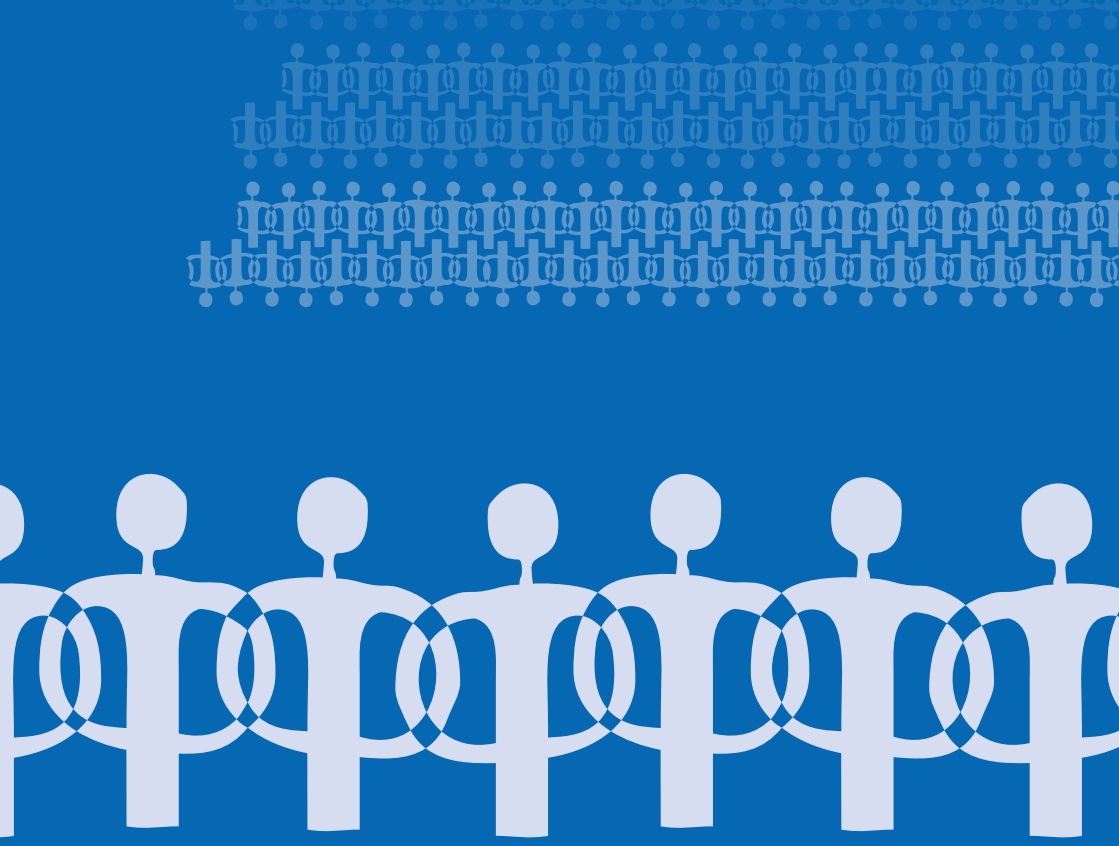

MEDICAL TREATMENT OF ASYLUM SEEKERS

SLOVENSKA FILANTROPIJA
MÉDECINS DU MONDE
Co-funded by the Health Programme of the European Union

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INTRODUCTION

Franci Zlatar, M.A., Head of Migration Program

As trends are pointing towards an increasing commercialization of health care, it is becoming more and more difficult for certain population groups to access healthcare services. In that respect, the matter does not only concern a very specific group of vulnerable people in the field of health care, since constant changes in social circumstances are also causing structural changes of vulnerable population groups. Years ago, within the framework of partnership of various organizations, we had established a health clinic for people without health insurance. At that time, homeless people were the group with the most limited access to health care. The clinic had been established as a temporary solution until the issue of uninsured individuals had been resolved. Very soon it became clear new individuals and groups without health insurance or with a limited access to health care began to appear: homeless people, the erased[1], immigrants, and with the emergence of the economic crisis also many sole traders, who fell into debt with insurance companies. Consequently, we are not using the term vulnerable people, but are instead talking about vulnerability in the field of health care. Namely, we must be aware that in particular social circumstances every individual may experience the loss of access to health care.

Network for decreasing vulnerability in the field of health care, led by international organization Doctors of the World(Slovene Philanthropy is a partner organization of the network), established in their report[2] that out of 30.000 interviewed patients, who visited clinics of the organization Doctors of the World and their partner organizations from different European countries, 65,5% of them have no access to regular healthcare system,

1 The term »erased« refers to people, who were born in other republics of the former Yugoslavia, had a Yugoslav citizenship and the citizenship of some other republic of the former Yugoslavia, but had a permanent residency in the former Socialist Republic of Slovenia. In 1991, Slovenia declared its independence. All citizens of the former republics of Yugoslavia, who had their permanent address in Slovenia, had the right to apply for Slovenian citizenship within six months from the declaration of independence. Those who did not obtain their new citizenship, lost their permanent residency status, thus being »erased« from the register of permanent residents. Apart from losing their residency, they also lost other rights (social, economic, etc.).

2 Medecines du monde – Doctors of the World, International network 2016 Observatory Report: Access to the health care for people facing multiple vulnerabilities in health in 31 cities in 12 countries.

approximately 40% of women have no access to health care before and after childbirth and around 40% of children had not been vaccinated. 94% of the interviewees were migrants, most of them were not EU citizens.

Numerous data show that various groups of migrants have a very limited access to health care. Refugees are especially vulnerable, since they are exposed to different forms of violence in their home country, on their travel and in the country of their arrival. In Slovenia as well, certain groups of migrants (undocumented migrants and asylum seekers, with the exception of children) are entitled to urgent medical treatment and to a limited extent to some services, covered by supplementary health insurance policy. Needless to say, an appropriate access to health care, including psychological and therapeutic treatment, is crucial for a successful integration of refugees. Considering the aforementioned, we must not only strive for a better healthcare for migrants, but in a broader sense for a universal accessibility to health care for all population groups.

This publication is a result of work on the project »8 NGO's for migrants'/refugees health in 11 countries« and contains findings, suggestions and issues with regard to health care and in a broader sense psycho-social treatment of applicants for international protection.

PART 1

The following articles demonstrate the results and findings on migrants/refugees' health in practice and in the field of the project team including field/project coordinator, social workers, medical coordinators and assistants, psycho-social referents and interpreters that formed the so called mixed mobile unit, and other project members.

The words migrants, refugees are used interchangeably and include different groups of migrants (migrants, refugees, asylum seekers). Therefore, the different groups of migrants have different health rights in Slovenia and we use mainly the term asylum seekers as this is the population we work most with and as they have the least rights. We want also to emphasize the fact that many of asylum seekers may live in Slovenia for a long period of time without concrete health rights, which may result in poor or worsened health state with no proper access to health services.

MIGRANTS AND HEALTH

Helena Liberšar

- - - SUMMARY - - -

Arrival of large numbers of migrants, such as the one we have witnessed in October 2015, always causes fear of infectious diseases, of overload of the national healthcare system and of bypassing the waiting lists when using medical services.

Two aspects are important with regard to health conditions and health care of migrants in our area:

- upon their arrival in Europe (by term Europe we refer to a broader geographic area with similar characteristics, part of which is also Slovenia), migrants are far more medically jeopardized than local inhabitants. Namely, it often happens that otherwise healthy people fall ill during their travel and because of the travel,

- health condition of migrants should be considered in a broader sense, that is, from the viewpoint of their refugee experience. Many of them were forced to leave their homeland because of war and in severe conditions. Therefore, when considering migrants' health state, a broader picture needs to be taken into account - not only their current state of affairs, but their past experience need to be considered as well: travelling by foot, in closed trucks, on ships, in harsh weather conditions (very low or very high temperatures, in rain, in snow).

This is very important, since accessibility of health care and medical services depends on the status a migrant acquires in the Republic of Slovenia.

A person with international protection has equal rights as Slovenian citizens.

Children of asylum seekers have equal rights as children of Slovenian citizens.

Pregnant women have equal rights as Slovenian citizens - this applies to all services in connection with family planning, childbirth, childcare, etc.

In terms of health care, adult asylum seekers and other migrants are in the most difficult position, since they are entitled only to urgent medical treatment and there is no alternative status for them to acquire in the Republic of Slovenia, which would

enable them supplementary healthcare treatment.

According to definition and legal basis, health care of asylum seekers is often regarded as non-urgent. Furthermore, the definition of urgency is interpreted in very different ways. From a perspective of their overall health condition, their past health conditions and most of all of their refugee experience (travel, traumas, fear, flight, life-threatening danger), treating those patients is necessary even in non-urgent cases. It is also necessary to provide them with an appropriate medical treatment, which would not make their lives difficult or deteriorate their health condition. Even a simple common cold should be treated as if it was a case of emergency, because nobody knows what affliction a certain individual had to endure on his/her way here and what might develop out of a seemingly non-threatening condition.

PROJECT »11 NGO'S FOR MIGRANTS/ REFUGEES' HEALTH IN 11 COUNTRIES«: OBJECTIVES AND RESULTS.

At Slovene Philanthropy, we had an opportunity to devote ourselves in a greater detail to issues of health assessment of refugees seeking asylum in Slovenia in the year 2016.

In co-operation with an international network Doctors of the World, we participated in the project »8 NGO's for migrants'/ refugees' health in 11 countries«, which was meant to serve as a reply to the arrival of larger numbers of refugees in Europe. Participating in the project enabled us to get an insight into health condition of refugees, who crossed Slovenian territory, more specifically of those refugees, who applied for international protection in Slovenia.

Main objectives of the program: to ensure the newly arrived migrants, especially the most vulnerable ones, an easier access to basic and preventive medical treatment, to strengthen the capacity of the national health systems of the member states to appropriately respond to the medical needs of refugees, preventing cross-border health risks.

The project assured three components: health, social and psychological support.

The primary objective of the program was to monitor the health condition of refugees in transit situation. After the closure of borders on 9th of March 2016, we focused on the refugees, who applied for international protection in Slovenia. We thus acquired an insight into their health condition and issues through a more consistent and a longer lasting health assessment.

During the project work we have come to the following conclusions:

- it is important to consider medical treatment of asylum seekers in a broader sense, especially in the context of their

long travel and the circumstances, which caused them to flee,

- due to language barriers we need to take enough time to explain to the asylum seekers, how Slovenian health system works and what to expect from the treatment here, since they are accustomed to a different treatment with more rights,

- the asylum seekers as well as the medical personnel should be informed on asylum seeker's health rights.

PROPOSITION FOR MEDICAL TREATMENT OF ASYLUM SEEKERS

Asylum seekers are a distinct group of patients and work of physicians, who treat them, has its very own specific as well. In that respect, our findings show it would be sensible for the asylum seekers to have their personal and family physician. In that case, physician's work would involve treating a particular group of patients (i. e. asylum seekers) instead of focusing on treatment of a certain number of patients.

Our arguments for this thesis are:

- First of all, a physician needs quite some time to provide asylum seekers with a proper and detailed information on the scope of their health rights, on how the Slovenian health system works and on the range of medical services that they are entitled to.

- A physician needs a detailed information on the asylum seeker's health condition, his/her previous illnesses and therapies he/she might received, in order to be able to prescribe new therapies for the patient.

- In medical treatment of asylum seekers, language barriers need to be overcome. In certain cases, this can be achieved with the help of cultural mediators, who are familiar with Slovenian language and culture as well as the language and culture of asylum seeker's country of origin. It is also important that cultural mediators master the medical terminology and are able to translate unbiased, without implementing their personal opinion or altering the information during translation.

It is very important for the asylum seekers to be acquainted with their health condition. Due to language barriers, they do not understand most of what the physician tells them. A further issue is that when they see a doctor, they do not bring their health record with them, either because they do not know they need it or they do not have it. Consequently, a doctor also has no way of knowing their medical history and which therapies they had received. Due to a limited scope of their health rights, asylum seekers can be treated only by a doctor on duty, who also does not monitor their health condition (this can only be done by a personal or family physician).

During our fieldwork we established that the most important thing is to inform the

asylum seekers on their health rights and on how the Slovenian health system functions. They often do not understand they will have to wait their turn in order for a doctor to receive and treat them, since nobody explains that to them prior the treatment. Because they are not acquainted with the functioning of the health system in Slovenia, they believe they are not receiving a proper medical treatment and that they are not being properly sought after, which leads to discontent. The issue here is that asylum seekers are accustomed to different processes of medical treatment, since health systems differ from country to country, and they are simply not familiar with those differences. Basic information on how to act when visiting a doctor would spare the asylum seekers as well as the medical personnel annoyance and numerous misunderstandings.

Burdening of the medical personnel in health centres and rules of the Slovenian health system with regard to health insurance policies also need to be considered.

Health care of migrants is for many a sensitive subject. Many reproaches had arisen with regard to providing migrants with more rights while Slovenian citizens are not being appropriately sought after. There are suspicions on taking advantage of the system in order to enable asylum seekers to bypass waiting lists while our citizens have to wait their turn. One option is to offer asylum seekers private medical services, which is cruel, considering the fact most of them have no financial means for survival, let alone for medical services.

Offering the asylum seekers a broader scope of medical services does not mean Slovenian citizens will be deprived of their rights, since this way the range of rights in the field of health care would only expand. By including asylum seekers into the system of health insurance they would also be included in the system of waiting lists, which means they would access medical services under the same conditions as everybody else.

As dr. Uršula Lipovec Čebron stated at the conference on Medical Treatment of Asylum Seekers, organized by Slovene Philanthropy within the project at the end of November, the right to urgent medical treatment should not be perceived as a right, but instead as a foundation, enabling different scope of rights.

Ali is a 31-year-old man from Afghanistan. He has a wife and two children, is a tailor by profession.

In Afghanistan the Taliban threatened him. When they beat him, his right leg got broken. Ali went to the hospital because of the injuries, had a surgery, got osteosynthetic implant and stayed there for a month. During his stay in hospital, the Taliban killed his mother.

Ali came to Slovenia through the Balkan route. He fled with his family through Pakistan, Iran, Turkey, Macedonia, Serbia and Croatia. The exhausting travel lasted for 15 days. His leg was hurting him a lot while travelling.

On the journey from Iran to Turkey they had to climb the mountains and cross the rivers. That is when the leg got worse. Ali said that this part was really difficult not only because of his leg but also because he has seen frozen bodies of those who did not succeed in travelling the same way they did.

The family travelled by boat for five hours, crossing the sea between Turkey and Greece. When water started entering their boat, they had to throw away their luggage. At the same time, they were watching in despair how the boat behind them was sinking.

His problems with the leg escalated in the last six months. On 1st of April he went to see the nurse in asylum home, because of the pain and because the osteosynthetic material was already coming out of his knee. She said that she cannot do anything, since he does not have a health insurance. Once he will have a status, he will be allowed to visit the doctor for non-life-threatening situations as well. Our translator insisted on sending him to the ER, where she sent him and where they scanned the leg. The doctor said that the quality of osteosynthetic material in his leg is really good (the same they are using here), the only problem is that it is too long. Since his situation was not life threatening (literally: he is not dying from the pain), he couldn't do anything.

This is one of the stories that ended well. Through a series of fortunate events and concerned volunteer, he got an appointment with a surgeon, who later decided to perform a surgery.

Migrants without a status or temporary/permanent residence in Slovenia, such as asylum seekers, are entitled to urgent medical assistance only, therefore many of their health issues are not considered urgent as in life threatening, but are still necessary for a better quality of their lives or to prevent a degradation of their health in the long term.

Many times organizations working with and for migrants are faced with challenges to find solutions and even more often we need to take unbeaten paths to find help.

Working closely with vulnerable people who refugees always are, regardless of their gender or situation, gives one a different perspective on life itself and people offering services to them, whether they are medical personnel, social workers or volunteers, should always consider migrant's situation, not as current, but as a whole, taking in consideration his or her history, the months and kilometres they travelled to come to current destination and everything that happened to him or her during all this time. To treat him/her as a human being and equal.

Nearly 4 months after the operation, Ali is now happy and pain free. He can now enjoy his days walking and sporting, which wasn't possible before. His

condition didn't impact only his life but also the life of his family. His wife was before very stressed and passive and the children were behaving badly. Now also his family is happier and more content. They are more optimistic and children's behaviour changed significantly since they have his father "back".

Including asylum seekers into the system of health insurance only solves one part of the issue, with which the asylum seekers and the medical personnel have to confront (i. e. a right to basic health care). Yet unresolved would remain the issue of overcoming language barriers and intercultural differences between various health systems of the countries of asylum seekers' origin.

On the whole, the refugee situation should not be considered from a single standpoint and the issues should not be solved one-sidedly, but instead on all levels, beginning with respect for human dignity.

URGENT MEDICAL TREATMENT

Every person has the right to urgent medical treatment. Urgent medical treatment includes unpostponable medical services, CPR, life support and prevention of deterioration of medical condition of an ill or injured person. The treatment urgency estimation is given by a personal physician or a medical commission in charge, in accordance with general acts of the Health Insurance Institute.

Urgent medical treatment involves CPR, services necessary for preservation of vital functions and prevention of drastic deterioration of health condition of the injured, chronically ill or suddenly ill. The services are provided until stabilization of vital functions or until a patient begins treatment at the appropriate institution. Urgent medical transport is provided as a part of urgent medical treatment services.

Urgent medical treatment and unpostponable medical services include:

- immediate treatment after an urgent medical treatment (if necessary),
- treatment of wounds, prevention of sudden and fatal deterioration of chronic diseases and medical conditions that could lead to permanent damage of specific organs and of their functions,
- treatment of sprains, fractures and injuries acquiring specialist treatment,
- treatment of poisoning,
- services for prevention of spread of infections, which might cause a septic shock in a patient,
- services or treatment of diseases, which are mandatory by law and are not funded by the state, employer or the insured person,
- subsidized prescription drugs, needed for treatment of illnesses and conditions listed in previous paragraphs,

- instruments needed for treatment of conditions, listed in previous paragraphs (to extend and according to standards and norms, defined by the Article 103 of Health Insurance Rules).

Mohammad is 34 years old, he has a wife and two children. Few days before their journey to Europe, his problems with kidney stones began. Doctor told him that a kidney stone is moving towards his bladder and prescribed him a 10-day drug treatment. They improved his condition until their arrival in Greece, where due to stress he lost the medicines together with the documents. On the way, he got various painkillers, which made the journey bearable, even though he knew the problem still exist.

He arrived in centre for asylum seekers in Ljubljana four months ago. Every day for 15 days he visited a nurse, who was giving him painkillers, until at some point he earned her attention – she sent him to hospital. The same day the family was transferred to different unit of centre for asylum seekers and he didn´t manage to get to the hospital.

In the new location Mohammad went to a social worker three times to get the painkillers, dr.C wrote two reference letters to the social worker to send him to the hospital for a kidney scan. She said she took him there, which was not true. When dr.C wrote the third reference letter, he gave it to a NGO social worker, who said he will try to get him into the hospital in the following two weeks. He didn´t manage to arrange it. This was postponed until Mohammad gave up.

Asylum seekers in Slovenia are entitled to emergency health treatment exclusively. In examples like Mohammad´s, a social worker must hand the reference letter of a general practitioner to the special commission working within asylum home in charge for granting additional health services. They are the ones making the decision, whether the asylum seeker is entitled to a specialist check or not.

Two weeks ago Mohammad´s blood was examined, which proved that something is not right (his calcium level was higher than usual).

Mohammad is really tired and desperate at the moment. He is sitting with his arms crossed around his torso. At first I thought he is uncomfortable because of the interview, but he explains that he is like this because of the pain. He refuses to visit dr.C, social worker or any other organisation representatives. He said: *˝I am not going to bother them until my kidneys stop working. I made friends with the pain.˝*

One negative aspect of urgent medical treatment in practice is that the medical personnel decides on the spot, whether certain medical condition requires urgent medical treatment or not. If the personnel estimates a patient is not entitled to an

urgent medical assistance, they may reject the application for the treatment. The urgency of the treatment may also be established subsequently. In case it had been established the condition was not urgent, a patient must pay the bill for the services.

ACCESS TO MEDICAL TREATMENT OF ASYLUM SEEKERS

Health care of asylum seekers is defined by the International Protection Act. The act also defines health care of asylum seekers is financed from the state budget.

With regard to understanding asylum seekers' rights in the field of health care and in medical treatment, first issue that appears here is the access to a physician, since Slovenian health system is based on the Health Care and Health Insurance Act. The medical personnel also relies on those provisions, since they are in a dilemma on who will fund the service and to what extent they may even treat the patient every time they provide a treatment.

The second issue are long-running asylum procedures during which asylum seekers may wait several months, even years without being able to claim their health insurance. No matter how long they must wait for the asylum procedure to come to a conclusion (one possible solution to the issue could be that after 6 months of their stay in Slovenia, asylum seekers would be given the right to a basic health care to the extent, defined by provisions of the compulsory health insurance), they are only entitled to an urgent medical treatment as defined by Act 86 of the International Protection Act from 16th of March 2016.

Urgent medical treatment of asylum seekers includes the right to:

1. urgent medical assistance and emergency transport (in accordance to prior decision of a physician) as well as emergency dental medical treatment;

2. urgent medical treatment in accordance with the decision of the treating physician, which includes:

- preservation of vital functions, cessation of bleeding and prevention of exsanguination;
- prevention of sudden deterioration of medical condition, which could result in permanent damage of individual organs or vital functions;
- treatment of shock;
- treatment of chronic diseases and conditions which, if left untreated, could directly and in a short time-span cause disability, other permanent health damage or death;
- treatment of febrile conditions and prevention of spreading of infections, which could cause septic shock;
- treatment/prevention of poisoning;

- treatment of fractures and sprains as well as other injuries, which require the intervention of a physician;

- subsidized and partly-subsidized medication in accordance with the list of interchangeable drugs, which are prescribed for treatment of illnesses and conditions, listed in previous paragraphs;

3. health care of women: contraception, abortion, health care during pregnancy and after childbirth.

Asylum seekers may claim their health insurance when they become employed. After 9 months of their residency in Slovenia (in case they had not yet obtained decision regarding their application for international protection), asylum seekers may acquire their working permit in accordance with conditions, defined by Act 87 of International Protection Act:

(1) The asylum seeker has the right to free access to the labor market nine months after submission of the application, if he at that time was not served with the decision of the competent authority and this delay cannot be attributed to the asylum seeker.

(2) The asylum seeker shall after the expiration of nine months after the submission of an application have access to vocational training courses in accordance with the rules set out in the fourth paragraph of Article 78 of this Law.

It would be sensible to consider the possibility for the asylum seekers to receive their work permit as soon as possible. Many of them are highly educated or have specific skills. That way, they would be able to work and pay for their health insurance, which would significantly unburden the state budget.

I would like to feel useful and do something

An applicant approached the social worker and started a conversation about the possibility of work.

Asylum seeker: Could you help me? I'd like to do something, something useful, to help somebody and use the skills that I've got. I can't go to work because I haven't been here for nine months yet, but I'd like to occupy myself somehow for the time to pass and for me to do something good for the community.

Social worker: Yes, it's really a problem that you can't work until you've been here for at least nine months. Maybe you could try some volunteer work? Would that be OK with you?

Asylum seeker: Sure, anything. It's a nonsense that I'm forced to become idle and feel useless. Why wait when I can be active and do something for others?

Social worker: OK, I'll check the options for volunteer work. What would you like to do? What can you do best?

Asylum seeker: As a matter of fact,

I don't rely mind doing whatever, I can do physical work, I can teach dancing and skating, I can help with industrial work, which is what I was also trained for. The important thing for me is to become of use for the community and to occupy myself, so that I can get rid of all the negative thoughts filling my head while I'm waiting and waiting.

Social worker: OK, I'll check the options and we'll discuss them.

Act 86 of International Protection Act also defines:

- A vulnerable person with special needs, exceptionally, each asylum seeker is entitled to additional health services, including psychotherapeutic assistance approved and established by the Commission in the fourth paragraph of Article 83 of this Law.

- Children of asylum seekers and asylum seeking unaccompanied children, are entitled to healthcare to the same extent as children who have compulsory health insurance as family members. To the same extent of health care are also entitled schoolchildren under 18 years of age, and by the end of training, but only up to the age of 26.

Children and women with regard to reproduction and contraception have equal rights as Slovenian citizens. Nevertheless, in practice difficulties often arise, either because doctors are not familiar with those rights, or because language improficiency and communication barriers.

Samira is in her late twenties from a Persian speaking country. She arrived in Slovenia with her husband, in her early pregnancy, seven months ago. After her arrival in the centre for asylum seekers, she asked for a doctor examination because she had minor pain in her stomach. The nurse told her this is normal and that they will make an appointment for a sonography examination, for which she waited two months. Luckily, everything went well, but the waiting period was very stressful for her.

The volunteer Ana, a mother of two, helped her with preparations on labour. She explained (with help of an interpreter) to Samira what is going to happen, how it will look like. They even watched the video of a labour together.

Today, the baby boy is 20 days old. She remember that the labour was really long, difficult and very painful, because she got appendicitis after the labour and had to stay in hospital for a longer period than is usual. Samira recalls: *"I did not have an interpreter who could help me express my wishes, concerns about baby's health. The baby had a small outgrow on his finger, which was later removed. I was not able to ask the doctor about the procedure, what I am supposed to do, nor how to take care of it. Soon after the birth, the baby had a disease I could not understand (jaundice), nor was I able to ask medical professionals what was happening."*

When a midwife came to explain her about how to take care of the baby, they couldn´t talk because of the language barrier. Here Ana stepped into the story and told and showed her everything once again.

In terms of health insurance, the asylum seekers who are children and pregnant women are entitled to a full coverage. This is the information the majority of them don´t have. Uncertainty about the baby´s health, the pregnancy after the journey they made, is a tremendously stressing factor, which keeps many mothers-to-be awake at night.

The language barrier is one of the biggest obstacles in situations such as the one described above. Having a first child in an unknown country, in an unknown health system, medical procedures, without the possibility to speak up in a language health professionals could understand and the uncertainty of the child´s foreseeable future is a challenge, which could be facilitated with an accompanying interpreter and/or cultural mediator.

A special commission may help the asylum seekers to acquire a broader scope of rights in the field of health care.

COMMISSION FOR GRANTING ADDITIONAL HEALTH RIGHTS

Within the Ministry of the Interior, a special commission is in charge of granting additional health rights to adult asylum seekers, who only have rights to urgent medical treatment. The commission may ensure access to additional healthcare services in cases, when urgent medical treatment does not suffice and a broader medical treatment is necessary (see section Access to Medical Treatment of Asylum Seekers).

The commission is composed of the representatives of the Ministry of Interior, Ministry of Health, a doctor and a representative of a non-governmental organization.

SOCIAL WORKERS' FIELDWORK REPORT

Jaka Matičič, Urška Živkovič

- - - SUMMARY - - -

This article presents observations of social workers, partaking in the project work, and contains summaries of weekly reports on conditions in asylum centres, admittance of asylum seekers in asylum home and acceptance of asylum seekers by the local population. The purpose of those reports is detection and following special circumstances and needs of asylum seekers. The structure of the article follows the content and structure of the reports.

The integral medical treatment of asylum seekers includes numerous service providers: social and other services of Ministry of the Interior, non-governmental organizations, local community and others. At the Slovene Philanthropy, we organized a special service, the so called mobile unit, which also included services of social workers. In general, we have addressed mostly psycho-social aspects of health assessment processes, which contributed to a broader conception of health and general health condition of asylum seekers. Our work included following the situation of asylum seekers, gathering information on their basic needs, assistance in medical referrals and providing information on their health rights.

PSYCHO-SOCIAL ASSISTANCE AND INTEGRATION ACTIVITIES

The greatest challenge in psycho-social assistance and integration activities is lack of personnel for a concrete work with this particular vulnerable group. Challenges in psycho-social assistance and integration activities are namely connected with execution of concrete activities, since various aspects need to be considered here, such as life situation, flee from their country of origin, long journey and traumatization as a consequence of violence, which many were exposed to in their homeland or on their travel. At the same time, psycho-social assistance and integration activities would

help them to overcome cultural and linguistic differences in the new environment while they are waiting on their international protection.

Long-lasting procedures and rejections of their applications for international protection have an additional negative effect on the already unpleasant situation in which the asylum seekers are in, and on their general wellbeing and health.

Such state of affairs may be attributed to the fact that the approach towards concrete integration is bad. Integration should have been implemented while asylum seekers wait for their international protection, which would alleviate the future integration of persons with international protection, since Integration in fact begins not until a person acquires the status of a refugee or status of subsidiary protection.

During our work, we have noticed that many health issues within the asylum seekers population in fact arise from general ill-being, fears and traumas they carry within themselves. While treating asylum seekers, most often we noticed they have a need for conversation and mental relief. Social workers offered a psychological first aid due to traumas and fear the conversations were often demanding. In providing a broader psychological support, the presence of a psychotherapist and a psychologist working on the project proved to be very valuable, since apart from that, psychi-atrist (contracted by MoI) is only present 2 hours once a week in the asylum home in Vič.

It would be necessary to provide continuous psychological and/or psychotherapeutic assistance and environment in which the asylum seekers would feel safe and accepted. This is namely the basis for a person's well-being and development of a state of mind, needed for initiation of integration process, which can only be successful if an individual is motivated enough to become an independent member of a community as soon as possible and to access services, which the asylum seeker needs in his/her everyday life. The biggest issue is the access to medical treatment services, since according to the International Protection Act and the Health Care and Health Insurance Act, asylum seekers are only entitled to urgent medical treatment. This also means, they do not have the right to choose a personal physician, but instead may only be treated by a doctor on duty. In addition, in order for them to be more integrated and to be able to manage their life situations, asylum seekers would need to be familiar with Slovenian legislation and their rights.

If there is nobody to help them in receiving basic medical treatment in the beginning and later in case of more complex medical issues to help them receiving a specialist examination or admittance to the hospital, this may lead to complications in their psychophysical condition and to deterioration of their well-being, as this is very often the case at the moment.

At the moment, there is one social worker working in one shift at units of Asylum home in Kotnikova and Logatec, where there are

between 50 and 70 asylum seekers (the personnel is being provided by the Ministry of the Interior). In the asylum home in Vič the situation is no different. In comparing this to other programs, funded in the field of social care in 2016, we may establish that the programs require one social worker to continually work with 8 to 25 regular users of the service. During our work with asylum seekers, we have come across cases, which can be categorized into several different groups of vulnerable people, therefore, for the purpose of working with asylum seekers, we propose professional staff, skilled in the field of social work with asylum seekers and with vulnerable groups to be provided to 20 persons at the most in order to ensure successful work in the field of psycho-social assistance and prevention of health and social risks. We believe the suggested ratio (i. e. one social worker pro 20 asylum seekers) to represent the maximum possible efficiency, considering the complexity of work with such vulnerable group, which includes not only traumatized individuals, but also other vulnerable groups, such as physically impaired, the elderly, victims of violence, children, etc. Of course, difficulties in communication due to language and cultural differences, which demand additional time and engagement by the professional worker, also need to be taken into consideration.

Information flow is also of key importance, although it is generally impeded, because most of the information on the health of asylum seekers remain in hands of one professional worker, while an efficient work requires a complete knowledge of the asylum seekers' health situation. It often happens the medical record stays with social workers in the asylum home and that asylum seekers visit a doctor without bringing it with them. A more systematic information flow would ensure a better medical treatment as well as any further treatments of the asylum seekers' condition.

Specialist examination, July 2016 - issues with transfer of information

After a girl has been examined by a specialist, the nurse stepped up to her family and shared the information about the girl's condition with her family and a social worker accompanying the family.

Nurse: There, the girl has been examined. So far the doctor hasn't noticed any risks with regard to her condition. If her condition deteriorates, come again, otherwise you have your next appointment in two weeks.

Social worker: So the doctor couldn't find anything wrong with her?

Nurse: Yes. Next time bring another reference letter because this one was urgent and is only valid for 24 hours. Try to get a reference letter, which will be valid for a longer time period. Oh, that's right, she won't be able to get it because she isn't entitled to it.

Social worker: Really? I didn't even know this one is valid for such a short time. But we can get a reference letter,

which will be valid for a longer time period, because children of asylum seekers have equal medical rights as children of Slovenian citizens.

Nurse: I'm not sure if this is true, they are not Slovenian citizens.

Social worker: Miss, this is definitely true. It is defined by the International Protection Act.

Nurse: Boy, you sure are fervent. Why don't you wangle me some good specialist check for my problems ...

Social worker: What about the results? How are we to inform the doctor on the findings?

Nurse: Hold on a second, we'll ask the doctor.

ENTRANCE INTO THE DOCTOR'S OFFICE

Social worker: Doctor, what about the girl's results? The doctor in the asylum home will want to know, what's her condition like, because he's monitoring her health.

Doctor: We will send the results there.

Social worker: Do you have any address? It is our first time here, so we haven't managed to exchange any contact data.

Doctor: We'll send the results to the pediatrician in Logatec and let this doctor call him, if he will need the information.

Social worker: Thank you and goodbye.

REPRESSED EMOTIONS AND PASSIVENESS

We have heard many sad and painful stories during our work. Conversations with asylum seekers revealed to us their emotional condition. In the beginning they told us their stories with tears in their eyes, thinking about their home, family and friends, who were left behind. Some of them did not and still do not know, what happened to their relatives, if they are alive and whether their cities and homes are still standing. They are deeply worried, because they have not received this information, which adversely affects their general and health condition. Some of them received the information on their families and home some time later. If the information they received was encouraging, their health condition greatly improved. The opposite was true for those, who received information on the death of their friends and family. The most difficult find it the ones, who know something had happened, but are not sure about the outcome of the events.

Let me go home, please - illustration of mental state of asylum seekers due to long wait

Unpredictability of the situation in which asylum seekers in Slovenia find themselves in is starting to eat away their well-being. Some of them were forced to apply for international protection one way or the other, since the system did not offer any other solution. When they are disappointed to see that the situation in the country of their refuge is not any better for them then in their homeland, many asylum seekers resign themselves to their fate and accept the fact they will not have it any better here than at home. They also feel unsafe and in the end many decide to return home despite the danger. Nevertheless, the procedure for returning is equally lingering and leaves a person uncertain, just the same as people are insecure and worried when waiting for their application for international protection to be resolved. One of such was the case of a man, sitting outside alone and gazing into distance. When a social worker approached him, the man addressed him.

Asylum seeker: Everything is the same as it was six months ago. Children are playing like they played six months ago and I received a telephone call that my mother died. What am I even doing here? I am ill myself, my father back at home is also very ill and there is no one that could help him. I am stuck here. Let me go home as soon as possible. My home is in my country. Please, don't let my father die while I'm waiting here to be able to get back home.

Long-running procedures of assessment of eligibility of their request for international protection drives these people into passiveness. Even those, who were convinced nothing can break them and showed optimism and shared some creative insights on the matter, later became very passive. Their motivation for activities in- and outside of asylum home had dropped significantly. Participation in activities, which could at least to some extend avert their negative thoughts, is less and less effective and is dropping in spite of initial interest.

It's my birthday, but I'm not happy

Social worker ran into one of the asylum seekers and started a conversation with him, since they have a good relationship and like to talk to each other.

Social worker: Hey, how are you today, good?

Asylum seeker: It's my birthday, but I'm not happy.

Social worker: Happy birthday! What is troubling you, can I help in any way?

Asylum seeker: My wife is crying because everybody here received their status and are leaving the asylum home. All acquaintances we made here are leaving, while we are still here waiting, not knowing what will happen to us. All I wish for my birthday is for my family to be happy. I'm very grateful for everything you do for us. But I also wish for the sadness and crying to stop.

Social worker: Things will get better, you'll see. Today is your birthday - use it for making your family happy, you are good at that.

Asylum seeker: I'm trying, but it doesn't help and I'm also worried people sometimes understand us the wrong way. Everybody says how lively and disobedient my daughter is, but nobody knows how was it like in my country. There she couldn't play the way she can here - outside the house, playing with other children. Because of the danger she couldn't leave the house and became very passive. Here she can go out and play all kinds of children's plays. Here she can experience childhood, she hadn't had before. That's why she is so vivacious, because she couldn't be like that before we came here. But some people don't understand that.

Social worker: Then take a rug and go outside with your family. Go for a walk and make a picnic in a glade. Have a little celebration. You'll feel much better when you'll be together, you'll see.

Asylum seeker: I'll try, you're probably right, this could help.

ACCOMMODATION

The rooms are too small for the number of accommodated asylum seekers. In some cases there are different families living in the same room, divided in half by a curtain, which does not ensure any privacy. The rooms are not suitably equipped for winter cold or summer heat, since the building itself is not sound- and heatproof and there is no air-conditioning. Heat in the summer and cold due to insufficient heating in the winter is having a stressful impact on the residents. Such factors often have a negative influence on a broader aspect of psychophysical well-being and health. The same applies to lack of privacy, which causes numerous cultural clashes and disagreements between sexes.

The location and the structure of the building of Asylum home and its units has a significant influence on the social exclusion of the asylum seekers, resulting in poor integration in the local community as well as access to services, needed for a quality living - clinics, schools, etc. In the Asylum home in Vič and in the unit in Kotnikova those issues are not as prominent as they are in the unit in Logatec, where accessibility to public infrastructure is poor. The same applies to access to medical facilities, which can be especially problematic in winter when cold and respiratory disease rates are higher than usual, which can present a higher risk for their health.

INFORMATION AND COMMUNICATION

Upon their arrival, asylum seekers very often had a limited access to information and appropriate means of communication. Translations of official procedures and

guidelines for understanding their situation are improving, nevertheless the asylum seekers are still not receiving enough information for them to function independently without the help of others. Despite the attempt of local residents to provide them with internet access asylum seekers, residing in asylum home in Kotnikova, obtained their internet access late this year. Besides costly cross-border telephone charges, internet represents the only means of communication with their relatives. When internet access had not been available to them, asylum seekers felt severely frustrated and helpless, since they did not know what was happening to their family. Visits to the doctor were more frequent. It is difficult to describe those kinds of issues, but due to uncertainty of their condition and the situation of their family, which stayed at home or were still on their way to Europe, asylum seekers were in need of intensive psychotherapeutic or other form of treatment. In most cases, such treatments are very difficult for those implicated due to various issues, such as language barriers, cultural and other differences.

Communication with the local community is also impeded, because institutions in which they reside are dislocated and closed, forcing the residents into a slum-like lifestyle, associating only with their kind and not being able to come in touch with reality outside their four walls. This hinders the possibility of integration and independency within the local community.

Contact with the »real« world and mobility within the local community have a positive impact on their well-being. Participating in community services, in which asylum seekers sincerely wish to partake in, would enable them to feel they are doing something purposeful. At the same time, this would improve the public conception of them, which is mostly based on prejudices and fear.

Poorly informed local population and various public services are having an impact on access to different services, such as access to pharmaceuticals, medical treatment or simply living in the community. Asylum seekers are living in a closed institution, separated from the local population. Such state of affairs leads to misconception of the local population with regard to their situation and status, making asylum seekers frequent targets of verbal abuse, occasionally also of physical violence. A conception of asylum seekers' situation is created by the public opinion, which is in one way or the other manifested in form of a negative perception.

Visiting the pharmacy, May 2016 - example of expressing contempt in public

A volunteer went to the pharmacy with one of the asylum seekers to show him around so that he would be able to find it by himself the next time. She led him to the counter to buy medicine he needed. Because the whole situation was entirely new for him, the volunteer explained him how the health and pharmaceutical system works in Slovenia. Meanwhile, the pharmacist stated

that Hitler knew how to handle such specimens when he wiped them out of Europe, because this is not a place for them. Upon receiving the medicine, the volunteer and the asylum seeker indignantly left the pharmacy.

Within the institutional system, asylum seekers are subjected to numerous complications due to poor information and non-communication, developing as a result of cultural differences, which we are not sufficiently familiar with as we perceive them as a standard practice. In reality it is evident that precisely because of those differences asylum seekers are exposed to unnecessary rule restriction and mobbing, which in the long turn negatively effects their well-being. For instance, complications with regard to use of bathrooms, kitchens and other public surfaces often lead to a state, when nobody explains to what is the appropriate way of using them and then due to incorrect use the rules get restricted, which results in prohibition of using the kitchen, cancelling separate meals in time of fasting, sometimes the rules are being restricted simply due to bad mood and hard feelings for which asylum seekers are being blamed, because they did not use toilets according to our standards with which they themselves are not acquainted with.

Other information is insufficient and is not complete as well. At the moment, asylum seekers still do not have sufficient information with regard to access to medical treatment, on dangers and possibilities of infections, present in the EU and Slovenia (for instance tick-borne diseases in Logatec, with which they are not familiar at all) and on local medical standards hygiene, illnesses rates, treatment, operative procedures and medication therapies. Receiving those information would significantly lessen the possibility for additional medical complications.

Complete and concrete information is also needed for breaking stereotypes of asylum seekers and for dispersing fear of the local population from accepting asylum seekers into the local community. Very often, lack of information on the asylum seekers leads to a negative public opinion, due to which the local population has a negative and hostile disposition towards them. This is making the integration in the community difficult and has a negative impact on the asylum seekers' well-being.

POLICE SURVEILLANCE AND SAFETY SERVICES

Although the asylum seekers are relatively free to move around the territory of the Republic of Slovenia, they have often been accompanied by police forces. In Logatec, where only families are accommodated, we have several times witnessed police patrols escorting the asylum seekers on their walk through the village from the place of their encounter right up to their intended destination. At times the asylum seekers tell us about such events. In other locations the police forces are exercising continuous control. Such occurrences

leave unpleasant feelings and surely do not contribute to integration of asylum seekers into the local environment. Safety services in charge for providing security of asylum seekers and visitors of the Asylum home are sometimes exhibiting violent behavior towards the asylum seekers, which indicates an overload of security services, since it is evident that the current situation exceeds staff efficiency needed for a quality work of the personnel and for the treatment of asylum seekers. We have also witnessed cases of minor mobbing and inappropriate treatment by the security guards when this was unnecessary and when the asylum seekers could have been treated differently. Although this is a minor part of the whole situation, such actions never the less have a negative impact on the well-being of asylum seekers, who are already in a unenviable situation.

ASSURANCE OF APPROPRIATE DWELLING STANDARDS AND BASIC NEEDS

Clothing for asylum seekers is mainly acquired through donations, which are most welcome but do not always provide what they truly need. In asylum homes, some asylum seekers were frequently given clothes that did not entirely fit them. Some of them did not manage to acquire clothing and footwear suitable for wearing outside the asylum home in spite of many months of searching through the donations. Before they went to school, juveniles and children expressed their fear several times about what their peers will think of them if they will see them wearing unfit clothing. There are also several seniors, who used ropes and similar accessories instead of belts in order to be dressed at least roughly decent for them to be able to walk in public, but the unsuitable clothing nevertheless had a negative impact on their self-image. Clothing, which does not meet social standards, causes fear of contempt, stares of amazement and social exclusion.

Asylum seekers have no umbrellas, unless they buy them themselves, and are practically forced to stay indoors in case of bad weather. Such a small matter is the cause of their increased social exclusion and at the same time is preventing them from attending activities outside the asylum home, which could beneficially influence their well-being. That way, rainy days are even harder to overcome.

DIET

Asylum seekers are entitled to three meals a day, with the exception of children, who receive five meals a day. The food they get is not suitably adjusted to their dietary habits, which results in numerous health issues and gastric disorders. Appeals for introducing foods which suit their dietary habits (more rice and spices they are accustomed to use) bore some fruit, although in time the situation worsened again. With the appropriate diet numerous health and

dental issues could have been avoided, for instance constipation, diarrhea, abdominal pain, gingivitis, toothache, malnourishment, anemia and other conditions, which are troubling children and young mothers and are very common. Examples of inappropriate nourishment are the so called lunch packages, given to them at weekends (during the week asylum seekers receive cooked meals), which mostly contain foods with high content of sugar and salt - chips, sweets.

Most of the asylum seekers would like to cook for themselves and be able to prepare food best suited for their dietary habits and digestion. In asylum homes, there is some possibility of food preparation, but the kitchens are small and not suitable for food storage or meal preparation for a larger number of people. From the food they receive, mostly they express the need for rice, vegetables, black tea and spices, which they are accustomed to use.

Cooking would also enable them to maintain their everyday activities, which would have a beneficial effect on the general well-being, health and family care. Institutional arrangement of the accommodation and diet dispossessed them of their everyday-life activities. Such state of affairs forces the asylum seekers to become passive, unmotivated and helpless, which additionally increases their concerns and anxiety.

SYSTEMIC ARRANGEMENT OF MEDICAL TREATMENT IN COMPARISON TO MEDICAL PRACTICE

In practice, there are issues appearing with the administrative treatment of asylum seekers within the health institutions, even in treatment of pregnant women and children, who according to the law have equal rights as Slovenian citizens.

Asylum seekers card is used for identification and also serves as health card. Due to disorganization of the system (which is probably a result of interministerial discrepancies between the Ministry of Health and the Ministry for Foreign Affairs, which is in charge for managing the functioning of the asylum home), there are cases when upon visiting a medical institution, asylum seekers do not know how to acquire medical examination and the medical personnel, responsible for administrative treatment prior to the examination, does not know how to record them into the system, which is constantly up-dated and designed for registering patients with a health insurance. Due to lack of information on asylum seekers' health rights, it also happens that their request for medical treatment is denied. Most frequent issue is misunderstandment and disinclination of the medical personnel, who does not know how to treat asylum seekers and which services to provide to them.

Appointment for a specialist examination, June 2016 - issues with ad-

ministrative treatment

Caller: Hello, I am a social worker calling on behalf of a boy from the family of asylum seekers. I would like to appoint the boy on a specialist examination at your clinic, where he had been referred to by a pediatrician from a local health centre.

Nurse: His health insurance number please.

Caller: Miss, since he is an asylum seekers, he has no health insurance.

Nurse: Mister, we cannot make an appointment if he hasn't got his health insurance. This is impossible. Does he even have a medical card? Who is the obligor in this case?

Caller: Miss, he is a minor and an asylum seeker and as such he is by law entitled to the same medical rights as Slovenian citizens. He has an international protection applicant card, which is an ID and a medical card at the same time. He also received a reference letter by a pediatrician, where it states that the obligor in this case is the Ministry of Health, which is obliged to pay the expenses of the treatment.

Nurse: But how am I supposed to know this? We haven't received any notice on the matter. We called the Ministry, but nobody answered.

Caller: This is precisely why I am explaining this to you, because the ministry ensured us to pay for the treatment.

Nurse: Listen, I know nothing about that. Let me put you through to a doctor.

PUTTING THROUGHTO THE DOCTOR

Doctor: Hello.

Caller: Hello, the nurse has put me through to you to discuss the appointment for a specialist examination of a boy from the asylum home, whose family is applying for international protection in Slovenia. He needs a specialist examination, for which he received a reference letter by a pediatrician from a local health centre.

Doctor: Yes, yes, talk to the nurse about that.

Caller: But the nurse have put me through to you, because she doesn't know how to arrange this matter and told me to talk to you and ask you, if this is possible, which it is since children of asylum seekers have equal medical rights as Slovenian citizens.

Doctor: Yes, this is true. Tell the nurse to make an appointment.

Caller: Thank you.

Doctor: Goodbye.

Caller: Goodbye.

PUTTING THROUGH BACK TO THE NURSE

Caller: Hello, the doctor said you may arrange an appointment for the boy.

Nurse: But sir, I don't know which number to enter into the record. I can't make an appointment if I have not got his number.

Caller: Miss, I am not familiar with how the system in the health centre functions, but that boy really needs this examination.

Nurse: I understand, but we received no instructions on how to act in this situation.

Caller: Then contact the ministry, I have already told you what to do, but if you like we can give you the number of the ministry in charge.

Nurse: No, no, let the doctor deal with that.

Caller: Have you made the appointment then?

Nurse: I don't know, I'll just make a separate notice somewhere and we will keep him in mind. When would you like me to make an appointment, in the morning or in the afternoon?

Caller: If possible in the morning, because it is easier to get transportation in the morning.

Nurse: OK. He should come on the chosen date and make sure he brings his reference letter and please enclose that number of the person from the ministry you were talking about. We will somehow deal with that later on.

Caller: We will. Thank you for your time and kindness. Goodbye.

Nurse: Goodbye to you too.

During our project work, we have also come across complex issues of patients with chronic diseases. They require regular medical treatment and access to medication (in cases of patients with heart disease or diabetes), but the system is not allowing it, which may lead to deterioration of the patients' medical condition and feeling of well-being. Every further visit to a doctor in order to acquire medication is demanding and in certain cases even impossible without the help of social and other workers, who offer help in mediation, logistics and other activities for preventing the worst case scenario.

Cronical problems and lack of regular medical tretement

Vladimir is 56-year-old Russian man who lives in Slovenia for five months now.

He has chronical cardiovascular problems. Doctors at home prescribed him daily usage of medicines for the rest of his life.

His problems started six years ago due to his highly stressful profession and adrenaline sports activities. It all started with a heart attack, which was followed by another. His friend who is a doctor advised him a surgery, which he had in Moscow.

In Slovenia he has problems with access to urgently needed medicine. If he notices that he is slowly running out of them, he has to go to a nurse in another unit of asylum centre who appoint him to a doctor on duty. He never knows how long will he have to wait to see a doctor – it happened before that he had to wait for two weeks. Since doctors on this position are changing on a daily basis, he has to explain what he needs and why he needs it to every one of them. Also, the doctor is a general practitioner not a specialist and does not follow his condition. Vladimir had a specialist check eight months ago and if his health doesn‘t deteriorate in the meantime, he should see a specialist no sooner than in one year‘s time. He is worried how this will be possible here, if even getting the medicines is complicated.

His story is a good example of insufficient health care available to asylum seekers in Slovenia. Asylum seekers are entitled to a specialist visit only in case of life threatening condition or if a special commission in asylum centre approves their written request. This procedure can be long, which is a problem especially for people with chronical conditions who need a regular and consistent medical treatment which needs to be monitored. He also doesn‘t have the right to choose a personal phisician, who would monitor his condition regularly and appoint him to a specialist. He can only visit doctors on duty and every time this can be a different person. His treatment starts from scratch every month and is based only upon on his words, not on a specialist's opinion, which may result in unnoticed slowly progressive changes in his condition. At the same time, it is highly possible that he will run out of his medication before he will get a new prescription, which just adds to the the overall inconsistency of the treatment.

All this, together with his highly unpredictable life situation while waiting for the answer regarding his international protection, is definitely not improving his health.

Vladimir recalls how it was in Austria, where he got an appointment at a specialist right away and got the prescription for the medicine for a longer time period. It would be a good idea to learn from their example of good practice.

DENTAL TREATMENT

In asylum seekers population, there is a prevalence of dental problems, which is a result of various factors, improper diet being one of them. With persons, treated as long-running asylum seekers (on aver-

age 6 months, sometimes one year), the biggest issue is they are only entitled to an urgent dental treatment, which means that either a tooth is extracted, or a dental drill is being made without filling the tooth afterwards. The exposed tooth presents a possibility for development of further dental problems and a general deterioration of asylum seeker's health condition.

Ayesha is a mother of a few-months old baby boy and has problems with her teeth. She was reporting her problems to the nurse in asylum centre since she arrived in Slovenia, which was approximately eight months ago. All she received were painkillers. When the pain worsened, she went to see a dentist, for which a nurse notified the health centre. Because the asylum seekers do not have their personal dentist, she had to go to the dentist that was on duty that day. The volunteer accompanied her.

Teeth problems are one of the most common health problems reported by asylum seekers. One of the challenges of providing adequate dental services is communication. Not everyone has the chance of being accompanied by an interpreter. If they are lucky, the volunteer can go with them. In Ayesha's case this resulted in treatment of the wrong tooth. She was too embarrassed to speak up, the volunteer was also very angry, but she didn´t do anything.

"When the next toothache began, the pain was tremendous. I was crying, I couldn´t sleep – the pain was strong as when I was in labour. I took six painkillers (4 Lekadol and 2 Nalgesin), but told the nurse next day that I only took two. My baby, whom I breastfed, slept for two days. I am certain that this is because of the medicines. I went to the dentist, who pulled the tooth out. I had to sign that I agree with the procedure, even though I didn´t understand what I was signing."

Wih regards to dental problems, the stories are mostly all similar, as asylum seekers have rights only to urgent dental care. This influences the asylum seekers' personal life in a broader sense. They are aware that they will be given only painkillers until the pain is so strong, that the tooth has to be pulled out.

In Slovenia, healthcare insurance for asylum seekers covers only life-threatening conditions. Toothaches, no matter whatthe cause or strength of it, are treated in the same procedure: *˝It´s always the same.The dentist opens and cleans your tooth, does the temporary filling, which falls out in few days. When the pain returns, you visit the dentist again, who pulls it out.˝*

Health problems add additional challenges and stress to the long waiting for international protection decision. The basic healthcare insurance with a basic preventive and curative health treatment would make numerous lives easier.

Note: The stories and testimonies in the publication were collected by social workers on the project.

PROJECT WORK - HEALTH ASSESSMENT OF ASYLUM SEEKERS

Lea Bombač, M.D., Špela Brecelj, M.D., Helena Liberšar, dr. Erika Zelko, F.M.M.D.

- - - SUMMARY - - -

This article introduces an insight into project work, during which we have offered health assessment to asylum seekers, whose rights to medical services in Slovenia are limited. We will present our personal opinions on dilemmas and possible improvements of current medical treatment available to asylum seekers.

INTRODUCTION

With closure of Balkan route in March 2016, medical needs of refugees have changed. This also applies to methods of medical treatment and attendance to migrants' medical needs. Those who stay in our country and apply for international protection are treated as asylum seekers, which means they have limited rights to medical services. Before the closure of migrant routes, there was an increased need for treatment of wounds, injuries and dehydration. Such cases are seldom at the moment, instead a need for a more extensive medical treatment has appeared, including treatment of chronic non-infectious diseases, which are not considered emergency cases.

At the moment, there are approximately 300 asylum seekers in Slovenia, which counts 1 refugee on 7000 Slovenian citizens. Asylum seekers are accommodated in the Asylum home and its units. As a team of medical coordinators participating in the project work, executed by Slovene Philanthropy and Doctors of the World (8 NGO's for migrants/refugees' health in 11 countries), we strived to provide a more extensive health assessment to asylum seekers, since according to law they have a very limited access to medical treatment. The team consists also of 3 medical coordinators, we communicate

with asylum seekers with help of Farsi and Arabic interpreters and an medical assistant ensures that the work is carried out without complications. We work in all three units of asylum home: in Vič and Kotnikova (Ljubljana) and in Logatec.

We provide 26 hours of health assessment a week, asylum seekers are assessed in an improvised rooms, we have only basic instruments at our disposal. Assuring health assessment is a demanding task, especially since it involves treating a distinct population, vulnerable people, who require a more attentive approach. Our work often demands a great deal of improvisation and flexibility.

As the project is coming to its end, so does a more extensive health assessment and a more efficient communication with the asylum seekers in sense of providing for their health needs while they are waiting for their status acquisition. Number of asylum seekers is increasing and a new wave of refugees is anticipated, therefore we would wish to contribute to an effective and continuous medical treatment of asylum seekers in the future, as well as ensure that treating asylum seekers in community health centres wouldn't cause any complications, delays of examinations due to solution seeking and would at the same time enable asylum seekers a proper medical treatment.

WORK PROCESS

Asylum seekers in need of health care first go to a clinic in the asylum home in time of working hours or made an appointment with staff who provides information regarding work of the medical staff in the institution. In case of language proficiency (Slovenian, English, Croatian, Serbian), asylum seekers come and talk to us by themselves. In case of communication barriers and language improficiency, a translator is present at the visit (exceptionally we use translation services via telephone or internet). Work is very diverse. We assess everyone in need of medical attention by listening, assessing them with basic instruments and discussing their issues.

Before directing a patient in need of laboratory examination, further diagnostics or further referrals to a health centre, we contact the doctor on duty or a nurse in health centre and arrange an appointment for further diagnostics and appropriate therapy in case this is needed and is considered part of urgent treatment.

With help of translators we prepared a record of asylum seekers' health condition in order to avoid language barriers during the examination in the health centre. It is preferable for asylum seekers, undergoing an examination at the general practitioner or at the specialist, to return with all results and to be acquainted with the type and characteristics of their disease.

We help asylum seekers to receive their medicine as soon as possible. In case when they need further examination outside the asylum home, a transport to health institution has to be organized and a translation service needs to be provided (when trans-

lators are available). Translators usually alleviated work, but communication barriers nevertheless remain an issue, mostly with regards to understanding asylum seekers' health state.

MEDICAL TREATMENT AND HEALTHCARE OF ASYLUM SEEKERS AS DEFINED BY LAW

In the Official Gazette, Article 78 of International Protection Act (chapter Rights and Obligations of Applicants for International Protection) states that an asylum seeker has the right to urgent medical treatment in place of his/her admission. Free medical services available to asylum seekers are defined in Article 86 of International Protection Act. Children of asylum seekers (up to age 18) and asylum seeking women have somewhat more rights, regarding specific medical conditions. Children of asylum seekers have equal rights as children of Slovenian citizens. Pregnant women have equal rights as pregnant Slovenian citizens, the same applies to breastfeeding women. Female asylum seekers have equal rights as Slovenian citizens in field of family planning and reproductive health. Measures of ensuring health care of asylum seekers are defined in Rules on the Rights of Asylum seekers, measures for ensuring patient care of asylum seekers are defined in Article 17 (according to statutes, valid in time of project execution, new regulations are in preparation -Ed.).

WHY IT WOULD BE SENSIBLE FOR ASYLUM SEEKERS TO HAVE A PERSONAL PHYSICIAN

- Since his arrival trough Austria to Slovenia, a 37-year-old man is complaining of a recurring abdominal pain. He was examined by different doctors in different locations, there are no records of his medical treatment. One evening he was brought to the ER due to unbearable pain. Since there were no medical documents and records of his existing treatment available, medical staff in the ER treated him without any knowledge of his medical condition. Language barrier was an issue as well. His treatment had to once again start from the very beginning. He underwent different medical imaging, but results showed no signs of disease. Upon his discharge, he received instructions for a diet for irritable bowel syndrome. We explained the instructions in detail to his wife. His condition improved considerably. If the asylum seeker had a personal physician, he would have received instructions for the diet sooner and the costs of expensive medical treatment could have been avoided.

- 35-year-old asylum seeker is suffering from nasal congestion. At first it seems as if he has a cold, since he is always wearing lot of warm clothes, but assessment of his health condition showed symptoms similar to that of hay fever. The asylum seeker tried different

treatments (nasal irrigation, vitamin C supplements), but his condition did not improve. Different doctors recommended a different therapy, according to their knowledge and information they received from the asylum seeker. It is not known which medicine the patient took. He was not referred to a further examination, since his condition is chronic, supposedly lasting for several months now, possibly even several years, but we do not know for sure due to communication barriers, because there is no interpreter available for the language he speaks.

- 20-year-old asylum seeker is suffering from migraine headaches for approximately 12 months now. Headaches appear weekly, last for several days and disappear spontaneously. His last headache lasted for five days, analgetics did not seem to relieve the pain. His mental state was altered, he was referred to a health centre and from there further to a hospital treatment, where additional examinations showed he was having a migraine attack. A personal physician would have been able to monitor his condition and would have known that his attacks usually begin with these symptoms, therefore he could have treated him with an appropriate anti-migraine therapy and costs of additional treatment could have been avoided.

- 8-year-old child is suffering from cerebral palsy and epileptic seizures since his second year of age. He would require a personal pediatrician to monitor his condition and if needed to arrange referrals for a specialist examination, appropriate therapy and obtainment of a wheelchair. It would be much easier for the boy, his family and doctors, if the boy would be monitored by a single physician. This way his family would not need to explain his condition to different translators and doctors all the time.

- 29-year-old asylum seeker is suffering from rectal pain and is experiencing bleeding from the rectum, presumably due to haemorrhoids. Until now, he visited different clinics and received haemorrhoid treatment, but his condition did not improve. He did not know which medicine he received, he had no medical results and was not referred to a further examination, since his condition was not considered urgent. A proctology examination showed no signs of haemorrhoidal disease, instead he was diagnosed with intertrigo (i. e. inflammation of skin folds). The affected area is painful, bleeding and gives false impression of haemorrhoids. To improve quality of the life, skin folds ought to be surgically removed. The skin folds are now enlarged and chronically inflamed, the patient cannot sit, walk or lie down, but the inter-ministerial commission declined the request for funding the operation.

DILEMMAS AND PROPOSALS FOR CHANGES IN TREATMENT OF ASYLUM SEEKERS

Limited rights to medical treatment put asylum seekers in an unenviable position, especially because it may take many months or even years for them to obtain international protection. They might live in Slovenia for several years and during that time they will only have rights to urgent medical assistance, with the exception of children and particular categories of women. Another issue is there are no rules, official procedures or guidelines on how to provide medical treatment of asylum seekers. In order to make admission and treatment of asylum seekers more transparent, ministry and health centres made an agreement, according to which a referral is to be made for an asylum seeker prior to an examination, or a doctor on duty is to be informed of the asylum seeker's arrival. Social worker or healthcare professional from the Asylum home can call and appoint asylum seeker to appointed health centre. Asylum seekers from unit of asylum home in Vič are referred to Health centre Vič-Rudnik, asylum seekers from unit of asylum home in Logatec are referred to Health centre in Logatec. However, it is more difficult to establish a suitable co-operation for asylum seekers from unit of asylum home in Kotnikova - they are being referred to the General Urgent Medical Assistance (GUMA), which provides an urgent medical assistance and is therefore not the most convenient location for treating asylum seekers. It would be significantly more suitable to establish co-operation with nearby Health Centre Metelkova, where asylum seekers would be treated by doctor on duty, in accordance with prior appointment.

Currently, entire management and execution of medical activities is being run by a nurse in unit of asylum home in Vič, which is inconvenient for those who are accommodated in other units of asylum home - asylum seekers from unit in Kotnikova or from unit in Logatec cannot use services, provided by the nurse in Vič. If an asylum seeker from unit in Logatec falls ill, he/she will not go to see a nurse in Vič and after that a doctor in Logatec. Consequently, the responsibility for managing medical affairs falls on shoulders of staff, unqualified for administrating medical activities - most often on social workers. Definition of urgent medical assistance, as defined by law, is inexplicit and therefore enables various interpretations. Furthermore, in comparison to Slovenian citizens, in the first 9 months after their arrival asylum seekers are unable to engage in substantial gainful activities, which would enable them to pay for health insurance or medical services. Asylum seekers would require at least a basic health insurance. This is not about granting asylum seekers above-standard treatment, unavailable to Slovenian citizens - it is about the importance of providing a basic health care and human dignity to asylum seekers in need of medical services. A more extensive medical treatment of asylum seekers would also unburden the system, for instance on-duty services. In executing requests, the inter-ministerial commission

(see page 17) focuses solely on urgency factor, nevertheless the quality of asylum seekers' lives is greatly diminished by non-urgent medical states as well. Second issue is that even when the commission grants additional medical treatments, there are no clear criteria for selecting a service provider.

Therefore, it would be necessary:

1. to employ a medical coordinator at national level to ensure continuous medical treatment and supervision of asylum seekers' health conditions. The coordinator would also manage the information flow between different services, functioning at different levels and participating in health care of asylum seekers and - in broader sense - of migrants;

2. to employ a family practitioner, integrated in the system, qualified for working with refugee population, with a suitably equipped clinic, a basic medical team and a translator. Such treatment would offer asylum seekers a primary health care and in particular cases a specialist examination if approved so by the commission, provided the asylum seekers are not already entitled to specialist treatment (pregnant women, breastfeeding women, children).

3. to improve referral system. In case a general practitioner issues an urgent referral, a patient uses the service as a citizen. In case a general practitioner issues a cursory or regular referral, inter-ministerial commission assesses, whether the services will be approved. The current legislative does not explicitly define, whether a patient who was referred to further examinations by a general practitioner needs a reference letter (reference letters are being managed by Health Insurance Institute of Slovenia).

4. to define, whether asylum seekers whose referral have been approved by the commission ought to be placed on a waiting list (waiting lists are being managed by the Health Insurance Institute of Slovenia).

5. to set deadlines for issuing request approvals by the commission, e. g. 7 days. Current system of informing is not functioning well. Some asylum seekers can wait up to several months for an answer, during which time nobody knows, when the commission will have been in session.

6. to ensure an active participation of the inter-ministerial commission. The commission should establish clear distinction between urgent and non-urgent medical services - the latter should be financed by the Ministry of Health. The commission should asses the requests prudently, namely if the commission would approve every request, there would be no need for its services in the first place.

7. to establish a systematic method of informing asylum seekers of patients' rights and obligations, concerning different possibilities for their treatment, possible complications and functioning of our health system. This is crucial, since dur-

ing medical treatments there is not enough time to acquaint asylum seekers with all the information they need.

8. to prepare clinical pathways for taking measures in case of infectious diseases (e. g. tuberculosis, HIV, hepatitis, STD).

9. to define guidelines and methods for treating mental illnesses, including addictions.

10. to prepare simple leaflets in languages asylum seekers understand. The leaflets should contain explanation on how our medical system functions and which rights and obligations in terms of medical are available to them.

11. to employ a nurse in all units of asylum home (for a full-time or at least part-time position). For instance, a nurse would execute preventive measures, educate asylum seekers, distribute and store medicine, attend to non-complicated health issues, maintain contacts with physicians and arrange referrals.

12. to enable asylum seekers to choose a personal physician, pediatrician and/or gynaecologist at their local health centre - this is crucial, since some asylum seekers live in the asylum home for many months or even years. Such measure would ensure monitoring their health condition, storing their medical documentation, referring and supervising all in one place.

CONCLUSION

In the course of our work and project execution, we established good connections between our team and medical teams in community health centres. In the future it would be necessary to determine measures and activity procedures as well as to define guidelines for medical treatment and patient care of asylum seekers, since there are none to follow at the moment.

MENTAL HEALTH CARE OF ASYLUM SEEKERS

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- - - SUMMARY - - -

This article introduces our personal opinions with reference to dilemmas, regarding mental health care of asylum seekers, and discusses some suggestions for its improvement. During our project work of providing health assessment to asylum seekers some of the most common health issues we noticed were depression, insomnia, anxiety and somatic symptom disorders, such as headaches, unexplained pain and nausea.

Insomnia and nightmares

Even the strongest men can break when they see asylum seekers, who had been transferred to the Republic of Slovenia under yearly quota, receiving a reply with regard to their application for international protection in one month. When some must wait several months for first interviews in order for the procedure to even begin, the feeling of insecurity does nothing but increase. Insomnia is just one of the consequences.

One of the asylum seekers regularly went out in the middle of the night, since he could not stop thinking about what will happen to him. Bad mood and insecurity started affecting the relationship with his wife and son. The child started waking up from nightmares in the middle of the night. While an adult, receiving appropriate psychotherapeutic treatment, might recover from the traumas, it is much harder for a child, witnessing discontent of their parents and experiencing stressful events in the most sensitive years of their personal development, to overcome these long-term consequences in the coming life situations. We may only guess, what will happen to this family in the future.

Situation in which they found themselves in (state of war or state of crisis in their homeland, death of family members and friends, exposure to violence, torture and

terrorist attacks, loss of home, family and social network, exhausting journey, uncertain future) makes mental state of asylum seekers one of the most critical aspects of health. Accommodation in country of their arrival and applying for asylum does raise some hope in the beginning, nevertheless during their stay in the asylum home asylum seekers encounter new stressful situations, for instance social isolation, financial insecurity, loss of their role in society and family, limited access to health care, work and activities, which give one a sense of dignity, purpose and hope. According to experience we acquired during our work with asylum seekers, we believe applying measures for preservation and improvement of mental health of this population is one of the most crucial preventive measures in field of health care. To prevent secondary traumatization and development of mental illnesses, »self-treatment« with psychoactive substances, as well as somatic symptom disorders, developing as result of imbalance in the psycho-neuro-endocrine-immune system, we propose to those responsible for organization of dwelling conditions in asylum homes the following measures (substantiated with recommendations of European project called EUR-HUMAN):

- **Enabling asylum seekers a full or at least partial active participation in meal preparation.** This proved to have numerous positive effects on physical and mental well-being: it creates a daily rhythm of purposeful activity and a sense of responsibility, it gives individuals a role in their new community, creates a sense of collective co-creation of dwelling conditions in the asylum home, enables the opportunity to prepare meals in fashion of their traditional cuisine (in order to avoid malnutrition due to loss of appetite as well as weight gain due to disproportionate intake of carbohydrates) and thereby acts as a prevention measure to avoid diseases linked to improper diet (vitamin deficiency, obesity, diabetes, hypertension, gastrointestinal diseases etc.).

- **Actively involve asylum seekers in processes of sanitation of bedrooms and common rooms.** Taking care of the rooms in which they dwell creates a sense of intimacy, homeliness and responsibility towards self - that is a foundation of feeling of dignity. As already mentioned in the previous paragraph, such activities create a daily and weekly rhythm.

- **Providing opportunity to work (paid or voluntary) in the vicinity of the asylum home.** Purposeful work reestablishes a sense of capability and self-worth. Providing work opportunities in outdoor maintenance and community assistance (raking leaves, shoveling snow, mowing lawns etc.) would in our opinion attribute to prevention of general drop in morale and mental health deterioration of inhabitants of asylum home. Should the work provide a source of extra income (for those who have been waiting for 9 months or more) and a possibility to connect with social surroundings, that would be even more so valuable.

Proposed changes should not be perceived simply as a financial burden, but instead should be considered as a reorganization of dwelling and work processes in the asylum home, which shouldn't function as an authoritative institution. A common goal of all of us who work with asylum seekers is to enable them to become actively involved in taking care for and providing for themselves, which would greatly contribute to their recovery from previous traumatic experiences. An opportunity for asylum seekers to prove themselves as orderly individuals, who are capable of work and are being actively included into the society (as opposed to e.g. idle alcoholics, which they may very well become, considering the situation they are in at the moment), would also contribute to breaking the stigma and fear of this population as well as alleviate the acculturation process, to which asylum seekers from various environments and cultural backgrounds may richly contribute to.

PSYCHOTHERAPEUTIC WORK WITH REGUGEES

Dr. Zuzanna G. Kraskova

- - - SUMMARY - - -

I perform psychotherapy on clients, who in the past were victims of war violence or violence in general. The users are asylum seekers in the Republic of Slovenia or those who already acquired international protection. Those individuals suffered deep traumas, affecting their personality structure, emotional, behavioral and thinking patterns. In most cases they come from war zones or had fled from perils of war and violence and after toilsome journey came to find their refuge in Slovenia. In the majority of this population group, consequences of fear, tension and anguish result in form of mental disorders.

Cognitive behavioral therapy, which I perform on clients, is the most appropriate therapy for treating mood disorders, since the symptoms of those clients show unadjusted thinking and consequently feelings of unease or discomfort. In its secondary form they show symptoms of obsessive-compulsive disorder and several types of phobia. Keeping journals, which clients bring to the therapy sessions, help us discover when, why and to what extend a disorder appears in everyday life. Cognitive behavioral therapy is based on identification and alteration of unadjusted thinking, originating from an incorrect basic patterns. By modifying this basic pattern, the level of emotional ill-being decreases and during psychotherapy treatments even disappear. I practice psychodynamic approach with all clients; it is appropriate for uncovering deep thinking patterns, personality structure as well as for establishing the client's psychological profile, needed for performing psychotherapy treatment.

I perform creative psychotherapy on all clients, since the creative approach to therapy offers the clients a divergent way of thinking, enabling them a broader view on the issue and the surrounding environment. It helps the clients to achieve a higher level of thinking and enables them to achieve a higher level of consciousness. Occasionally, I combine creative psychotherapy with cognitive behavioral therapy.

Mindsight - this therapy is based on introspection and is suitable for clients, showing symptoms of anxiety disorder, especially generalized anxiety disorder. With those clients, this approach is optimal since it involves dwelling deep into a specific traumatic event from childhood or youth; the client is absorbed into the traumatic event and internalizes it. This way, the client confronts the event and sees its mirror image, which helps to discover unconscious patterns that preserve the trauma in state of active thought dynamics - mindsight therapy helps to disintegrate the trauma until it finally fades away completely.

I perform the acceptance and commitment therapy (Socratic method) on the majority of clients; this method enables a direct confrontation with a traumatic event on a level of comprehension, internalization of the trauma and modification of basic patterns. In the past the clients namely experienced specific traumatic events and this type of therapy, which is also based on questions (also from the aspect of the answer), helps the clients to accept the frustration, enables them to change their thinking pattern and when they remember the traumatic event this helps them to use a new, fresh thinking pattern, which will alleviate the level of unease and discomfort.

PART 2

Asylum seekers and migrant medical treatment is not a completely new practice in Slovenia. Some doctors, working in health centres that receive migrants, and those working voluntarily in the Health clinic for persons without health insurance, are constantly dealing with difficulties of treating migrant population, nevertheless there is no systematic approach to migrants/refugees' medical treatment in sense of collaboration between all subjects included in the process: ministries in charge, health institutions, researchers and NGO's working closely with the migrant population. It is necessary for all practices to be linked in order to ensure the best medical treatment for refugees and migrants.

In the following we introduce three perspectives on migrants/ refugees' health treatment that exemplify that all practices are well in line with regard to what is needed and what obstacles need to be overcome for a proper and successful medical treatment of migrants.

OUR EXPERIENCE WITH THE TREATMENT OF ASYLUM SEEKERS

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INTRODUCTION

In Health Centre Ljubljana-Vič, we are treating asylum seekers from the Asylum Home for several years now. During our work we acquired a great deal of experience, which we tried to sum up in several notes on drawbacks of the existing system and added our proposals for its improvement.

In Health Centre Ljubljana-Vič, asylum seekers are mostly admitted by a doctor on duty as unappointed patients. Patients are treated by a different doctor each time - this results in issues with record keeping, decreased continuity and unnecessary prolongation of treatment.

DRAWBACKS OF EXISTING SYSTEM

1. It is not uncommon for asylum seekers to visit health centres sporadically, without a prior consultation and appointment by the authorized person from the asylum home. Frequently, they are not acquainted with their rights and possibilities for their treatment, since in most cases asylum seekers are only entitled to urgent medical treatment - consequently, any additional treatment is unavailable to them.

2. Communication barriers are prolonging and hindering the treatment.

3. Migrants often do not have any information on their (chronic) health condition and medicine they take, they also have no record of their previous treatments.

4. Due to unorganized and unappointed arrivals and treatments of asylum seekers, rights of insurants of Republic of Slovenia are often violated.

5. Treatments are dispersed and incoherent - as a consequence, such treatments are not only incomplete, but

can also be hazardous for individual asylum seekers.

6. Occasionally we come across ethical issues, for instance when women refuse to take off their clothes during a clinical examination, or when men refuse to be examined by a female doctor.

PROPOSALS FOR IMPROVEMENTS

1. Prior to a medical treatment, individual asylum seeker should visit an authorized person in the asylum home, who would consult the doctor prior to the treatment.

2. If possible, a translator should be present at the examination (if there are no professional translators available, a layman native-speaker should suffice).

3. If possible, patients should bring their complete medical record to each treatment.

4. Notice on visits to the clinic should be given at least several hours beforehand - epidemiological aspects are important (e. g. due to necessity of a quarantine when facing a suspicion of infectious diseases).

5. Since project »8 NGO's for migrants'/refugees' health in 11 countries« started (executed by Slovene Philanthropy in units of Asylum home), we noticed a decrease (see »Table 1«) in number of asylum seekers visiting the health centre, apart from that, when they visit a doctor, they bring a reference letter from a medical coordinator.

6. We support the possibility of asylum seekers being able to choose a personal physician. Such measure would simplify and standardize treatments, enable continuity and increase the overall quality and safety levels of the treatment.

MONTH	Number of patients treated
January	16
February	25
March	23
April	29
May	26
June	9
July	4
August	15
September	22
October	11
November	5

Table 1: Number of migrants treated in Health Centre Vič (according to months in 2016)

Most visits were made due to following requirements: drug prescriptions, medical tests, wound care, first medical examination.

EXPERIENCE WITH MEDICAL TREATMENT OF REFUGEES AND MIGRANTS

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- - - SUMMARY - - -

The importance of communication between a patient and a doctor lays the groundwork for a successful treatment and is therefore a part of undergraduate as well as postgraduate medical studies. Ability to communicate is particularly important in intercultural treatments. Apart from overcoming language barriers, medical doctors must also consider patient's socio-cultural and religious beliefs and different prevalence of certain illnesses in patients from different cultures and minority groups. In a doctor-patient interaction, communication must each time be accustomed to the patient's needs – this applies to treatment of the majority population as well as to treatment of ethnic minorities and refugees. Although interpreters generally alleviate patient-doctor communication, researches showed they may also have a negative influence. Regardless of the patient's cultural background and language barriers, doctors, medical technicians, psychologists and other experts must build a confidential relationship, which must be based on mutual respect since the very beginning of treatment.

INTRODUCTION

Since the beginning of crisis in Syria, a number of refugees in Slovenia is constantly increasing (1). Migration flow consists not only of Syrian refugees, but also of migrants from other war zones and economically underdeveloped areas. In 2015,

Slovenia needed to face the refugee crisis. As a part of the Balkan route, it was an important so called »transit state« for immigrants, which brought forth not only political and social, but also community health issues (2,3).

In Europe there is no fixed and standardized method of evaluating medical needs of migrants and refugees, many of whom experienced several weeks and months of different methods of transportation and had differently appropriate access to food, water and accommodation. Due to numerous factors, they were more exposed to risks for suffering injuries or developing diseases, at the same time they had various possibilities of access to medical treatment.

In some EU states, primary triage and medical examinations of newly arrived migrants, economic migrants and refugees are compulsory, in some they are not. Furthermore, the methods of such evaluations are not standardized in all EU states - for instance, in most states the so called referral letters or results are not issued upon the treatment. Consequently, upon their first contact with newly arrived refugees or migrants, medical staff in certain states cannot evaluate and consider information of previous medical treatment.

This article introduces general findings on the refugee crisis in Europe with the emphasis on communication and describes issues, concerning interpreters and translators. In conclusion, the article puts a special focus on the often underestimated aspect of refugees' mental health.

REFUGEE AND MIGRANT CRISIS

Refugee and migrant health crisis can be divided into different segments:

- accessibility to medical treatment;
- means for treatment of migrants and treatment related costs;
- communication with migrants and refugees;
- diversity of illnesses, appearing within this population;
- possibility of further hospital medical treatment;
- psychological support.

In countries, where issues with refugees are present for some years now (e. g. Norway, Sweden etc.), different researches (4, 5) showed that individual approach is crucial for a quality medical treatment. Namely, refugees and other migrants come from various environments (urban as well as rural), they had different upbringing, received different education and have different customs. As communication needs to be adjusted during the treatment of the »local« population, so too it must be adjusted to every particular individual in treatment of refugees and migrants - language is an additional issue in this case. Although the presence of interpreters and cultural mediators usually alleviates patient-doctor communication, researches showed (6)

they may also have a negative influence. Firstly, it must be assured that they are the right gender (e. g. female interpreters in treatment of female patients - the same applies to doctors). When interpreters or translators are related to patients, they may also be biased while interpreting the information; relatives may regard a specific symptom as more important than for instance a person, who is taking medical history of a patient, and may therefore present the information differently due to their emotional involvement. Apart from that, feelings of shame and unease may appear in the presence of an official interpreter, which affects the accurateness of the given information that may be of vital importance for the medical staff.

Access to medical treatment is another issue. Slovenia was foremost a transit state, therefore an essential part of treatment of refugees was that doctors were available in all accommodation centres - that way, migrants knew where to go in case of health problems. It is entirely different with refugees, who wish to stay, because they have to be acquainted with the principles on which our health system functions (where and how to acquire health insurance, where to go in case of emergency and where to go in case of acute and chronic conditions, locations of clinics of family physicians, working hours of medical institutions etc.).

From a medical perspective, it is important for a doctor to be educated on illnesses that are more prevalent in other parts of the world and less common in our region. In order to provide refugees with a professional assistance as well as appropriate psychological support, co-operation of different professional services (psychiatrists, psychologists, social workers, etc.) and an integral approach to treatment of patients are crucial. For refugees, the travel alone has been extremely difficult and stressful, in addition, many of them endured atrocities of war, abuse and trauma in their homeland. We have to consider this fact and we need to actively encourage them to seek help, because some of them are not accustomed to openly discuss those issues due to ethnic and/or religious reasons. Children in particular will need special help, in addition we need to enable them the possibility of being included into the educational system.

It should not take us by surprise if the migrants will expect the kind of medical treatment that they are accustomed to and have received in their home country. Their perception and interpretation of diseases may be completely different as well (4). Consequently, some may put doctors under more pressure, since they have different expectations with regards to the treatment.

COMMUNICATION

Appropriate communication promotes the development of a satisfying relationship between a patient and a medical professional, enables an adequate exchange of information, determines the plan and efficacy of the treatment and ensures the patient's co-operation in the treatment

process (9). The ability to communicate is especially important in intercultural encounters. Apart from overcoming language barriers, medical doctors must also consider the patient's socio-cultural and religious beliefs, as well as variable prevalence of some of the most common illnesses in patients from different cultural backgrounds (10).

Satisfactory communication leads to development of trust. Refugees have a possibility to convey important and sensitive information that enable the doctor to accurately assess their condition and take further decisions. That way, refugees have a greater sense of autonomy and they estimate that they contribute their autonomy to the process of treatment, therefore they are more motivated for changes and co-operation in the treatment. With regards to the communication, some refugees have negative experiences, which may be summed up into four categories: mistrust, low-quality treatment, excessive or insufficient use of medical resources, consequently dissatisfaction with non-involvement in the treatment process. When refugees are dissatisfied with communication, they look for second or third opinion, they seek health care elsewhere and are avoiding further contact with medical service providers. Consequence of negative experiences is the feeling of frustration and rejection. Because they feel they have not been taken into account, their motivation for further treatment is diminished (11).

SPECIFICS OF COMMUNICATION WITH PATIENTS FROM DIFFERENT CULTURAL BACKGROUND

When working with individuals from different cultural background, it is good to be familiar with »culturally related syndromes«, which define interactions and communication between a patient and medical staff. Some refugees respond to health issues in a very emotional way. Misunderstanding their way of expression, medical experts may mistakenly declare them neurotic. Some economic migrants may present their health issues less grave then they really are because of fear for their employment, which may unintentionally mislead a doctor to other diagnostic algorithm (12).

Communication with individuals from different cultural background should include the following principles:

- communication should be a »two-lane highway«, where both participants should listen and be listened;
- efficient communication demands qualification, which means using simple words that are easy to understand, speech should be intelligible, instructions short and simple;
- doctor should be flexible and for the purpose of efficient communication various means of communication should be used;

- doctor should have patience while communicating with a patient.

A doctor should learn to accept diversity and should therefore get educated on specifics of refugee's culture by asking the refugee about his/her knowledge and notion of the disease, about his/her expectations and what would he/she like to know with regards to his/her health state. Most of all, a doctor should be empathetic.

TRANSLATORS, INTERPRETERS AND CULTURAL MEDIATORS

Refugees, who came to Slovenia, are not one homogenous group of people, neither can they be divided to several minor homogenous group, e. g. to »Syrians«, »Afghans«, »Somalis« etc. There is a plurality of social, cultural, socio-economic, ethnic and religious factors existing within this population. A new research has been made in the Schengen area (Slovenia, Croatia), which confirmed results of previous researches, namely that poor communication is the biggest issue in treatment of refugees. Communication issues caused medical experts to be under considerably greater stress due to the possibility of making incorrect diagnosis and/or giving incorrect treatment, since in order to provide a high quality medical treatment, it is important to take the medical history of a patient correctly - this applies to all medical fields and the treatment of migrants is no exception. A qualified interpreter should be at the doctor's disposal all the time, the latter should of course approach each patient individually. Web service Google Translate and non-verbal communication (which many healthcare professionals had to use during our Schengen research) may serve as an additional help, but this should not be a primary means of communication, since vital information may get lost during the process.

Co-operation between cultural mediators and translators differs from case to case. In official procedures (e. g. filing applications for international protection), a translator is to be present at all times. Those procedures and translation services are arranged by the Ministry of the Interior. In such cases, official interpreters should provide the services, however, two issues appeared regarding that matter: firstly, it is difficult to acquire official interpreters for certain languages, since there are few available or none at all; secondly, interpreters are generally paid considerably more when providing court interpreting services, than when providing services for the Ministry, therefore they usually refuse to participate in official procedures and services of official translators must be used instead.

In cases when presence of an official translator is not compulsory (e. g. medical treatment procedures), majority of doctors turn for help to people, who speak one of the languages of the refugees/migrants. In translating, one should always aim towards objectivity, which is not always the case with non-professional translators, since they often interpret statements of health-

care professionals in their own way and often to the patients' detriment. Therefore, Slovene Philanthropy strives for introducing a profile of so called »cultural mediators« (research of practices and introduction of the term, carried out by dr. Uršula Lipovec Čebron, will be presented in continuation - Ed.). Cultural mediators should be fluent in both languages, they should be familiar with both cultures and should receive appropriate education.

UNDERRATED IMPORTANCE OF MENTAL HEALTH IN REFUGEE POPULATION

After being exposed to atrocities of war and to stressful events, refugees are at risk of developing mental health problems. Extent of mental health problems varies (from 75% to less than 5% of posttraumatic stress disorder in refugee population). Systematic reviews of research results (research included children and adults) showed children recover from traumatic events better than adults (13).

Refugees often leave their homeland after they have been exposed to life-threatening situations, for instance war conflicts and violence. By becoming refugees they might get exposed to perilous situations and risk prison sentence or death of their beloved. They can become victims of persecution and oppression due to their ethnicity, religion or sexual orientation. In some countries, gender violence and mutilation of female genitalia is still allowed (14). Apart from the abovementioned, upon their arrival in a new country refugees might realize their expectations and ideas on developed world differ from actual circumstances and all their hopes of a better life vanish instantly (15). Consequently, states of denial, negativism, excessive irritability and depression might develop (16, 17). In migrant population the prevalence of posttraumatic stress disorder counts for 20-40% and prevalence of a major depressive episode for 30-70%. In comparison to a general population, the prevalence of mental illnesses in refugee population between men and women is comparable (18).

CONCLUSION

Migrations and globalization cause changes in structure of patient population. When communicating and treating patients from different ethnic and cultural backgrounds, doctors and medical staff must consider specifics of cultural environments from which the patients originate. They should overcome language barriers with the help of interpreters and cultural mediators. Treatment of patients from a different cultural environment demands a doctor's self-reflection and awareness of his/her own norms and values, which are brought in interaction with a patient.

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ON IMPORTANCE OF IMPLEMENTING INTERCULTURAL MEDIATION INTO SLOVENIAN HEALTHCARE INSTITUTIONS

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WHAT IS INTERCULTURAL MEDIATON?

Intercultural mediation is an internationally established concept and practice, used for reducing inequality and ensuring quality treatment in healthcare and other institutions (EQUAL EP TransKom 2012; Verrept 2008, 2012). It is intended for overcoming misunderstandings that emerge because of linguistic, cultural, social and other differences between users and providers in public and private institutions. In this context, the term ***culture*** does not only refer to ethnicity of an individual, but also to other economic and social aspects of life that influence the occurrence of different misunderstandings. In such context, mediation surpasses linguistic interpretation, since it includes translation of different notions and practices. If interpretation refers to translation of language, then mediation refers to translation of cultural meanings (Bowen 2000: 8). Cultural mediator is not simply a person, who speaks a language of a certain community, but is instead someone who is acquainted with and »speaks« the culture of a user. Language proficiency should thus not be equated with cultural proficiency. Cultural mediator is a professionally qualified individual, who acts as a third party in a relationship between a user and provider. In healthcare institutions, cultural mediator represents a bridge between health care providers and health care users (Bofulin, Farkaš, Lainščak, Gosencaand others 2016).

WHY IS CULTURAL MEDIATION NEEDED?

In today's modern world of fluidity and fast social changes, communities are becoming increasingly more culturally and socially diverse - this phenomenon is also present in

environments, which appear internally homogenous. Slovenia is no exception here. In such altered environments, it is not only important to consider the existence of various population groups, but also the fact that differences inside those groups might be even greater than differences between the groups themselves. Migration and other social trends reveal a multifaceted diversity of population - not only because of increasing numbers of members of different »ethnic groups«, but also because of social stratification and numerous other factors that are influencing on inclusion or exclusion of population (Standards for Equity in Health Care for Migrants and other Vulnerable Groups 2013; Chiarenza and others 2016). Those changes in general population are traversing to the healthcare system and represent challenges, which the healthcare system needs to address in order to provide quality healthcare services.

In context of health care, cultural and social differences manifest for instance as differences in social position, differences in understanding health and disease, differences in practices of health care and responses to health issues. Differences between users and providers of medical services are not only limited to differences in education, language proficiency etc., but are present in all aspects of medical treatment. Those differences are not always evident, nevertheless they always have relevant clinical implications.

In Slovenia, an increasing number of healthcare professionals istreating patients from different cultural and socio-economic environments are on a daily basis. Those users do not speak or understand Slovenian and/or have experienced different medical practices, they have a different notion of body, pain, disease and health and are not appropriately acquainted with the Slovenian healthcare system. Since there are no cultural mediators and interpreters available to them at the moment, healthcare professionals are left to their own resources while treating those patients. This very often makes their work difficult, causes numerous misunderstandings and reduces the quality of healthcare services. Consequently, healthcare service users from different environments often experience unequal, low-quality services, which results in less successful treatment while the patients themselves are exposed to greater health risks (Bofulin, Farkaš Lainščak, Gosenca and others 2016; Chiarenza and others 2016).

In many countries, such issues have been resolved by implementing interpreters and/or cultural mediators and by qualifying healthcare professionals to develop their cultural competence. Experience from abroad shows such methods of problem solving can bring numerous obstacles and dilemmas (Kleinman and Benson 2006; Gregg and Saha 2006) when health institutions seek hasty, unprofessional and short-term solutions and do not address issues[3] that need to be resolved in order to ensure

3 Those issues are, for instance: how to ensure the independence of cultural mediators, who is to set the criteria for cultural mediator's work, who in how will be in charge for their education, how to fund their work, etc.

an efficient co-operation of cultural mediators in health institutions. The opposite is true in cases, when introduction of cultural mediators was thoughtfully planned, regularly evaluated and profesionally managed while at the same time it served as a complement of long-term development of cultural competence among healthcare professionals (Verrept, 2008, 2012). In cases when cultural mediation has been appropriately implemented, it is considered as an example of good practice that significantly increases the quality of healthcare services and in that regard, the reasons for implementing cultural mediators can be summed into following paragraphs:

- it decreases inequality in medical treatment (because they understand patients' needs better, healthcare professionals are able to ensure not only formal but actual, equal, impartial and quality treatment, prevent unwanted discrimination and manage risk factors for its emergence);

- it increases the quality of medical treatment (presence of a cultural mediator ensures a greater accuracy of conveyed information and therefore enables an establishment of a more accurate diagnosis, also the patients are able to understand instructions for taking medicine and following other therapies and preventive measures);

- it increases responsiveness of users (due to improved communication with healthcare professionals, the users develop trustful relationship with them, they can follow the prescribed therapies easier as well as respond better to preventive programs);

- decreases costs (due to presence of cultural mediator, healthcare professionals spend less time for overcoming misunderstandings during the treatment; a greater quality of treatment results in improved health state of the users and at the same time they use medical services more rationally (less visits to the ER, less hospitalizations, etc.). (Verrept 2008, 2012).

OUTSET OF IMPLEMENTATION OF CULTURAL MEDIATION IN COMMUNITY HEALTHCARE IN SLOVENIA

In Republic of Slovenia, there are several provisions, which can be used as legal basis for implementation of cultural mediation into the system of health care, for example ***Patients' Rights Act*** and ***Code of Ethics on Medical Treatment and Patient's Care***, nevertheless, guidelines for implementation of cultural mediation into the healthcare system have not been determined yet. Apart from that, cultural mediators have not been officially included into Slovenian healthcare system.

One exception is a recent trial implementation of a cultural mediator for inhabitants of the Albanian community in Celje. The

trial implementation was carried out within the framework of a project »For better health and decreasing inequality in health care - Together for health«. This project was carried out during 2013 and 2016 by the National Institute for Public Health[4]. Special emphasis was placed on decreasing inequality in health care and including various vulnerable groups of people into preventive health care. During the project, a qualitative research has been conducted by researchers in different parts of Slovenia. Researchers established, which population groups are the most marginalized with regards to health care, what are the most common obstacles, regarding access to health care services and what are some possible options for solving those issues (Farkaš Lainščak 2016: 14-25). The findings revealed, refugees/migrants are the most vulnerable group in system of health care - they must face numerous obstacles (exclusion from health insurance system, limited access to health insurance and urgent medical assistance, etc.), many of which are also linguistic and cultural in nature (ibid.). As a response to those findings, co-workers on the project carried out 20-hour education project for developing cultural competence in healthcare professionals[5] and prepared a handbook titled ***Cultural Competence and Health Care: Handbook for Developing Cultural Competence in Health Care Professionals*** (Lipovec Čebron 2016). In the course of the project, the team of co-workers prepared a proposition of systemic measures for decreasing inequality in health care (Chiarenza and others 2016: 18–19) and translated the handbook ***Standard for Assurance of Equality in Health Care of Vulnerable Population Groups and Tool for Self-evaluation of Health Institutions*** (Chiarenza and others 2016). As previously mentioned, one of the most crucial programms of the project were services, provided by the cultural mediator (September - December 2015) in Health Centre Celje[6], which proved to be very successful and necessary for healthcare professionals as well as Albanian users of healthcare services (Jazbinšek in Pistotnik 2016). Groundwork for this trial implementation of cultural mediation was set with the ***Declaration of Necessity for Implementation of Cultural Mediation in Health Care Institutions in Republic of Slovenia***, prepared by co-workers of the project »Together for Health« in co-operation with various non-governmental organizations[7]. The declaration includes the following proposals for implementation of intercultural mediation into the system of health care in Slovenia:

1. Intercultural mediation should not be a spontaneous and unprofessional activity.

4 The project was funded by the Norway Grants program 2009-2014.

5 The education project took place in Health Centres in Celje, Sevnica and Vrhnika from January to June 2016.

6 More precisely, in the Centre for Health Enhancement in Health Centre Celje and in the Reference Clinic in Health Centre in Vojnik.

7 Non-governmental organizations, which prepared and together with the National Institute for Public Health signed the declaration are: Association Mozaik, Association for Awareness and Protection - Anti-Discrimination Center, Slovene Philanthropy, Association for the development and integration of social sciences and cultures – Relation, Institute for Multicultural Research, The Peace Institute, The Association of Free Trade Unions of Slovenia.

The function and significance of cultural mediation cannot be replaced by a spontaneous or an unorganized form of support (for instance relatives and others) when solving cultural misunderstandings.

2. Intercultural mediator should be professional and should be bound to secrecy.

Organized and professional work binds the mediator to secrecy.

3. Intercultural mediator should be appropriately qualified:

a) he/she must originate from the same linguistic and cultural environment as the user or must at least be very familiar with the language and culture of that environment.

Proficiency in language of the user is a necessery but insufficient skill to work as a cultural mediator, since cultural mediation also includes a good knowledge of the user's culture.

b) he/she must be familiar with the basics of medical discipline and how the healthcare institutions function.

Cultural mediator must receive basic knowledge on medical discipline and healthcare institutions. At the same time, he/she must master the medical terminology in the language of the user as well as in the language of the medical service provider.

c) professional qualification of cultural mediators must be executed by an interdisciplinary group of experts.

Qualifying cultural mediators should not be a one-time and generalized passing of information on a theoretical level, but should instead include a complete and in-depth qualification, carried out by an interdisciplinary group of experts.

4. Funding of cultural mediator should ensure the independence of his/her work.

Funding services of a cultural mediators should be provided by an institution, which ensures impartiality and respects the principles of cultural mediator being an independent expert in his/her field.

5. Intercultural mediator should strive for a co-operative relationship with all parties, especially the users of healthcare services.

He/she should function consistently with the interest of all parties, never against the interest of the user or against the user's will.

6. Intercultural mediator should be familiar with his/her local environment and should have a solid network of contacts (governmental and non-governmental organizations, contacts with initiatives of inhabitants, etc.), with whom he/she may co-operate if necessary.

All governmental and non-governmental organizations as well as individual orga-

nized groups of people, working in the field of protecting vulnerable groups of people and ensuring their rights for treatment are relevant for cultural mediator's work.

7. Intercultural mediator should be active in different community health institutions and services.

Cultural mediator should mediate in health centres, hospitals, rehabilitation centres and other medical institutions. If necessary, he/she should also engage in fieldwork (home nursing care), home visits and other forms of medical assistance, executed outside medical institutions.

8. Intercultural mediator should be aware of positions of power in the medical environment.

Cultural mediator should intervene in the relationship between medical service provider and user only if he/she detects any unequal treatment. At the same time, he/she should be aware of the consequences of unequal positions in medical treatment and should pay special attention to them.

9. It is sensible to implement a cultural mediator only if healthcare professionals are being simultaneously educated on cultural competence.

Intercultural mediation, together with a cultural competence of healthcare professionals, is an integral solution to understanding intercultural and social differences and overcoming obstacles that arise as a consequence of those differences.

10. Healthcare professionals must be qualified for co-operating with an intercultural mediator.

Because intercultural mediation is a new practice in our environment, healthcare professionals should acquire skills on how to co-operate with third parties during the treatment.

11. Intercultural mediator must receive appropriate payment for his/her work.

Work should not be voluntary. A stable, appropriate and quality intercultural mediation can only be assured by appropriate payment and a good work plan (Farkaš Lainščak in Lipovec Čebron 2016: 93 -96).

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APPENDIX 1

LEGAL FRAMEWORK OF THE SLOVENIAN HEALTHCARE SYSTEM AND ACCESS TO MEDICAL SERVICES IN SLOVENIA[8]

Helena Liberšar

In continuation, we will present the Slovenian healthcare system in order to better illustrate the difficulties which accessing healthcare services imposes on the asylum seekers and healthcare professionals.

STRUCTURE AND PROVISION OF FUNDING FOR HEALTHCARE SYSTEM IN SLOVENIA[9]

Slovenian healthcare system consists of two types of health insurance: compulsory health insurance and non-compulsory or supplementary health insurance.

Compulsory health insurance is defined by the Health Care and Health Insurance Act and by the Compulsory Health Insurance Rules.

For covering the difference between the total costs of health services and the costs of services covered by the compulsory health insurance, an insured person may take out supplementary health insurance, provided by insurance companies in accordance to the Insurance Act and the Health Care and Health Insurance Act.

8 Report on legal framework of access to healthcare in Slovenia was prepared within the project European Network to Reduce Vulnerability in health in cooperation with Medecins du Monde.

9 For more information on organization and funding of the Slovenian health care system see WHO report 2009 http://www.euro.who.int/__data/assets/pdf_file/0004/96367/E92607.pdf?ua=1, pages 17-61, and the webpage of Health Insurance Institute of Slovenia http://www.zzzs.si/zzzs/internet/zzzseng.nsf/o/F233938E2AD0AAA3C1257BB000452FD9.

Institution in charge for providing compulsory health insurance is the Health Insurance Institute of Slovenia.

The health sector is provided at the primary, secondary and tertiary level. Healthcare services at the primary level comprises primary health care and pharmacy. Healthcare services at the secondary level comprises specialist outpatient and inpatients activity. Healthcare services at the tertiary level comprises the occupation clinics, clinical institutes or clinical departments and other authorized healthcare institutions (Article 2 of the Health Services Act, 13. 2. 1992, final provisions at February 15. 2. 2013).

Primary healthcare services are provided by public healthcare centres (62 health centres across Slovenia[10]).

INSTITUTIONS IN CHARGE FOR REGULATING HEALTH CARE IN SLOVENIA

Ministry of Health: Ministry of Health is the highest body in the field of health care in Slovenia. Its areas and priorities are:

- Strengthening public healthcare, taking into account its financial sustainability, with an emphasis on maintaining the right to compulsory health insurance that is as comprehensive as possible, and a clearer demarcation between public and private healthcare services (abolition of the supplementary health insurance).
- Ensuring the financial sustainability of the compulsory health insurance scheme by way of achieving greater solidarity in terms of users' contributions and the greatest possible preservation of existing rights.
- Implementing a transparent and uniform public procurement system in healthcare in order to ensure efficient procurement of medicinal products, medical devices and other equipment for the needs of healthcare services.
- Reorganizing the management operation and supervision of public health institutions and increasing the liability of the directors and councils thereof[11].

Health Insurance Institute of Slovenia: Implementation of compulsory health insurance is a public service performed by the Health Insurance Institute of Slovenia as a public institute. The headquarters of the Institute are in Ljubljana. The Institute is organized in such a way that the services are available to insured persons in the proximity of their place of residence or permanent address. The Institute sets up organizational units for specific sectors and areas (Article 69 of Health Care and Health Insurance Act).

10 For more information see Public network of Primary healthcare services, September 2013, Ministry of Health, page 8.

11 See http://www.mz.gov.si/si/delovna_podrocja_in_prioritete/.

Health insurance companies: There are four health insurance companies in charge for providing supplementary health insurance. Their functioning is defined by the Insurance Act (17. 1. 2016). Insurance companies may only provide supplementary health insurance to persons with compulsory health insurance or other supplementary health insurance (for instance, above-standard medical services). Supplementary health insurance cannot replace compulsory health insurance.

National Institute of Public Health: National Institute of Public Health (NIPH) is a central national institution in charge of research, protection and increase of health of the population of the Republic of Slovenia through raising awareness and other preventive measures. Apart from its central role in the Slovenian public healthcare system the NIPH also participates in international projects, covering various areas of healthcare and general public healthcare issues. The NIPH also represents an expert assistance for resolutions of the state on the national and local level with direct or indirect influence on health[12].

FINANCING OF THE PUBLIC HEALTHCARE SYSTEM

Funding for compulsory health insurance are provided through contributions paid to the Health Insurance Institute of Slovenia by the insured persons, employers and other persons as defined by the Health Care and Health Insurance Act. With regards to the status of the insured person (retirees, unemployed etc.) also other institutions are bound to pay the contributions (Pension and Disability Insurance Institute of Slovenia, Health Insurance Institute of Slovenia, the state budget, Employment Service of Slovenia, municipalities).

Medical services are funded by the compulsory and supplementary health insurance. A person insured only with the compulsory insurance is obliged to pay the costs of difference between the total costs of health services and the costs of services covered by the compulsory health insurance. The costs must be covered from own or other sources if a person meets the criteria for the costs to be paid by the third party.

In some cases costs of medical services are covered by the state budget of the Republic of Slovenia:

- emergency treatment of persons of unknown residence, foreigners from countries which have not concluded an international agreement, as well as foreigners and citizens of the Republic of Slovenia with permanent residence abroad who temporarily reside in the Republic of Slovenia or are travelling through the country and they were unable to obtain payment for medical services, as well as other persons who, under the provisions of this Act, are not included in compulsory health insurance and are not insured with a foreign health

12 For more information see http://www.nijz.si/sl/nijz/predstavitev/osebna-izkaznica.

insurance (Article 7 of the Health Care and Health Insurance Act).

ACCESS TO HEALTHCARE IN SLOVENIA

The insured person acquires access to medical services with the health insurance card[13]. The health insurance card is an official identity document of persons insured under the compulsory health insurance scheme. The card is issued by the Health Insurance Institute of Slovenia. An insured person must submit the health insurance card when visiting a doctor, or when that person claims and enforces his/her health-related rights.

Every resident of the Republic of Slovenia should have health insurance and access to medical services. Every insured person chooses his/her personal physician[14]. Access to medical service is possible only through personal physician and by having a health insurance card. A personal physician is also in charge for referring the patients to a specialist examination or to a hospital treatment. The same applies to gynecologist and dentist[15].

Personal physician: decides on the temporary incapacity for work; refers the patients to a particular physician, medical commission or invalidity committee; refers the patient to a specialist examination[16]; prescribes medication; provides services of ambulance and other transportation (Article 81 of the Health Care and Health Insurance Act).

The aforementioned does not apply for cases of urgent medical assistance[17].

Every person with a compulsory health insurance in the Republic of Slovenia is entitled to medical services to an extent and in the way as it is defined by the compulsory health insurance procedure.

According to the stipulations and procedures of the current regulations insured persons have a right to healthcare services. These are a right to: primary healthcare services, dental medical services, services in specialized social institutions, specialist medical treatment, hospital medical treatment and tertiary medical treatment, health resort services, restorative care and rehabilitation, transportation with ambulance and other vehicles, prescription medication, medical accessories, healthcare services while traveling and residing abroad. With particular groups of people (children, school-age youth and students) or insured persons with specific medical conditions specific medical services are entirely covered by compulsory health insurance (as defined by Article 23 of the Health

13 For more information see http://www.zzzs.si/zzzs/internet/zzzs.nsf/o/667843302118EB9CC1256E8B003135E0.

14 See Zakon o zdravstvenemvarstvu in zdravstvenemzavarovanju, 1. 9. 2015, Articles 80-85, and Pravilaobveznegazdravstvenegazavarovanja, 17. 11. 2014, Articles 161-180.

15 Article 80 of the Law on Health Care and Health Insurance.

16 For more information see http://www.zzzs.si/zzzs/internet/zzzseng.nsf/o/711DAD33F7FB1CB8C1257BB000456695.

17 See Article 179 of Compulsory Health Insurance Rules.

Care and Health Insurance Act. The article also defines which medical services covered by the compulsory health insurance ought to be paid for entirely or partially in a certain percentage, i. e. specific percentage of the full price).

INSURED PERSONS

Insured persons are the insurance holders and their families.

Insured under this Act (as defined by Article 15 of the Health Care and Health Insurance Act) are:

1. persons who are employed in the Republic of Slovenia;

2. persons employed by an employer based in the Republic of Slovenia, and sent to work or for professional training abroad, if they are not subject to compulsory insurance in the country in which they were sent;

3. persons employed by foreign and international organizations and institutions, foreign consular and diplomatic representative offices based in the Republic of Slovenia, unless otherwise specified by an international treaty;

4. persons domiciled in the Republic of Slovenia, and employed by a foreign employer, who are not insured with a foreign health insurance;

5. persons on the territory of the Republic of Slovenia engaged in an economic or professional activity as their sole or main occupation;

6. the members of a partnership, members of limited liability companies and founders of institutions if they are shareholders of the companies or institutions founders managerial persons performing managerial function as the sole or main occupation;

7. farmers, members of their holdings and other persons in the Republic of Slovenia who perform agricultural activity as their sole or main occupation;

8. top sportsperson and chess players - members of sports and chess organizations in the Republic of Slovenia who are not insured somewhere else;

9. unemployed persons receiving the employment compensation;

10. persons with permanent residence in Slovenia who receive pension according to the regulations of the Republic of Slovenia or receive alimony according to the regulations of the Livelihood Protection of Farmers;

11. persons with permanent residence in Slovenia who receive pensions from foreign pension insurance carrier, unless otherwise specified by the international agreement;

12. persons domiciled in the Republic of Slovenia insured with a foreign health insurance during their stay in the Republic of Slovenia cannot use the rights in this respect;

13. family members of a person insured with a foreign health insurance with permanent residence in Slovenia who are not insured as family members with foreign health insurance;

14. foreigners who are educated or refined in the Republic of Slovenia and are not insured somewhere else;

15. persons domiciled in the Republic of Slovenia who are recipients of disability benefits under the regulations on military invalids and civilian war invalids, the rights under the regulations on the protection of war veterans, victims of war and other was participants and users of the republic of financial assistance, if they are not insured somewhere else;

16. persons with permanent residence in Slovenia who receive compensation under the law on social protection for mentally and physically handicapped adults, if they are not insured in any other;

17. persons domiciled in the Republic of Slovenia receiving permanent social assistance in cash and the persons to whom the Republic of Slovenia granted refugee status or subsidiary protection in accordance with the rules on international protection if they are not insured somewhere else;

18. persons domiciled in the Republic of Slovenia who are recipients of financial assistance under the regulations on the protection of participants in the war, if they are not insured somewhere else;

19. military servicemen residing in the Republic of Slovenia in the civil service and military service allowances;

- conscripts residing in the Republic of Slovenia during his military service or during training for reserve composition of the police;

20. persons domiciled in the Republic of Slovenia, if they do not qualify for insurance under one of the points of this paragraph and decide on their own pay contribution;

21. citizens of the Republic of Slovenia and foreigners with permanent residence permits who are under the law, which regulates the exercise of rights from public funds, granted the right to payment of contributions for compulsory insurance;

22. detainees who are not insured somewhere else until the moment of occurrence of detention, or whose insurance is terminated at the time of detention, convicts serving prison sentences in juvenile prison, juveniles serving the educational measure of placement in a correctional facility, the person to whom it is a security measure of compulsory psychiatric treatment and custody in a medical institution and compulsory treatment of

addiction to alcohol and drugs. Detainees in the insurance application Institute prisons in which detainees serving detention, the other persons referred to in this section, institution or organization in which they are present, no later than the next working day after receiving such persons;

23. persons who acquired the right under the law governing parental protection, namely:

- beneficiaries of parental benefits to which employment was terminated for the duration of parental leave,
- one of the parents, who by virtue of their activities paid social security contributions for at least 20 hours a week and cares for a child under three years of age,
- one parent who leaves the labor market in order to care for four or more children;

24. children under 18 years of age who are studying and are not insured as family members, because their parents do not care for them or because their parents do not qualify for inclusion in the compulsory insurance;

25. family assistants under the law governing social security.

SUPPLEMENTARY HEALTH INSURANCE

Supplementary health insurance covers the difference between the total costs of health services and the costs of services covered by the compulsory health insurance. In case, when an insured person takes out supplementary insurance, the difference between the total costs of health services and the costs of services covered by the compulsory health insurance is covered by the health insurance company, with which the insured person took out the insurance policy.

Supplementary health insurance covers the expenses of healthcare and all the concerned services, provision of medication and medical instruments.

Compulsory and supplementary health insurance are a part of social security of insured persons.

APPENDIX 2

MEDICAL TREATMENT OF ASYLUM SEEKERS

Jaka Matičič, Helena Liberšar

Within the framework of the project, we have conducted a research on medical treatment of asylum seekers and on knowledge of their rights in the field of health care by health-care professionals. With this research, we have tried to gain a deeper insight into the process of admittance and medical treatment of asylum seekers in the Republic of Slovenia, and tried to establish how well the medical staff in public health centres is informed on the matter, whereby we focused on medical doctors and nurses/medical technicians, who are directly involved in the treatment of those patients.

ANALYSIS RESULTS

We have addressed our survey to the management and the personnel in 56 different health centres as well as some general hospitals across Slovenia. Total reach of the survey counted 449 persons (i. e. 449 persons clicked on the link to the survey and skimmed the questions without answering them), 187 persons answered the survey questions (i. e. respondents). The survey has been conducted during 5th and 31th of August 2016.

REGIONAL PLACEMENT OF RESPONDENTS AND THEIR EXPERIENCE WITH TREATMENT OF ASYLUM SEEKERS

We wished to include in our survey all the regions and their major cities in Slovenia, with the intention to examine the knowledge of healthcare professionals on the subject of treatment of asylum seekers, in case one of those regions could become a hosting region for a new unit of asylum home, should migrations continue in the future, as it was the case with Logatec. The basis for our survey was the notion of necessity for a health centre in charge to be appropriately informed on rights of asylum seekers, admittance procedures and procedures of medical treatment for a purpose of efficient and undisturbed work in treating asylum seekers. The majority of respondents comes from Ljubljana (44%), followed by Celje (15%) and Maribor (12%). The smallest percentage of the respondents come from Nova Gorica (1%), Kranj (3%) and Murska Sobota (5%).

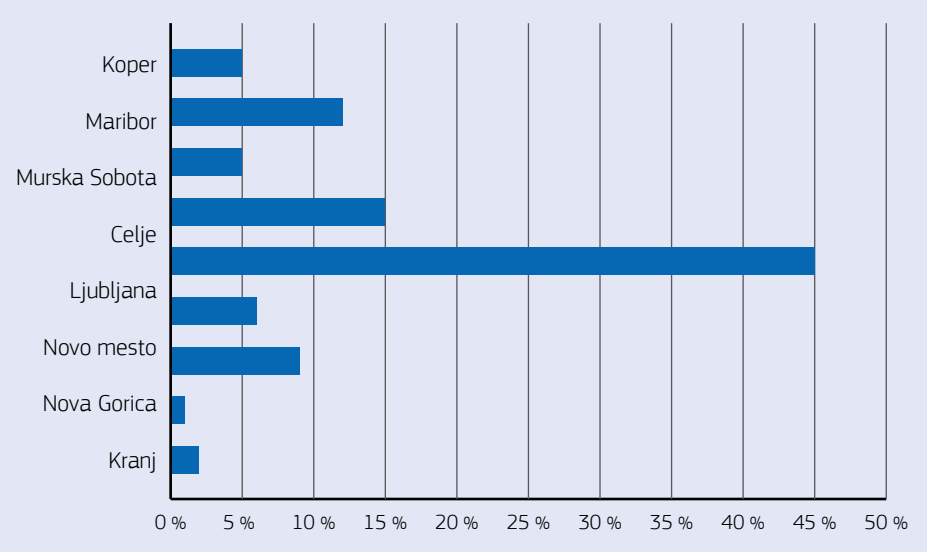

Image 1: Regional placement of respondents (n=185)

The reason for a large percentage of respondents from those regions may well be the fact those are larger regions with the largest number of health centres and with some of the largest hospitals in the country. Reasons for such structure are that the addressees did not respond to the survey, since they have not had any contact with the asylum seekers thus far, namely, because asylum seekers and refugees, who already acquired their international protection, are primarily accommodated in broader areas around Ljubljana and Maribor.

Of all the respondents, who stated what their function in a public health centre was, almost half of them (44%) are medical doctors (M.D. or D.M.D.), followed by medical technicians (28%), nurse practitioners and physician's assistants (14%) and other medical professionals such as therapeutists, dental assistants, radiology engineers and other (15%). The majority of respondents (69%) acquired a higher education (graduate level), a fifth of the respondents acquired secondary education and the rest a tertiary education (post-graduate level).

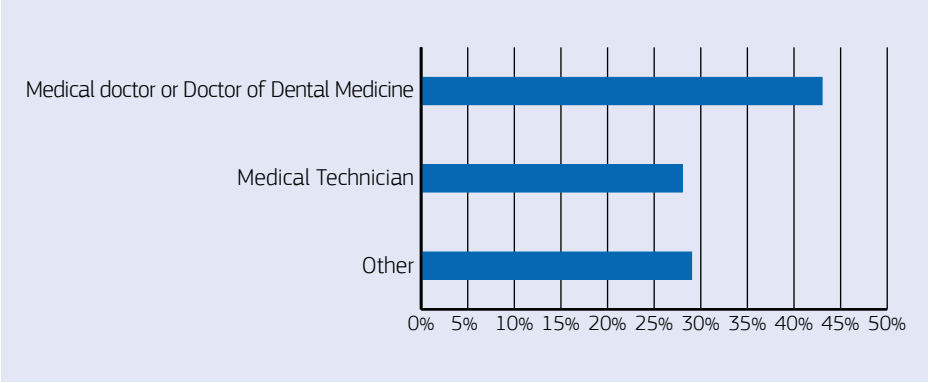

Image 2: Function in a public health institution (n=110)

FREQUENCY OF TREATMENT

We were interested in knowing, how often and where the respondents treated asylum seekers. Two thirds of the respondents have never been included in the treatment of asylum seekers. A little less than a fifth of the respondents (18%) treated the asylum seekers at least once in the past six months. The rest of the respondents (14%) have treated asylum seekers at least once a month. The reason for such low percentage of treatments may be attributed to the fact that asylum seekers are accommodated in units of Asylum home in Vič, Kotnikova and Logatec.

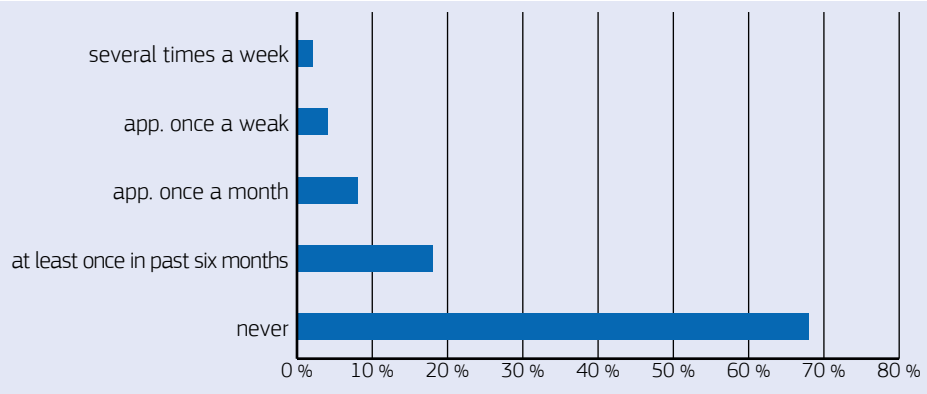

Image 3: Frequency of treatment up to the present day (n=184)

INFORMATION FLOW AND ACTUAL METHODS FOR TREATMENT OF ASYLUM SEEKERS

In health centres, locally in charge for medical treatment of asylum seekers, one issue is a lack of adequate information that would enable an appropriate treatment of asylum seekers when needed and without additional complications. There were cases when due to inadequate information at their disposal and unadapted tools, necessary for administrative treatment of asylum seekers (for instance, asylum seekers do not have a health insurance card and they use their asylum seeker card instead), the personnel did not have the knowledge or the means to appropriately treat asylum seekers. Consequently, their work as well as asylum seekers' access to medical treatment were impeded and the asylum seekers would not have been able to seek medical assistance without the help of social workers or volunteers. In the survey, we posed a question on whether the respondents were given any information or instructions with regards to treatment of asylum seekers by the departmental ministry or the institutions in charge. Slightly less than half of the respondents (45%), who answered the question, knows for a fact that the departmental ministry did not provide any information or guidelines on the subject, while a fifth of the respondents (25%) does not know, whether such instructions were given.

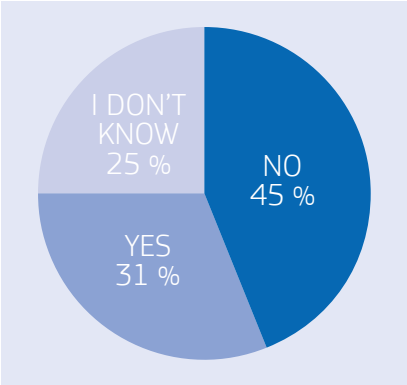

Image 4: Have you been informed by the departmental ministry or the institutions in charge on the methods for treatment of asylum seekers? (n=183)

To those, who received information on methods of treatment of asylum seekers (30%) by the departmental ministry and the institutions in charge, we posed a supplementary question regarding the content of instructions. Different answers were possible. The majority (84% of those who replied YES) stated, they received instructions for administrative treatment and 53% of those, who answered YES, stated, they received a protocol for taking measures in case of outbreak of infectious diseases and conditions, 39% respondents, who answered YES, stated, they received information on rights of asylum seekers and 27% of respondents, who answered YES, stated they received information on referential personnel and clinics for treatment of asylum seekers.

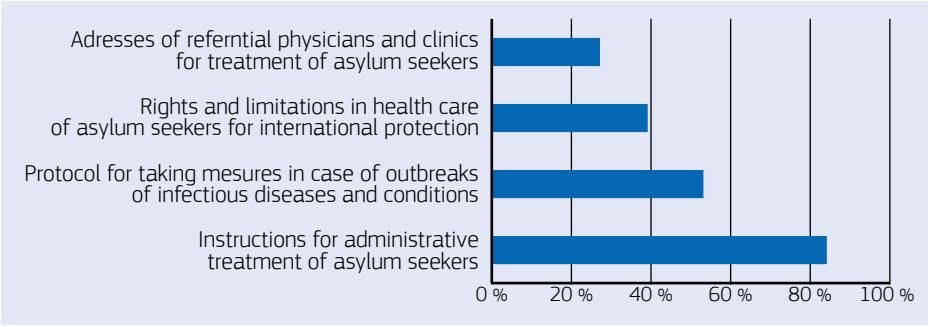

Image 5: What information did the respondents receive from the departmental ministry and the institutions in charge? (n=51)

It is an interesting fact, that the respondents from Ljubljana region, where the majority of asylum seekers are accommodated, stated they did not receive information on asylum seekers' rights. The conclusion is, that the medical personnel, employed at public health

centres, included in the treatment of asylum seekers and regularly working with them, must also face challenges regarding lack of information needed for their work. Practice showed that lack of information leads to stress and discontent of healthcare professionals as well as asylum seekers. It has also been noticed that administrative as well as medical treatment of asylum seekers was more efficient, if healthcare professionals were appropriately informed on how to admit, treat and refer asylum seekers to further examinations. Therefore, our further activities included focusing on providing the asylum seekers as well as the medical personnel the needed information on asylum seekers' rights.

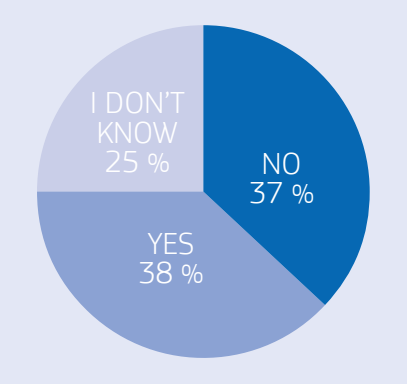

Image 6: Information given to the medical personnel by the departmental ministry and institutions in charge in LJ region (n=82).

We wished to establish how well the institutions are acquainted with and are ready for treatment of specific health conditions, that could appear within the population of asylum seekers. Considering the fact that certain illnesses have been rooted out or do not appear in Slovenia at all, health condition of patients from parts of the world, where such illnesses still appear, could drastically deteriorate if health institutions would not receive proper instructions or guidelines for an efficient medical treatment and procedures for treatment of such diseases. One of the questions in the survey was, whether the medical personnel is informed on existence of protocols/guidelines, used within their institute for treating diseases and medical conditions, which asylum seekers might have contracted in the country of their origin (listed in the image below).

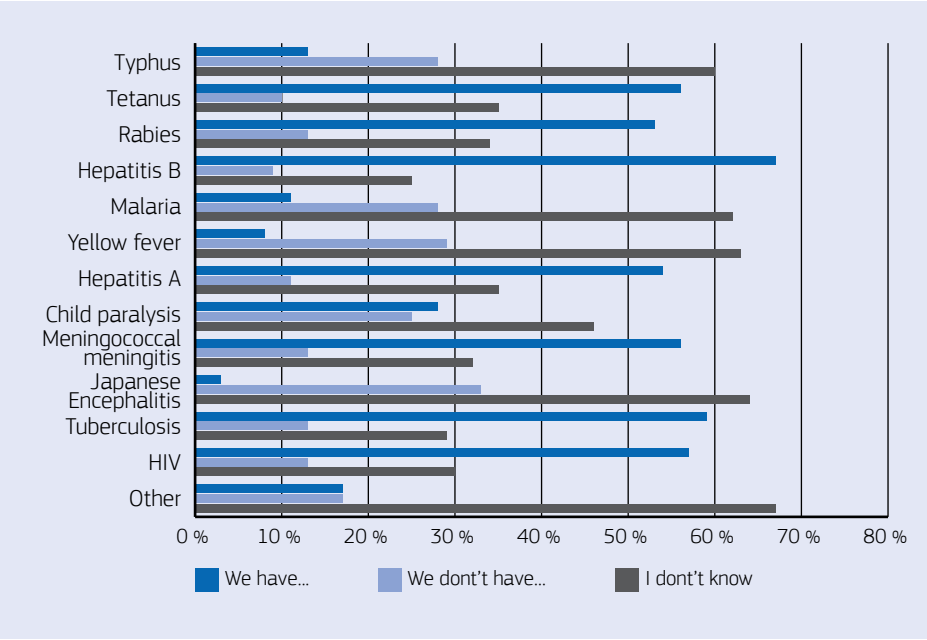

Image 7: For treatment of which infectious diseases did your institute provide a protocol/ guidelines? (n=102)

For most diseases, the medical personnel was acquainted with instructions/guidelines for treatment of individual diseases, with the exception of typhus, malaria, yellow fever, child paralysis and Japanese encephalitis (the respondents stated they have not received any instructions or that they do not know, whether such instructions are available). In case when patients with any of those diseases were admitted into their institution, the treatment process would be compromised, since treatment procedures would have to be additionally verified and in case of inappropriate treatment or prolonged waiting the patients' health condition might deteriorate. Past practice showed that at the outbreaks of certain illnesses, health institutions acquire appropriate treatment procedures only when they treated a sufficient number of such cases, which allowed them to develop the suitable treatment procedures. Our estimation is based on the fact that when we gathered information prior to conducting our survey, we have not managed to acquire those instructions and preventive measures from the National Institute of Public Health. It was interesting to find that in most cases the respondents, who answered I DON'T KNOW, stated they do not know whether there are any instructions/protocols available for treatment of certain other illnesses, such as Ebola, Zika virus or measles.

EVALUATION OF THE SITUATION OF ASYLUM SEEKERS AND RELATIONSHIP OF MEDICAL PERSONNEL TOWARDS TREATMENT OF ASYLUM SEEKERS

Due to numerous system impediments, which are hindering appropriate medical treatment of asylum seekers in various ways, we wished to establish whether the difficulties with treatment of asylum seekers develop as a consequence of administrative obstacles, interministerial inconsistencies and improper legislation realization, or by inappropriate understanding of the current situation with regards to rights of asylum seekers in the process of ensuring medical treatment within the public healthcare system.

We also wished to determine what is the relationship of the respondents towards asylum seekers, respectively, whether they are favorably inclined towards treating asylum seekers or not. The majority of the respondents remained undecided. 21% of the respondents replied, they have no issues with treating asylum seekers, while 20% of the respondents replied they do. It can be concluded that in general, healthcare personnel is favorably inclined towards the asylum seekers, nevertheless the percentage of those uninclined is rather high as well.

Image 8: I do not mind treating asylum seekers (n=177 - on a national level, n=80 - in Ljubljana region)

In continuation, we also focused on the analysis, in which we examined this statement from the aspect of the location, in which the majority of asylum seekers is accommo-

dated at the moment (i. e. Ljubljana). Propensity towards treatment of asylum seekers is slightly higher in Ljubljana than on a national level - 26% of respondents who are inclined towards treatment of asylum seekers come from Ljubljana. 11% of respondents from Ljubljana are partially inclined towards treatment of asylum seekers and 40% of respondents are undecided on the matter. 18% of respondents from Ljubljana are not inclined towards treatment of asylum seekers and 5% of the respondents are partially uninclined.

It is evident that the region with the highest level of exposure to treatment of asylum seekers is more welcoming towards them. The possible reason for such state of affairs may reside in the frequency of treatments and in a better interpersonal dialogue between asylum seekers and medical personnel. It is necessary to understand that a constructive intercultural dialogue will enable citizens of the Republic of Slovenia to understand asylum seekers' problems better and help the asylum seekers to accept and to live by the social norms of our country and, in broader sense, the EU. This way, the integration of asylum seekers into the society will be easier and their treatment in all levels of society, including health care, will be better.

We also analyzed the age aspect. Results showed older respondents are less inclined to the treatment (25%), while in younger generation the percentage of those uninclined is lower (12%). In general, younger respondents are in favor of treating asylum seekers.

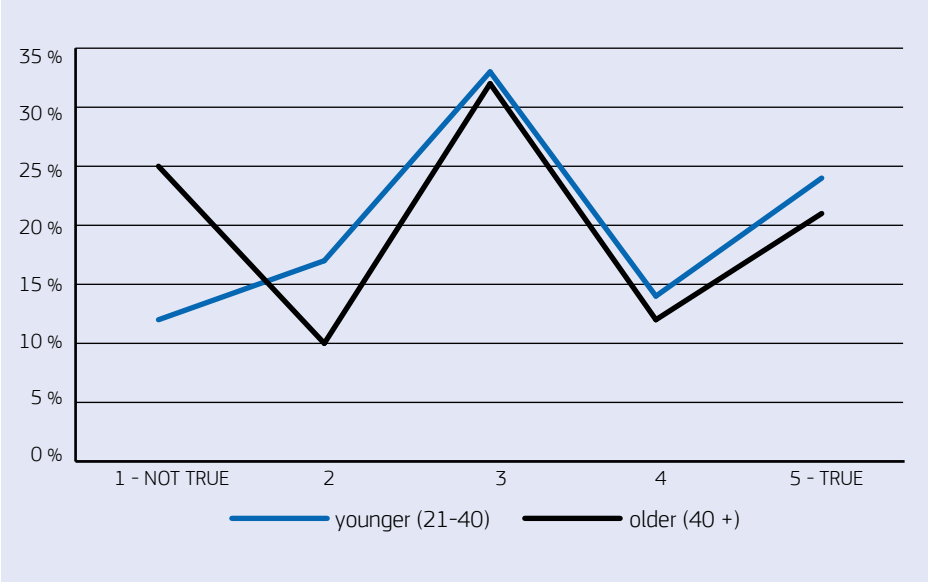

Image 9: Treatment of asylum seekers with regards to age structure (n- younger= 48, n- older=59).

Considering their function within the institution, there is a distinct difference between medical doctors and doctors of dental medicine, and medical technicians and nurses - according to survey results, we may conclude that nurses and medical technicians are more inclined to treatment of asylum seekers than medical doctors and doctors of dental medicine. We can only speculate on the reasons for such state of mind. Perhaps one of the reasons is that medical doctors and doctors of dental medicine are the ones responsible for the treatment and are well aware of the possibility of additional problems such treatments may bring.

We would need to acquire additional information for a more detailed analysis. It would be interesting to establish those reasons in the future, but a more accurate method of research would need to be used, e. g. interviews.

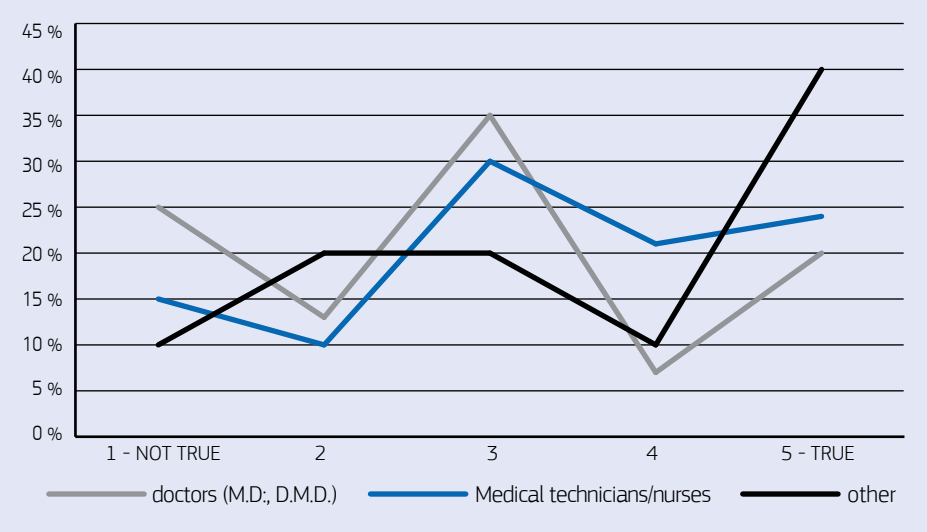

Image 10: Treatment of asylum seekers with regards to the function in the institution (n-doctors (M.D., D.M.D.), r=46, n- medical technicians/nurses=47, n- other=10).

We wished to examine, whether the medical personnel in general hospitals and health centres is informed on the current refugee situation. Results showed that respondents were well informed on the actual state of affairs.

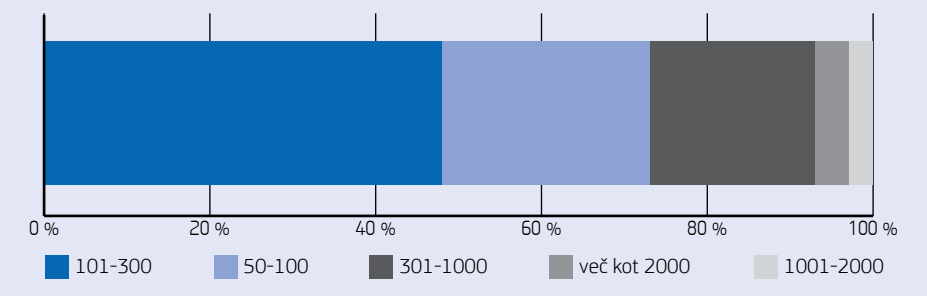

Image 11: Estimation of number of asylum seekers in Slovenia (n=103).

We were also interested in the opinion of the respondents on what illnesses do they expect to encounter when treating asylum seekers. They stated: acute diseases and conditions, infections, malnutrition and various forms of deteriorated mental state, but in fact the biggest issue is a limitation of a continuous access to medical treatment for patients with chronic diseases, since without regular treatment, their condition is not improving or is even deteriorating on a daily basis.

Furthermore, we also posed a question, regarding how well the respondents know the rights and the extend of rights of particular groups of asylum seekers. According to the legislative of Republic of Slovenia in connection to treatment of asylum seekers, they are entitled to urgent medical treatment, while children, pregnant women and breastfeeding women have the same rights to medical treatment as Slovenian citizens. Nevertheless, practice showed that healthcare professionals often need an additional explanation on that matter or need to be made aware of that fact. Survey results showed that a very high percentage of the respondents, who answered that question (80%), are well informed on the rights of asylum seekers. It is evident that experience from practice and survey results show eventual improvement of understanding those rights. It may also be that the medical personnel is familiar with those rights, but does not implement them into treatment processes, possibly due to reasons of personal nature or due to unadjustment of the system for treatment of asylum seekers with those rights. As already mentioned, in certain cases we have witnessed complications in administrative treatment of patients that puts both healthcare professional as well as the asylum seekers into an unpleasant situation.

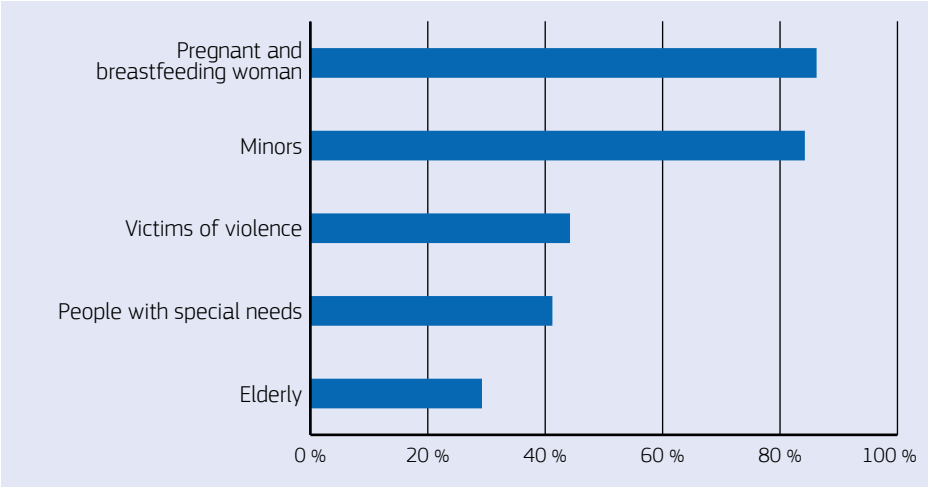

Image 12: Opinion on equalization of rights of asylum seekers with rights of citizens of Republic of Slovenia (n=103).

From a perspective of a complete treatment of asylum seekers, we were also interested in how the medical personnel perceives the treatment of patients with international protection. As previously mentioned, asylum seekers are entitled only to treatment in case of emergency, therefore, the treatment they receive is limited to urgent medical treatment. In practice, this means that when they are referred to a further examination without an urgent referral (except in case of self-funding of medical treatments, which is not possible for most asylum seekers), asylum seekers find themselves in a situation, where they receive a reference letter for a specialist examination for treatment of their particular health condition, but at the same time the reference letter is of no use to them, since they are not entitled to a specialist examination unless they are in a state of emergency. This may lead to additional aggravating circumstances, because asylum seekers are unable to pay for the services. Such complications also affect the work of the medical personnel, who is also put under additional pressure by the measures, imposed onto them by the system.

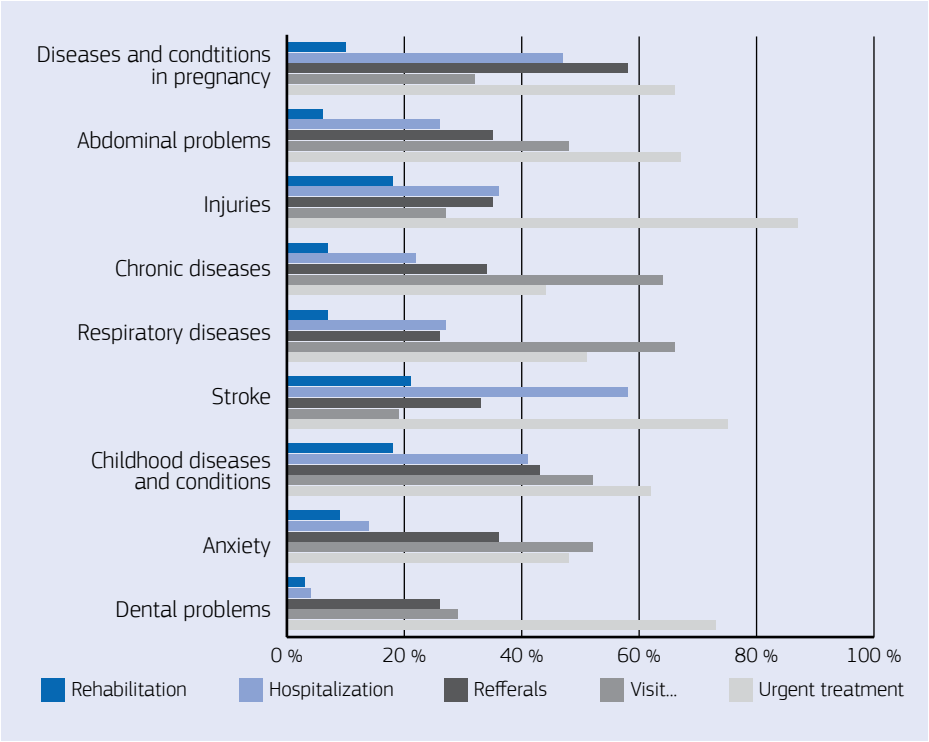

Image 13: Rights for different levels of treatment in case of certain health conditions (n=105).

It is evident from the answers that medical personnel is well aware of the fact that by the law, asylum seekers are entitled to urgent medical treatment. At the same time, a percentage of respondents, who agree that asylum seekers should have a right to a specialist examination, is also quite high. Nevertheless, in the beginning such examinations have proved difficult to be performed due to personnel shortage.

With the purpose of improving the existing system, which is unkind to the asylum seekers as well as to medical personnel, we posed a question regarding evaluation of current condition of treatment of asylum seekers, the relationship of the medical personnel towards the existing treatment system and possibilities for a change in the future. The available answers were listed in a table and the respondents evaluated them on a scale from 1 to 5, where 1 meant NOT TRUE and 5 meant TRUE. The answers and the respondents' evaluations are listed in the table below:

Statement/Evaluation	1	2	3	4	5	n
I believe that public health system efficiently covers the medical needs of asylum seekers.	8%	8%	33%	21%	30%	**106**
Asylum seekers should have the right to a specialist examination in non-urgent cases as well.	21%	21%	29%	16%	3%	**105**
In case of increased medical needs of asylum seekers, I would be willing to partake in treatment processes more intensely (pro bono clinics, voluntary work in my own clinic).	17%	15%	28%	15%	25%	**103**
Treatment of asylum seekers demands more effort and imposes a burden on health institutions.	2%	3%	20%	28%	47%	**100**
System-wise, a better organization of treatment of asylum seekers is necessary.	2%	4%	20%	24%	50%	**101**

Table 1: Evaluation of statements referring to treatment of asylum seekers.

It is evident from the answers that in general, the respondents believe the system already efficiently covers the medical needs of asylum seekers and that 42% of the respondents, who answered the question, do not agree with the statement on the right to a specialist treatment in non-urgent medical cases. The same applies for those respondents, who remained undecided (29%). As we noticed during our work, the issue with rights for a specialist examination in non-urgent cases is a complex matter, since the health condition of patients (the same also applies to patients with chronic illnesses) may deteriorate to the point, when their condition requires an urgent medical treatment. When this happens, it is difficult to treat people without having access to a record of their medical history, which could be easily resolved by giving asylum seekers the right for a specialist examination and the right to choose a personal physician. Precisely this kind of deterioration of their health has a profoundly negative influence on the patients' psychophysical state, which is evident from the occurrence of conditions, that require an intensive psychosocial or even psychotherapeutic interference. Waiting for the asylum seekers' health condition to develop into a state of emergency brings forth other issues in different areas and at the end leads to development of serious problems, which could be avoided if the asylum seekers had the right to a specialist examination in the first place.

On the question on voluntary work and offering free medical services, 40% of the respondents replied they are willing to provide medical treatment free of charge. A high

percentage still remains undecided on the matter.

Voluntary work in form of pro bono activities already provides the majority of help, offered to vulnerable groups (individuals without health insurance). Positive replies of the respondents with regard to the question whether they are willing to work voluntarily are an encouraging information for organization of medical treatment of asylum seekers, nevertheless, final conclusions cannot be made yet, since distribution of answers is very disproportionate and as such does not allow a more concrete inference.

A relatively high percentage of the respondents (75%), who answered the questions on whether they perceive the public health institutions to be burdened by the current system for treatment of asylum seekers and whether they perceive the system of treatment of asylum seekers to be efficient, agree that health institutions are overloaded and that medical treatment of asylum seekers should be organized more efficiently system-wise (74%).

Based on results of the survey, we may conclude that on behalf of the medical personnel, employed in public healthcare institutions, as well as on behalf of the asylum seekers, it is necessary to reconsider how to reorganize the system of medical treatment of asylum seekers in a way it would best serve the asylum seekers' interests. It would be necessary to ensure a system, in which asylum seekers could use medical services as independently as possible and without additional complications. It is also crucial to ensure that the medical personnel would not perceive those changes as an additional burden to their work and that the change in the system would administratively enable them to appropriately treat asylum seekers without encountering major difficulties, additionally burdening their work.

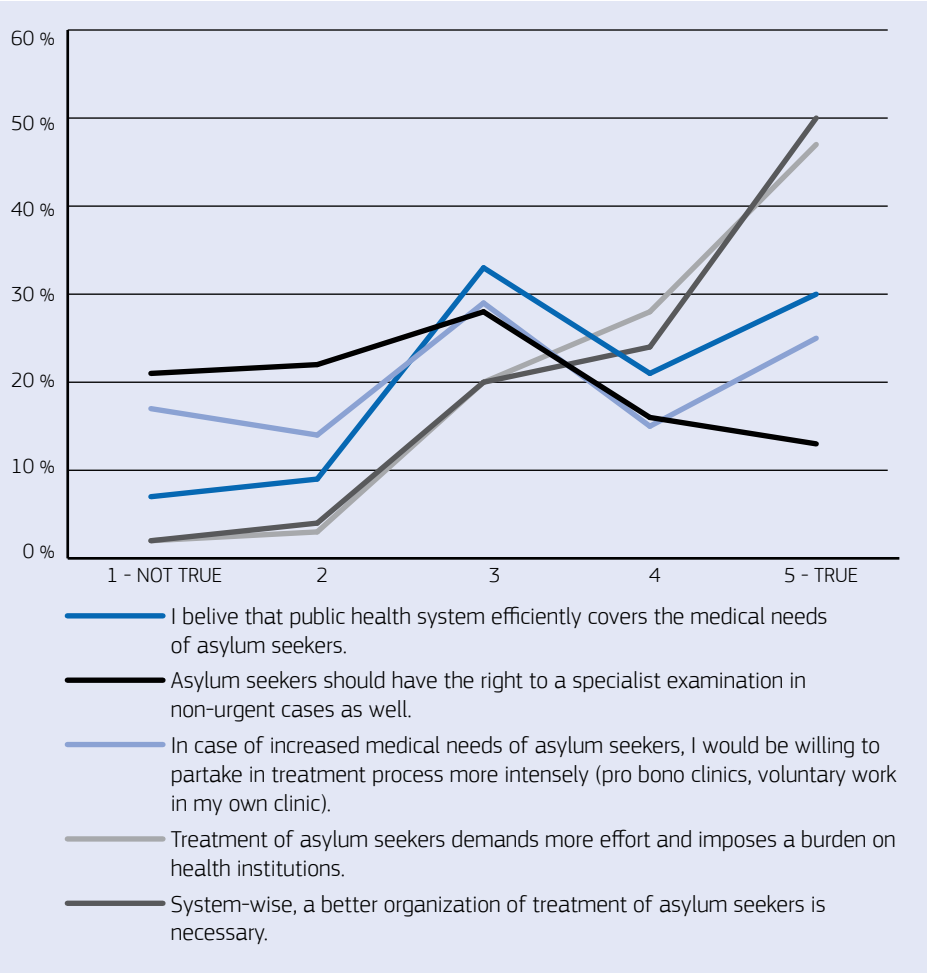

Image 14: Agreement/disagreement with the statement on treatment of asylum seekers and distribution of answers.

MEDICAL TREATMENT OF ASYLUM SEEKERS

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