight discussions were held in focus groups. They included two separate focus groups with migrant and Kenyan community members from each location: Mathare (n = 6 migrants, n = 5 Kenyans); Majengo (n = 4 migrants, n = 6 Kenyans); Kayole (n = 6 migrants, n = 5 Kenyans) and South B (n = 5 migrants, n = 4 Kenyans).	Despite Kenya's 2010 Constitution guaranteeing the right to health for every person in Kenya, migrants continue to have barriers to access to health care. A general recognition of the rights of migrants to access health care, and more specifically, the provision of more detailed information on drug treatment and availability is an unmet need of the migrant community. Interestingly, migrants and Kenyans described many of the same barriers to availability and geographic accessibility, while particular barriers to financial accessibility were different between migrants and Kenyans, and those related to the acceptability of services were reported almost that exclusively by migrants.
Kaluski	2014	Health Policy and Planning	A survey was conducted with 1698 people, of whom 767 were 19 years of age or older. More than 80% were considered romanose 14% (n = 07) did not declare ethnicity. Most interviewees, 82% (5.60), stated that they were domiciled, 7% (n = 55) were internally displaced persons, 11% (n = 85) were refugees and 89% (n = 684) had Serbian citizenship.	In Rome, refugees had limited access to health services. These findings led the Serbian Ministry of Health and National Health Insurance Fund to reduce the administrative and legislative obstacles in obtaining health insurance to ensure Roma's rights to health care. However, since many Romans in Serbia do not have a permanent or legal place of residence and do not have the capacity to be included in the recognized workforce, they can not exercise their right to medical care. The Ministry of Health has established health mediators to establish contacts with Roman communities and primary health care centers. Together with other health promotion activities, they work to familiarize Romans with their right to health and to use new policies to gain access to the health system.
Byrskog, Olsson, Essén, Allvin,	2014	BMC Public Health	17 women of childbearing age born in Somalia living in Sweden. All informants proved to have permanent residence permits in Sweden and their family situations were often complex, such as leaving behind biological children behind during the flight, forced separations and divorces; being pregnant with husbands living abroad, and experiencing the death of their own children in Somalia or Sweden.	Several factors reinforced the silencing of violence among women born in Somalia to migration. Therefore, diseases related to violence can be ignored in the health system. Narratives of coercive marriage, sexual violence, intimate partner violence, and restrictions limiting sexual and reproductive health care have evidenced various forms of gender-based violence and violations of sexual and reproductive health rights. War-shaped survival strategies contain resources for resilience and the enhancement of well-being and health, sexual and reproductive rights in recipient countries after migration.
Keygnaert	2014	Globalization and Health	154 (60 women - 94 men) sub-Saharan migrants were interviewed. Most of the participants were young, well educated, immigrants predominantly from the Democratic Republic of Congo, Cameroon, Congo Brazzaville, Ivory Coast and Mali.	90% reported multiple victim cases, 45% of which were sexual, predominantly gang rape. Respondents said they relied on NGOs to seek help, identifying organizations such as the Red Cross or Médecins Sans Frontières (MSF) as sole providers of treatment for victims of sexual violence. This is an unsustainable situation and ignores migrants' right to health care.

Author	Year	Journal	Sample	Main Findings
Crush, Chikanda, Tawodzera	2013	Journal of Ethnic and Migration Studies	A hundred in-depth interviews were conducted with migrants in Johannesburg and Cape Town, 50 in each city. A total of 10 focus group discussions were also held, five in each city.	Respondents reported that it is very difficult to get treatment in clinics and hospitals if they do not produce documents that have the right to be in South Africa. Private-sector facilities generally do not ask for such documentation, they are generally much more interested in the payment capacity of a patient. In the public sector, those who can not produce evidence of their legal right to be in South Africa are regularly refused treatment or removed from hospitals and government clinics, however sick they may be.
Scott	2013	International Journal of Migration, Health and Social Care	12 in-depth interviews with African black people seeking asylum, two of which were follow-up interviews with participants who had specific health problems at the time of their first interview. Participants included six women and four men living or living in a Duldung after the rejection of his application for asylum for periods ranging from two to seven years. Half the women were mothers and had given birth to at least one of their children while in a Duldung. One of the female participants had already obtained their residence permit through marriage and had statutory health insurance. As a result, she had the dual experience of negotiating the health system with and without beneficiary status under the ASBA.	None of the participants received information about available health services and how to access them. Participants understood that the asylum system did not support their health and well-being or enabled their efforts to find protection. Contact with the authorities and the experiences of daily life led the participants to internalize the sense of their "place" in relation to others and their triple disadvantage as asylum seekers, foreigners and African blacks. This was reinforced by the awareness of being at the bottom of an ethno-racial hierarchy of asylum seekers. Their pale-skinned counterparts and Eastern Europeans have been described as benefiting from certain privileges and exemptions while "all that is black is bad and criminal." As a consequence, his discursive tactics were grounded in the constructions of society and strategic institutional practices as inhumane, racist and disrespectful of their rights.
Vanthuyne	2013	Social Science and Medicine	Participants in this online survey were all professionals, administrators, researchers and support staff, based at 3 hospitals and 2 primary care centers in Montreal. This article uses comments provided by 237 respondents (23% of all respondents) detailed in the open space at the conclusion of the survey. 193 people (81%) were born in Canada. A total of 121 (51%) interviewed identified themselves as health professionals, 93 (40%) as support staff, 14 (6%) as managers or administrators, 3 (1%) as academic staff and 6 (2%) as occupying other positions.	For most respondents, the right to health of immigrants with precarious status has become a "privilege," which, as taxpayers, they are increasingly unwilling to contribute. A reconsideration of access to health care as a right is advocated.

Results

The research strategies related above have resulted in 201 articles. After analyzing titles and abstracts considering eligibility criteria, 186 articles were discarded, and 55 articles were recovered. In the following step, the 55 pre-selected articles

were entirely read and reanalyzed facing against the inclusion criteria. Thus, 45 articles were excluded by not fulfilling the key established questions so far. Only 10 articles remained included in the final sample (**Figure 1**). 40% of the selected articles were published in the year 2014, and the

Figure 1: Flow diagram showing eligibility process of articles hosted in BVS/MEDLINE and SCOPUS database.

Source: Schematic representation of the studies included in the systematic review using a checklist and flow diagram of the PRISMA Protocol.

remaining 60% were equally divided between the years 2-13, 2015 and 2017.

The meta-analysis of the proportions (**Figure 2**) highlights an I^2 (variation in ES attributable to heterogeneity) = 98.32%. Estimate of between-study variance $\tau^2 = 0.04$. Test of $ES=0$; $z=1.08$ $p = 0.00$.

Figure 2: Meta-analysis of the proportions of the studies.

From this analysis it is possible to verify that the proposed actions for refugees do not occur, since there is effective proximity and adjacency with the absence line.

Discussion

The 61th United Nations World Assembly on Health addresses the health of migrant and recognizes several issues comprising that matter. It recognizes that the health condition may be influenced by multiple dimensions involving the migration phenomena and that some of these groups have increased health risks. This resolution takes into account the health determinants in development of intersectoral policies, aware of the role of health in promotion of social inclusion [10]. Thirteen multilateral UNO treaties support the equitable access to Essential Emergency Surgical Care and Anesthe-

sia (EESCA) for all people, in coherence with the 68th World Health Assembly [11, 12]. Chawla et al; [11] have utilized these treaties texts to build up a structure consisting of three major issues concerning EESCA: Equitable access to EESCA; The care to wounded people and those in emergency surgical condition; and the third axis; protection, rehabilitation, psychosocial support and social security. However, the existence of rights and resolutions are not warranty for governmental mobilization nor effectuation of these rights, in manner that the population of refugees constantly face several difficulties in accessing health services, as well as flagrant violations of these rights.

Barriers to Effective Right of Access to Health

The major obstacles for effectiveness of the right of health on refugee population are related with require of proper documents to access the services, communicational barriers, financial issues, geographic difficulties and accessibility of services. In South Africa, migrants searching for asylum have right to health and emergency care. However, the providing institutions for health services, like hospitals and clinics, require documents verifying the legal right of these people for entering the country. Hence, in the lacking of these documents the patients are declined or put away from governmental facilities [13, 14]. The private sector, however, does not requires this kind of documentation, but demands the payment for its services [14]. In Serbia, the refugee population of Roma with no legal permanent residence also has not recognized their labor force and, therefore, hardly exerts their right to access of health assistance [15].

Apart from the legal difficulties with documentation, cultural and communicational barriers compromise the access to health services [16]. There is fail in providing information regarding the right of health, such as access to treatments and medication, a common insatisfaction on the migrant popu-

lation from Kenya [17]. A study performed in West Germany with black colored Africans in search for asylum verified that none of the participants have received any information about available health services whatsoever neither how to access them [18]. In Sweden, the information regarding rights and access (to?) must be provided by migration/customs authorities in the act of the arriving of asylum claiming people. Being compromised the evaluation of health status of these people, as well as identification of their needs, the search of help among their fellow countrymen for translation is the most viable and commonly adopted measure [16].

Some of the barriers to the access to health services found by the migrants are shared by the Kenyan population, like financial impediments. Nevertheless, the most concerning hardships related by these migrants were the fear for harassment and prison by the police forces while arriving or leaving a health facility, mostly among irregular residents. Or even so, the low acceptance of hosting health services regarding their cultural rules. Chiefly related to three major themes: (racial/sexual) discrimination, documents requiring and language barriers [17].

Violence and Violation of the Right of Access to Health

The refugee population has endured violence and violation of the right to access to health. Beyond of the compromising of access to information, these groups may not have the access to health itself, coming to acknowledge it as a privilege less accessible to the more socioeconomically vulnerable [19]. Violence reports, violation of rights and racial disparities are present in such manner that many times the refugees population rely solely on NGOs (Non-Governmental Organization) for accessing health services.

Violence related diseases may pass ignored by the health system due to a silencer mechanism of the violence perpetrated, above all on Somali women in refugee situation in Sweden [20]. Sexual violence

accounts are common in Morocco, mostly rape by gangs [21]. Coercive marriages, violence by intimal companion, and mostly restrictions to reproductive and sexual health access right, as well as unacceptable gender-based violence [20]. In Germany, strictly racial issues were experienced by black-colored Africans in search for asylum in the form of right of health access denial. West European and white skin counterparts were reported as privileged in regard of health care access [18].

Even for tax payer immigrants, the right of health has become considered as "privilege", specially for groups with precarious status in Canada, stablishing a context in which these people become less and less willing to contribute with the government [19]. In Germany, refugee groups fail to comprehend the asylum system as health and wellbeing supporter [18]. Interviewed persons in Morocco have reported being completely dependent on NGOs, such as Médecins Sans Frontières (Doctors Without Borders) for access health care, thought these institutions are sometimes the sole treatment providers to sexual violence victims in these population [21].

Conclusion

Inspite of laws and agreements assuring fundamental rights, such as the right of health for the refugees, since Geneva convention in 1951, the literature [13, 14, 15, 16] notes that the access to these services in the hosting countries does not occur satisfactorily. Studies [13, 14] also points that there are several difficulties endured by the refugee population, such as language incompatibility, the fear of suffering some kind of violence – mainly those in irregular immigrant status – as well as the lack of proper documentation in order to access health services. In that particular picture, the private health care providers have less protocol impediments, however, they require previous payment for the service, making it very difficult to access due to financial poverty of these people.

Beyond the difficulty on accessing health services, it is worthy of remark [19,20,21] the vulnerability that these refugees are submitted, having in account they are easy targets for abuse, specially of sexual nature. Such fact sets their sexual and reproductive health in risk, and consequently, their general health status. Along with this, there is still discrimination to some groups, particularly those with African ancestry. The lack of access to information is another factor contributing to precarization of the refugees health by making it difficult to access the services. Differences in language, culture e the sense of weirdness of the “strange” hosting country worsen even more the situation.

Corroborating with the report “Global Trends” by UNHCR [5] it is worth of remark that such difficulties on the access of health may be related to the socioeconomic level of development of the hosting countries. In many of these countries, the available resources for providing services on essential rights, such as health services, was yet limited before, and became much more compromised by the rapid increase in the number of refugees. Thus, the size of population, economy and development status of a hosting country are also important issues considering the burden of hosting refugees.

It must be remarked the importance of research over the subject in order to draw attention for the needs of these people, purposing that the State/ Government becomes aware and sensitized in finding means of making much more easy for these population to access health in all its aspects.

Conflict of interest

The authors declare that they have no competing interests.

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