Documentation and Access to Health: Challenges and Opportunities for Displaced Persons

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NRC NORWEGIAN REFUGEE COUNCIL

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Briefing note from the Norwegian Refugee Council

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Cover photo: NRC

NRC is working on rehabilitating a medical centre in Aleppo that could play a key role in the response to Covid-19, in cooperation with the Department of Health, Aleppo Governorate and Syria Trust for Development.

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Executive summary

> Before I went to NRC there were some centres which did not ask for papers, but mostly I just avoided going to the doctor. Once my son got sick, and the hospital refused to treat him because he did not have his papers. Now that we have the documents, I do not have to worry about whether or not they will accept us for the service.
>
> – Syrian refugee woman in Lebanon[1]

The right to health is an inclusive right linked to other human rights (such as water, safe food, healthy environment, etc.). Health services should be provided to all, including individuals affected by displacement, without discrimination.

While global data on forced displacement and access to health is scarce, it is evident that displacement is a key determinant of health and well-being, and IDPs, refugees and vulnerable migrants are among the most vulnerable populations with inadequate access to health services. Building on NRC's field knowledge and experience, this brief describes the documentation barriers faced by displaced persons in accessing health services. The evidence base is drawn from NRC's legal assistance (ICLA) programmes for displaced communities, case studies from eight countries and a global NRC survey conducted in November 2021 with responses from 25 countries.[2] The brief builds on NRC's extensive legal aid expertise supporting displaced individuals to access civil documentation around the world.

Despite the wide range of displacement contexts, NRC identified clear common themes from its operational experience, country level analysis and the survey. In the vast majority of the surveyed countries (86 per cent), displaced persons face obstacles in accessing health services. Key challenges include limited availability of services, distance, high cost, security concerns and administrative barriers including documentation requirements. NRC's experience shows that documents such as identification documents, residency and legal status documents, refugee and asylum seeker registration cards, health insurance and medical records, are required in the majority of the respondent countries (61 per cent) with great variation across location, type of health service sought and medical providers. Refugees and IDPs often do not have these documents required by the medical personnel to verify the patient's identity prior to the administration of healthcare. 79 per cent of the NRC countries surveyed stated that such documents are not easy to obtain by displaced persons due to unaffordable costs, lack of information about procedures and discrimination. In these contexts, the World Health Organization calls for the development of a clear protocol for the identification of patients who lack

documentation. NRC's experience shows that in practice, the lack of documentation can result in limited or even denial of healthcare services such as reproductive, maternal and child care as illustrated in the Iraq and Colombia examples. NRC experience in Palestine, Colombia, Panama, Afghanistan and Kenya shows that displaced populations face multiple layers of discrimination based on their place of origin, nationality, ethnic group and their displacement, marital and social status. This is often not based on laws or regulation, but on social practice and can result in impaired or denial of medical services with far reaching consequences beyond the individual and the household health. Lack of access to healthcare can and does drive negative coping strategies and has disastrous long-term consequences for different demographics, including women and adolescent girls and the elderly. The use of fraudulent documents, for instance has emerged as a coping strategy and as an unwanted consequence for some Syrian refugees in Jordan, Lebanon and Iraq when unable to obtain the documentation required to access services, including health.

Left unaddressed, administrative and documentation barriers will continue to make it difficult for displaced individuals and their families to access the healthcare services they desperately need. There are concrete opportunities to build on the Covid-19 momentum which has generated new, more inclusive policy guidance calling on states to remove all barriers, including those related to documentation to ensure access to vaccination, testing and treatment for all. While this has not always been followed in practice, it provides a precedent for the UN, (I)NGOs, governments and donors to broaden access to healthcare for all migrants, refugees, internally displaced people, asylum seekers and their families on a non-discriminatory basis, regardless of their nationality and migration status and to remove documentation barriers.

Introduction

While global data on forced displacement and access to health is scarce, it is evident that displacement is a key determinant of health and well-being, and IDPs, refugees and vulnerable migrants are among the most vulnerable populations with inadequate access to health services. Obstacles to healthcare include lack or limited availability or far distance to health services, high cost of the services and policy, administrative and legal barriers. Administrative procedures, such as requirements for documentation or discriminatory implementation of regulations, can result in lack of access to health services with life-threatening consequences for different demographics, including women and adolescent girls and the elderly.

This brief explores documentation barriers that populations affected by displacement face when accessing healthcare services. It starts with an examination of the relevant legal framework and then through case studies from eight countries

provides analysis on the challenges and the consequences of not being able to obtain medical services. It also describes the positive results that can be achieved through the provision of legal assistance, collaboration with health actors and advocacy efforts. The evidence base is drawn from NRC's Information, Counselling and Legal Assistance (ICLA) programming for displaced communities around the world and the global NRC survey conducted in November 2021 with responses from 25 countries where NRC has field operations.[3] The brief builds on NRC's extensive knowledge and expertise on access to identity and civil documentation for persons affected by displacement. The analysis concludes with a series of practical recommendations addressed to UN agencies, (I)NGOs, governments and donors.

A Ministry of Interior card used to prove Syrian refugees´ registration in Jordan. Photo: NRC

The right to health

Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.[4] The enjoyment of the highest attainable standard of health is a fundamental human right enshrined in various international human rights treaties[5] and applicable to all, without distinction, including persons affected by displacement. As the world continues to struggle with the Covid-19 pandemic, access to health has been at the forefront of global policy debates testing countries and the world's capacity to ensure adequate health coverage for all. Key aspects of the right to health are:

- The right to health is an inclusive right and is linked to other rights (such as water, safe food, healthy environment, etc.).
- Health services, goods and facilities must be provided to all without any discrimination.
- All services, goods and facilities must be available, accessible, acceptable and of good quality.[6]

The CESCR General Comment N°14 on The Right to the Highest Attainable Standard of Health (Art. 12) adopted in 2000 provides comprehensive guidance on the right to health.[7]

Beyond international human rights instruments, the Sustainable Development Goals call on all countries to "ensure healthy lives and promote well-being for all at all ages" (SDG 3)[8] with target 3.8 aiming to "achieve universal health coverage, including financial risk protection, access to quality essential healthcare services and access to safe, effective, quality and affordable essential medicines and vaccines for all" by 2030.[9] Universal Health Coverage means that all individuals and communities receive the health services they need without suffering financial hardship. It includes the full spectrum of essential, quality health services, from health promotion to prevention, treatment, rehabilitation and palliative care across the life course.[10]

The right to health for displaced populations

The 1951 Refugee Convention states that refugees should have access to the same or similar healthcare as host populations[11] and the 2018 Global Compact on Refugees calls for more responsibility sharing among states to host, protect and assist refugees, and to "expand and enhance the quality of national health services to facilitate access to refugees and host communities."[12] The 2016 New York Declaration for Refugees and Migrants, unanimously adopted by the UN General Assembly, reaffirmed the commitments of providing basic health, education and psychosocial development of all refugees and migrants regardless of status.[13]

The 1998 Guiding Principles on Internal Displacement call on state authorities to provide internally displaced persons with and ensure safe access to essential medical services and sanitation regardless of the circumstances of displacement and without discrimination and call for special attention for the wounded, sick or persons with disabilities, the healthcare of women, and the prevention and contagion of infectious diseases.[14] The 2021 UN Secretary's High Level Panel on Internal Displacement in its final report recommends that "mental health and psychosocial support should be provided to help IDPs and other crisis-affected populations recover from the experience and trauma of crises."[15]

The SPHERE Humanitarian Charter and Minimum Standards in Humanitarian Response defines essential concepts in health in humanitarian settings[16] and the Inter Agency Standing Committee Guidelines on Mental Health and Psychosocial Support in Emergency Settings[17] reaffirms that there is no health without mental health. These principles are also set out in the 2008 World Health Assembly 61.17 Resolution on the health of migrants, asylum seekers and refugees.[18] Further, the global health cluster, led by WHO, aims at relieving suffering and saving lives in humanitarian emergencies, while advancing the well-being and dignity of affected populations through the provision of coordination and technical support.[19] Health clusters/sectors are currently active in 31 countries affected by conflict or disaster.[20] In times of armed conflict, international humanitarian law provides rules to protect access to healthcare by calling for maintaining healthcare systems.[21]

An internally displaced young woman holding her Temporary ID after TIDs distribution in Abyan governorate, Alqarnaah Camp Yemen. Photo: Ahmed Aref/NRC

Challenges to access to health for persons affected by displacement

While global and country data on forced displacement and access to health is lacking, forced displacement is a key determinant of health and well-being, particularly when this is due to conflict or violence[22]. IDPs, refugees, asylum seekers, and vulnerable migrants remain among the most vulnerable populations in the

world, faced with discrimination, poor living and working conditions, limited and eroded support networks on the move, and inadequate access to health services.[23] This is further exacerbated by distinct needs linked to displacement and vulnerabilities related to age, gender, disability or other factors. This is echoed by NRC's experience. Most respondent countries (86 per cent) state that persons affected by displacement face obstacles in accessing health services. The main types of obstacles reported in accessing health include:

- lack or limited availability or far distances to health services (71 per cent of NRC surveyed countries)
- high cost of services (64 per cent of NRC surveyed countries)
- policy, administrative and documentation barriers (43 per cent of NRC surveyed countries)[24]

Additional barriers include movement restrictions affecting access to health services (reported in Myanmar, Ukraine, Palestine, Sudan); lack or limited availability of specialised or quality health services (Kenya, Jordan); lack of mental health services (Colombia, Panama, Ecuador); shortage or unavailability of drugs (Kenya, Afghanistan). Large-scale destruction of health facilities during conflict was reported in Syria.[25]

Box 1 Afghanistan: Decline in public health conditions and 'legal limbo'

"Lack of documentation presents challenges for access to health care in two ways. Some health facilities, especially government services, in practice require identification to treat people, which many do not realise. However, no laws can be found which stipulate this. In addition, more complicated medical cases may require travel to Pakistan or India, which is impossible without a passport." [26] Since the change of regime in August 2021, the public health situation in Afghanistan has rapidly deteriorated[27] and the country is in a state of 'legal limbo' with unclarity as to which laws and policies apply in terms of access to services, including healthcare.

NRC's work on legal identity, including civil documentation, and legal stay

NRC has developed, through its ICLA (legal aid) programme,[28] specific expertise on legal identity and legal stay, by supporting displaced persons to access civil registration, identification documents and meet residency requirements.[29] While general barriers in accessing documents may exist for all, certain barriers are specific to displacement contexts. For example, documents can often only be obtained in the place of origin and displaced persons cannot make the journey

because of security concerns, lack of resources or fear of jeopardising their legal stay in a host country. Also, the destruction of identity and civil registration offices and records as a result of conflict or disaster means that foundational documents are missing. In these scenarios, the ICLA programme supports displaced persons navigate the legal and administrative procedures they must confront to obtain their identity and civil documents, claim refugee status, or regularise residency.[30] In 2021, NRC assisted more than 900,000 individuals worldwide to register and obtain document. This is complemented by the ICLA support on access to essential services, such as healthcare and education. The themes are inter-connected and information, counselling, legal assistance, research, training and advocacy activities are used in combination to promote and protect the rights of persons affected by displacement.

Documentation requirements for health services

For the purpose of this brief, "documentation" refers to an official document that is often the product of administrative processes that state authorities require from individuals to give validity or recognition to various life situations (e.g. birth, death, nationality, refugee status, etc.).[31] According to the World Health Organization (WHO), healthcare providers have the responsibility to check and verify a patient's identity, while patients should be actively involved in understanding the importance of identification upon admission and prior to the administration of healthcare.[32] Documentation is therefore often a pre-condition to enjoying the right to health.

NRC's global survey found that documents are required to access health services in the majority of the respondent countries (61 per cent), with significant variation across locations, the type of health service sought and the medical provider.[33] Documentation requirements include:

- **Identification documents** to confirm one identity. These were required in 68 per cent of the countries surveyed.[34]
- **Civil documents** to provide proof of a vital event, such as birth (29 per cent[35]), marriage (6 per cent[36]), divorce or death.
- **Legal stay, residency or legal status documents** to prove that someone meets residency status. Residency documents can apply to both nationals (proof of residence in a certain part of the country) and non-nationals (legal stay in a foreign country). These were required in 25 per cent of the countries surveyed.[37]
- **Refugee or asylum seeker documents** to prove that someone has a refugee or asylum seeker status granting specific rights and entitlements.
- **Health insurance documentation** to prove coverage by a governmental or private health insurance plan (21 per cent of countries surveyed[38]).
- **Past medical records** to provide medical history.

Box 2 Iraq: multiple documentation barriers for women

In one case documented by NRC Iraq, "Eman, a woman from west Mosul whose husband was missing, could not give birth in two different hospitals because she did not possess a valid civil ID or a marriage certificate. She told NRC she was questioned about whether her husband was affiliated with Islamic State or if her child was conceived outside of a marriage. The hospital staff also threatened to keep her newborn in the hospital until the father presented himself. Eman gave birth at home without a doctor to supervise the process. Her daughter, Abeer, is now more than a year old and still does not have a birth certificate or any other form of ID. Her daughter recently fell ill and Eman wanted to take her to a hospital in one of the camps, hoping they had less stringent documentation requirements. However, she was unable to pass through the checkpoint on the way to the camp."[39]

Lack of documentation: a barrier to access health services

The documentation gap for displaced persons has been well documented by NRC in more than 16 countries, showing a pattern of exclusion through a diverse mix of legal, bureaucratic, and practical obstacles. The NRC analysis shows that in these contexts, women and girls often face disproportionate challenges in obtaining an identity document.[40] NRC's global survey carried out for this brief confirm these barriers with 79 per cent of the countries surveyed stating that the documents required are not easy to obtain by displaced persons, due to unaffordable costs, lack of information about procedures, and discrimination based in law or social practices. In these contexts, the WHO recommends that a clear protocol should be developed for the identification of patients who lack identification and for distinguishing the identity of patients with the same names.[41] However NRC's analysis shows that undocumented displaced persons generally have limited access to social services and medical care. In Lebanon for instance, only 10 per cent of primary health centres and hospitals contacted by NRC admit Palestinian and Syrian refugees without documentation.[42] For stateless persons and persons at risk of statelessness, the lack of documentation can be linked to their (potential) lack of nationality. Access to medical services for children of stateless persons is also a challenge as the documents of the parents or guardians of minor are often required.[43]

In 25 per cent of the surveyed countries NRC witnesses a denial of health services based on lack of required documentation. This applies to certain types of services, such as preventative healthcare not available to all, or when the capacity of the health facilities is over-stretched, and nationals are given priority over non-nationals. The lack of marriage certificate was reported as an obstacle for single, divorced or unaccompanied women, including for accessing reproductive and maternal healthcare.

NRC analysis also shows that lack of personal documentation can prevent one's meeting certain conditions which are a prerequisite to and/or facilitate access to health services. For example, to access healthcare one may be required to travel, qualify for insurance, be referred for out of camp services where documents play a key role. Documentation is therefore not only an enabler for the right to health, but also for other rights necessary to make the right to health effective.[44]

Box 3: El Salvador: Impact of violence and fear on the right to health

In El Salvador, the experience of displaced people has shown that "healthcare protocols or procedures can inadvertently be barriers to accessing services. For example, people displaced by violence often fear being followed or tracked down by their persecutors and prefer to avoid handing over their Unique Identity Document (an identity card that includes sensitive information such as home addresses) or providing other sensitive information, often a prerequisite for care. This same fear means that displaced people avoid crowded places such as hospitals, sometimes resulting in missing medical consultations and in self-medicating".[45]

Box 4: Kenya: a more nuanced situation for refugees

NRC's efforts in Kenya reflect that, "the relationship between refugees' ability to access healthcare and documentation does not appear to be straightforward. Several refugees said they experienced challenges accessing healthcare on account of lacking urban refugee documentation. One Ugandan refugee, who came to Nairobi in early 2015 and did not have a mandate certificate or alien card, said he had a thyroid problem and required medical care, but staff at a public hospital he visited reportedly told him that he could receive assistance only if he had a mandate certificate or alien card. An elderly Congolese refugee similarly said that when she sought treatment for an injured leg at a private hospital a receptionist told her that she could not be treated at the hospital without a mandate certificate and alien card. Her nephew instead bought medication for her from a pharmacy. An Ethiopian refugee reported that at one health clinic run by a charitable organisation, was told "if you don't have the mandate (certificate), you cannot get treatment – it doesn't matter how sick you are." However, other refugees said it was possible to access healthcare without any documentation at all."[46]

Multiple discrimination

Multiple discrimination (being discriminated against due to more than one personal trait) can be seen in countries where NRC operates. According to the global NRC survey, displacement affected populations face multiple discrimination in accessing healthcare in almost half of the surveyed countries (43 per cent) and this can lead to impaired or even denial of healthcare. Displaced individuals are discriminated based on their place of origin, nationality, ethnicity, their current place of residence, their displacement / migration status and/or their marital and social status. For example, in Palestine, access is regulated by law and depends on where one comes from and differs for East Jerusalemites, West Bankers or Gazans.[47] In most cases, however, discrimination occurs in practice and is not based in law[48] as illustrated in the box below.

Photo: Tom Peyre-Costa/NRC

Box 5: Challenges in Colombia and Panama for unregistered refugees

Access to public healthcare is problematic for undocumented and irregular refugees and migrants in Colombia and Panama. In Colombia, by law, asylum seekers, refugees and migrants can access public primary health even if undocumented or irregular. However, in practice they are turned away because of the lack of documentation. This means that unregistered refugees can only access emergency medical services which do not offer, for instance, reproductive, maternal and child health.

In Panama, irregular and undocumented refugees and migrants cannot access public healthcare. Migrants in transit can obtain limited medical services provided by NGOs in the migratory centre where they are being held.[49]

Nine of the countries reported that health providers keep patients' personal documents until hospital bills are paid. This practice affects the most vulnerable and poor including displaced persons.[50]

Covid-19 measures

About half of the NRC respondent countries indicate that specific Covid-19 measures affected access to health services during the pandemic: 32 per cent reported a general increase in access to health services, 25 per cent a decrease in access, and 18 per cent no change. Key policies and measures that resulted in increased access to health services are: better information and referral through hotlines set up specifically for displaced; medical expenses (partially) subsidised by the government; inclusion of displaced population in national Covid-19 vaccination plans (although these are not always followed in practice due to logistical challenges and administrative requirements).[51]

Measures that limited access to health services as reported by NRC include: restrictions of movement impeding access to medical facilities; medical services being directed towards Covid-19 response; non-life saving cases being deprioritised; temporary closure of borders; suspension of asylum, refugee registration or status determination procedures, leaving persons unregistered and as such unable to receive medical care; and difficulties in getting masks required to access medical facilities.[52]

Photo: NRC

Box 6: New Covid-19 policy on removal of documentation barriers

The pandemic has generated new policy guidance that calls on States to provide equitable access to Covid-19 vaccination, tests and treatment for all migrants, refugees, internally displaced people, asylum seekers and their families on a non-discriminatory basis, regardless of their nationality and migration status and calls for the removal of documentation barriers to vaccination.[53]

Consequences and coping mechanisms

The consequences of not having the required documentation can be life-threatening, putting the health of displaced persons at further risk with long-lasting and far-reaching effects for different demographics, including women and adolescent girls and the elderly. This can also push displaced individuals to adopt risky coping mechanisms such as obtaining or using fraudulent documents as illustrated in the box below. Many are also pushed into extreme poverty because of medical expenses. Finally, the lack of healthcare is interconnected with other important outcomes and sectors including for instance access to education, decent work and livelihood opportunities.

Box 7: Syrian refugees in Jordan, Lebanon and Iraq: Negative coping strategies and use of falsified documents

When unable to access the civil documentation they need, refugees may resort to coping mechanisms that can put them at further risk, such as engaging intermediaries, or traveling to Syria to access or obtain documents. Acting, or making decisions based on misinformation can also contribute to increased risks for refugees. The use of fraudulent Syrian and host country documents has emerged as both a coping strategy and an unwanted consequence for some refugees who are unable to issue, replace, or update documents, through adequate legal and administrative procedures. Refugees who possess and use fraudulent documents face significant short- and long- term consequences that can complicate their legal status, risk criminal penalties for themselves and family members.[54]

Conclusion and recommendations

When it comes to access to health, the lack of documentation can be a matter of life or death. Despite the efforts that have been put in place, IDPs, refugees and vulnerable migrants remain among the most vulnerable populations with inadequate access to health services including for the most essential services. If the administrative and bureaucratic challenges including documentation requirements,

are not urgently addressed, displaced individuals will continue to be at the margin of healthcare systems, exposing them to huge protection and health needs. Concrete steps can and should be taken to build on the momentum created by the Covid-19 response to ensure that essential healthcare is available to all, regardless of their identity, legal status, or nationality and level of documentation. Recommendations for the attention of the UN, (I)NGOs, governments and donors follow:

The UN should:

- Continue to broaden efforts to generate global disaggregated data on forced displacement and access to health. This would build upon important recent initiatives.[55]
- Develop and implement policy guidance, building on the momentum created by the Covid-19 response, to ensure access to healthcare for all migrants, refugees, internally displaced people, asylum seekers and their families on a non-discriminatory basis, regardless of their nationality and migration status and continue to call for the removal of documentation barriers to healthcare. Implementation of this guidance should be monitored and reported on.
- Strengthen multi-sectoral partnerships and collaboration: a well-coordinated, multi-sectoral and multi-country response to managing the documentation needs of displaced persons is required. Collaborative networks and international dialogue on access to legal identity documents are essential to manage and address barriers to enjoying the right to basic services including health.

(I)NGOs should:

- Document bureaucratic and administrative requirements to access health that exist in practice at country level and raise awareness on the negative consequences and coping mechanisms of such demands on the displaced highlighting the distinct and often disproportionate risks faced by certain demographics not least women and girls, people with disabilities and the elderly, and advocating for the lifting/reduction of these requirements.
- Strengthen the operational actions which assist displaced individuals obtain documentation required to access health services, as well as advocating for the removal of documentation requirements – whether by law or applied in practice - when these exclude persons affected by displacement and vulnerable groups.

Governments should:

- Include persons affected by displacement in national health systems on a non-discriminatory basis, regardless of their nationality and migration status and

without documentation and other cumbersome administrative requirements. The provision of health service must be anchored in the human right to health.
- Facilitate access to civil documentation for individuals affected by displacement.

Donors should:

- Work with national authorities and the Ministry of Health to ensure quality access to healthcare services for communities affected by displacement and remove documentation barriers.
- Invest in health programming that supports the inclusion of displaced persons in national healthcare systems without documentation requirements.

Endnotes

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[49] https://www.minsalud.gov.co/Paginas/En-60-dias-se-afiliaran-en-salud-700-mil-migrantes.aspx
[50] Global NRC Survey, November 2021.The practice was reported in Syria, Iran, Ethiopia, South Sudan, Yemen, Democratic Republic of Congo, Jordan, Ecuador and Bangladesh.
[51] Global NRC Survey, November 2021.
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[53] Joint Guidance Note on Equitable Access to COVID-19 Vaccines for all Migrants, OHCHR, IACHR, ACHPR and Council of Europe, https://www.ohchr.org/Documents/Issues/Migration/JointGuidanceNoteCOVID-19-Vaccines-for-Migrants.pdf and Open letter to G20 Heads of States and Governments, UNHCR, IOM and WHO, October 2021, https://www.unhcr.org/news/press/2021/10/617bffc64/open-letter-g20-heads-state-government-unhcr-iom.html
[54] Legal Identity and Housing, Land and Property Rights of Syrian refugees from a Durable Solutions Perspective: Challenges and Opportunities, NRC/UNHCR, December 2021, p. 17, https://www.nrc.no/resources/reports/legal-identity-hlp-rights-syrian-refugees-from-durable-solutions-perspective/
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