State and NGO Survey Report Findings:

High Needs Refugee Resettlement Cases

ATCR 2013

Canada Chair

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Introduction

At ATCR 2012, the NGO statement challenged all participants to work collaboratively to address certain integration needs, including the mental health issues faced by certain marginalized and extremely vulnerable groups. States indicated their own research show housing and employment to be key integration issues – and that not addressing these issues exacerbate the mental health issues.

When Canada took on the chair for 2013, we promised to pursue the work begun by others. As a community, resettlement states and the UNHCR often collect information about refugees' integration needs before they leave but this information is not always shared with the right people at the right time. As chair, one of our objectives is to develop a better understanding of high needs medical and high needs integration cases and then to explore how we can, as a community, ensure the information we collect is given to the right people, for example service providers, ministries of health, education and others in advance of refugees' arrival.

Within the context that the protection needs of refugees are first and foremost and in the spirit of enhancing our overall capacity to better meet the integration challenges of some resettled refugees, a group of states and Non-Governmental Organizations (NGOs) were invited to complete questionnaires for the purposes of:

- helping develop a common understanding within states and NGO's on what constitute "high needs medical conditions" and "high integration need" cases in order to help strengthen the ability to respond to UNHCR referred medical cases as well as refugees requiring specific integration support. A key starting point is to develop a common understanding and distinguish between high needs medical conditions and high integration needs. At the same time it is important to recognize that "medical needs" are not necessarily by definition "high needs", or at least not in the sense of long-term high needs. A refugee might need a medical intervention in the short term which thereafter may not impact his/her long term integration.

- developing better practices to ensure receiving countries and NGOs are able to provide appropriate integration support to resettled refugees after arrival;

- understanding how and what information states distribute to resettlement partners (e.g., service providing organizations, medical/health/social services, etc.) to enhance local integration process; and,

- identifying some “self-defined” promising practices delivered by NGOs that respond to high needs medical conditions and high integration need cases that might be incorporated into some specific workshops at the next ATCR and/or help to encourage bi-lateral information exchange opportunities with new and emerging resettlement states.

Methodology

Approximately thirty (30) countries, representing NGOs and and states, were invited to complete separate surveys on high needs medical and integration resettled refugee cases. NGO's from fifteen (15) states responded to the survey between December 2, 2012 and December 12, 2012; representatives from sixteen (16) states responded to the states-only survey. In total, survey responses were received from states and NGO's representing twenty-five (25) countries in total.

For countries where we received multiple survey responses (NGO only; states completed one survey per country), the data was summarized into one response per country and then combined for further analysis. NGO data was collected using both e-mail and a web-based survey platform; the statistics were compiled and analyzed using the survey platform data generator and Microsoft Excel. State data was collected and analyzed using Microsoft Excel.

NGO survey respondents represented different areas of refugee resettlement work in their different states. The responses and subsequent summary analysis must be kept in context as a sample, not a definitive conclusion, of the diverse experiences of respondents. The summary highlights the complexity of the issues and views dependent on the role of NGO's and the available resources in each state but also indicates a range of promising and innovative local integration practices in place to support the unique needs of a specific resettled refugee population.

State and NGO Survey Results

1. UNHCR Medical Needs Referral Category (States-only)

States were asked whether they accepted cases referred under the UNHCR's Medical Needs Referral Category, i.e., those submitted by the UNHCR that include a Medical Assessment Form as per the UNHCR referral handbook.

Of the 16 states that completed the survey, a majority (12/16) indicated that they did accept referrals under this category. However, only three of the responding states accepted Medical Needs Referral Category cases without condition. For the remainder:

- six states placed restrictions on the number of Medical Needs Referral Category cases they would accept in a year;
- two states indicated that they would only accept cases on an exceptional basis; and
- one state did not have a limit, but would consider cases individually based on the availability of services and as part of an integration prospects assessment.

2. Other Medical Conditions Cases

States were also asked whether they accepted other cases with medical conditions that are submitted under one of the other UNHCR resettlement submission categories.

The vast majority of states (14/16) indicated that they accept referrals under other submission categories that also have medical conditions, and the majority of those that accept such cases (10/14) do not limit the numbers of cases with other medical conditions.

Estimates of what percentage of the resettled refugee caseload are deemed to have medical conditions varies significantly due to a lack of a common definition amongst states. Based on their subjective assessment, those states that accept other medical conditions cases estimated their high needs medical caseload on a percentage basis as follows:

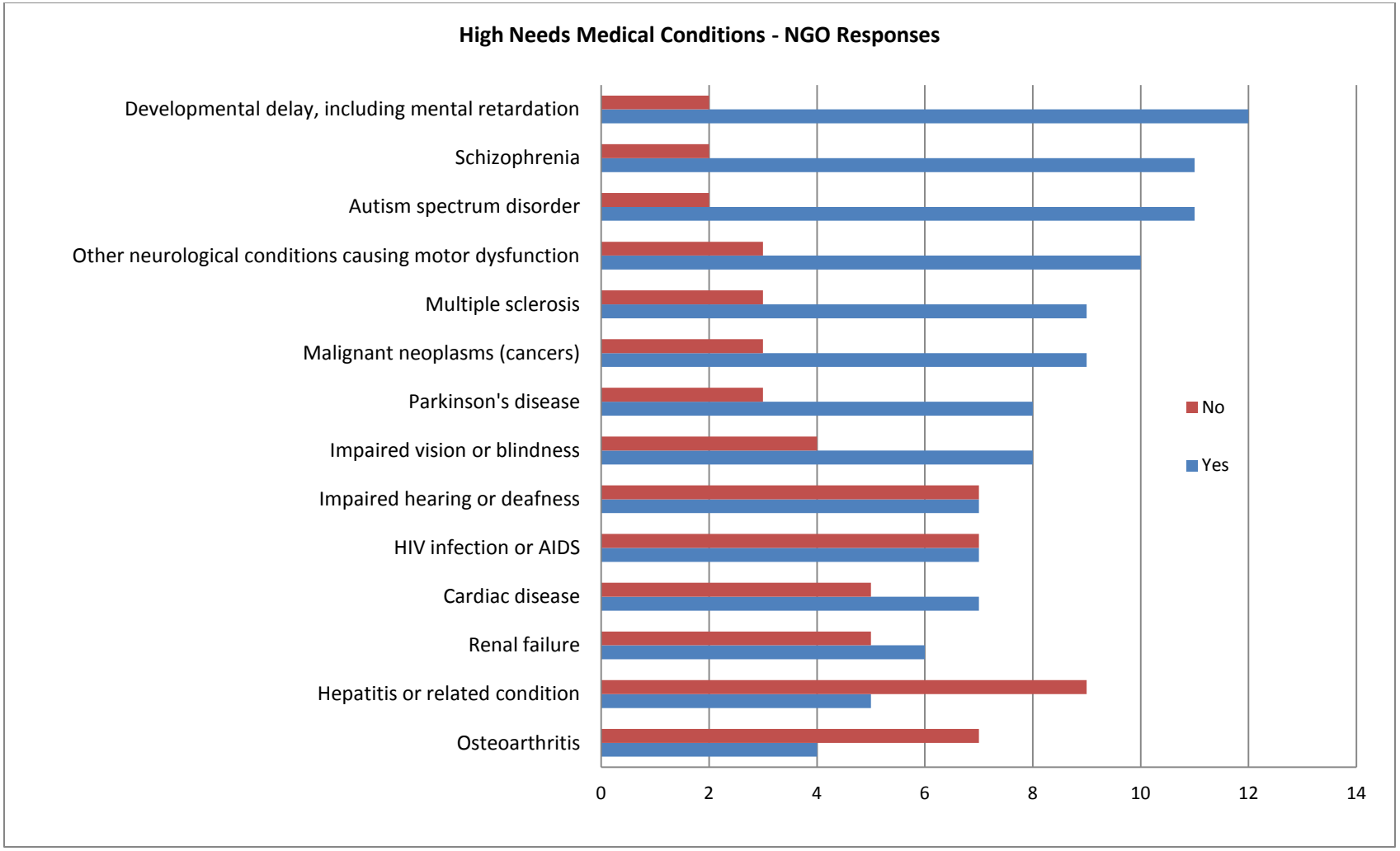
- 4 states estimate the number of high medical needs cases as being fewer than 10% of their overall caseload;
- 3 states estimate 10%-19%;
- 2 states estimate 20%-29%; and
- 3 states estimate 30% and over (with a high of 33%).
  (note: two states did not provide an estimate)

Several states with numerical limits on the number of Medical Needs Referral Category cases may also either limit other medical conditions cases, or will count both categories towards an established medical case target or quota. Numerous individual states also indicated that case-by-case assessments may be required for various reasons including community/state capacity, integration prospects assessments, public health risk, cost, and other considerations.

3. High Needs Medical Conditions Cases – State and NGO Findings

(a) NGO survey

If states and NGO's accept high needs medical conditions cases of resettled refugees, states and NGO's were asked to consider whether a refugee with a specific condition could be considered a potential high needs medical conditions cases.

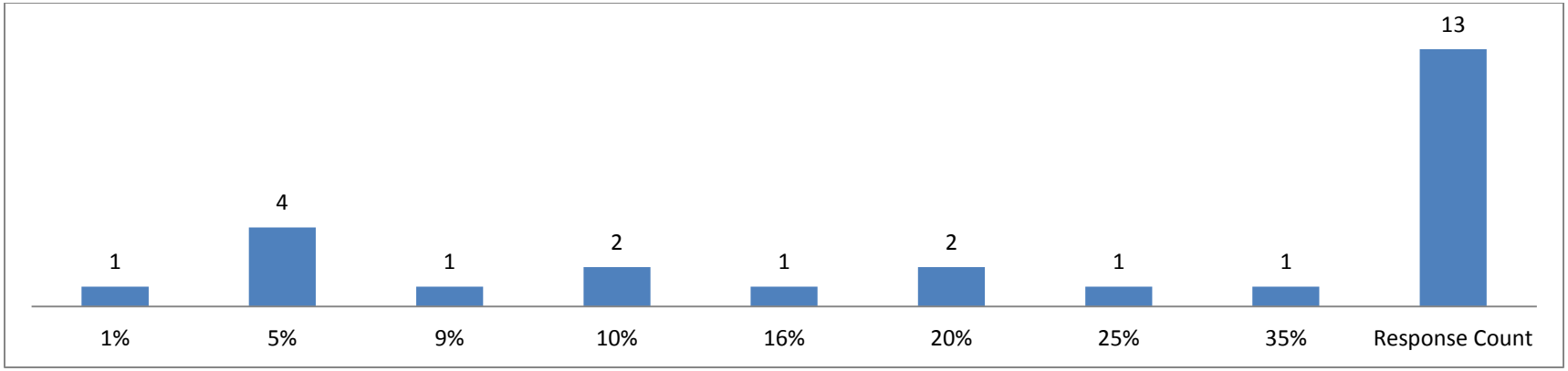


The following medical conditions were added by some NGO's as additional high needs.

- Diabetes

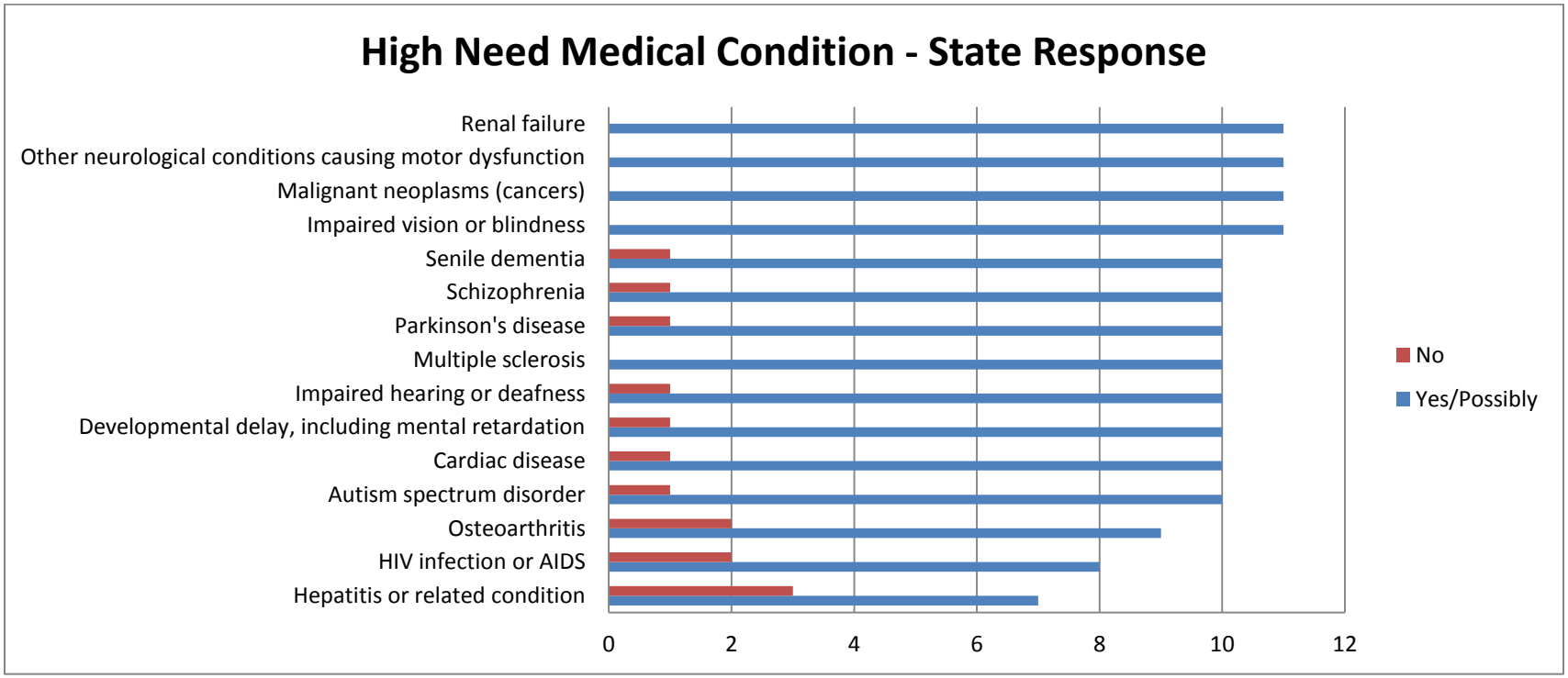
- Mental health issues of any kind (partially) paralysed persons, frailness due to age
- Heavy addiction or substances abuse (condition that requires immediate hospitalization)
- Bipolar disorder
- Amputation(quadriplegic)
- Thalassemia (requiring regular transfusion)
- Condition that requires transplant shortly after arrival
- Epilepsy
- Tuberculosis
- Addictions

NGO respondents were asked to indicate what percentage of the resettled refugee caseload would they estimate arrive with high needs medical conditions (whether referred under the medical needs resettlement category or not). Of the NGO responses received from thirteen (13) states, NGO's stated that on average thirteen percent (13%) of resettled refugees were arriving with high need medical. States were not asked this question.



(b) State survey

States were provided with a similar list and asked to indicate whether (a) they deemed a refugee with this condition to be a high medical needs case; and for the state only survey (b) if refugees with these conditions were accepted. The results are as follows:



The following medical conditions were identified by at least one state as additional high needs:

- Diabetes
- Mental health issues, including post-traumatic stress disorder
- Alcohol and drug dependency
- Thalassemia
- Sickle cell disease

- Terminally ill patients (irrespective of condition)

A significant number of states indicated that a listed condition may possibly be high needs, depending on the degree; examples cited include an HIV-positive case versus AIDS, whether a renal failure case requires a transplant, whether a condition is under control by medication, etc.

Several states also indicated that they did not have established policy on what constitutes a high-needs medical condition, and as such were unable to categorize the list of conditions as high needs or not. For example, some of these conditions might otherwise render some immigrants as inadmissible to Canada under legislative criteria[1], however resettled refugees are exempt from this criteria.

c) NGO and State Perspectives – Similarities and Differences

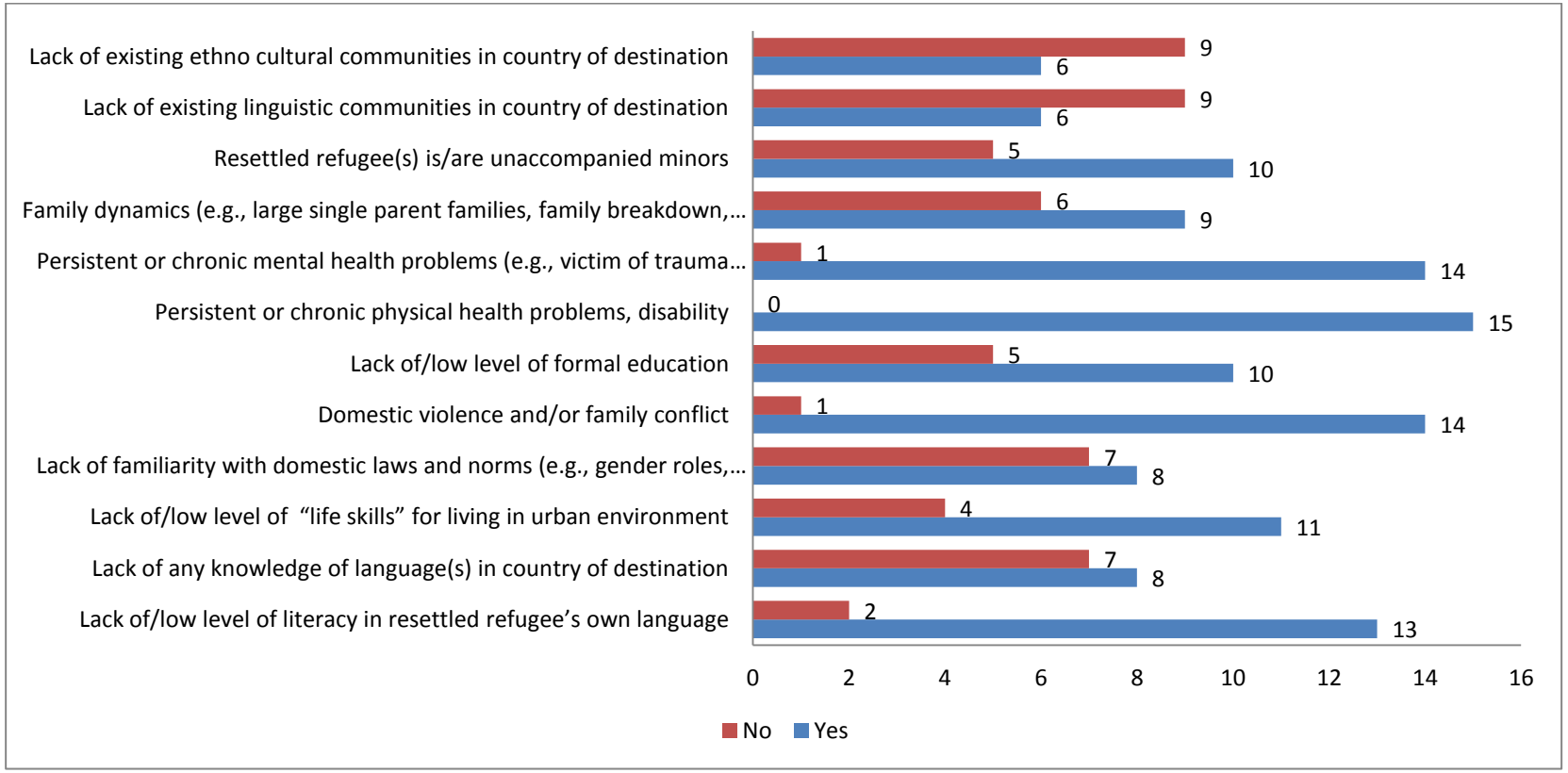
While similar, states as a whole tended to be more likely to classify a condition as high needs than NGOs; all conditions listed were deemed by states to be high needs whereas NGOs differed on several conditions (most notably hepatitis or related condition, HIV infection or AIDS, impaired hearing or deafness, osteoarthritis). Although not conclusive, one could speculate that states were more likely to focus on costs to the system than NGO's and hence the differences in responses.

4. High Integration Needs Cases – State and NGO Findings

Besides medical needs that may require a short or longer–term support intervention, there are other integration challenges that may require more intensive efforts by states, NGOs and other community partners to support local integration process after arrival. States and NGO's were asked to comment yes or no to several possible integration challenges that could categorize a case having higher need, and therefore require additional integration supports.

[1] Under Canada's *Immigration and Refugee Protection Act*, a foreign national is inadmissible on health grounds if their health condition might reasonably be expected to cause excessive demand on health or social services. Resettled refugees are exempt from this provision.

(a) NGO survey results

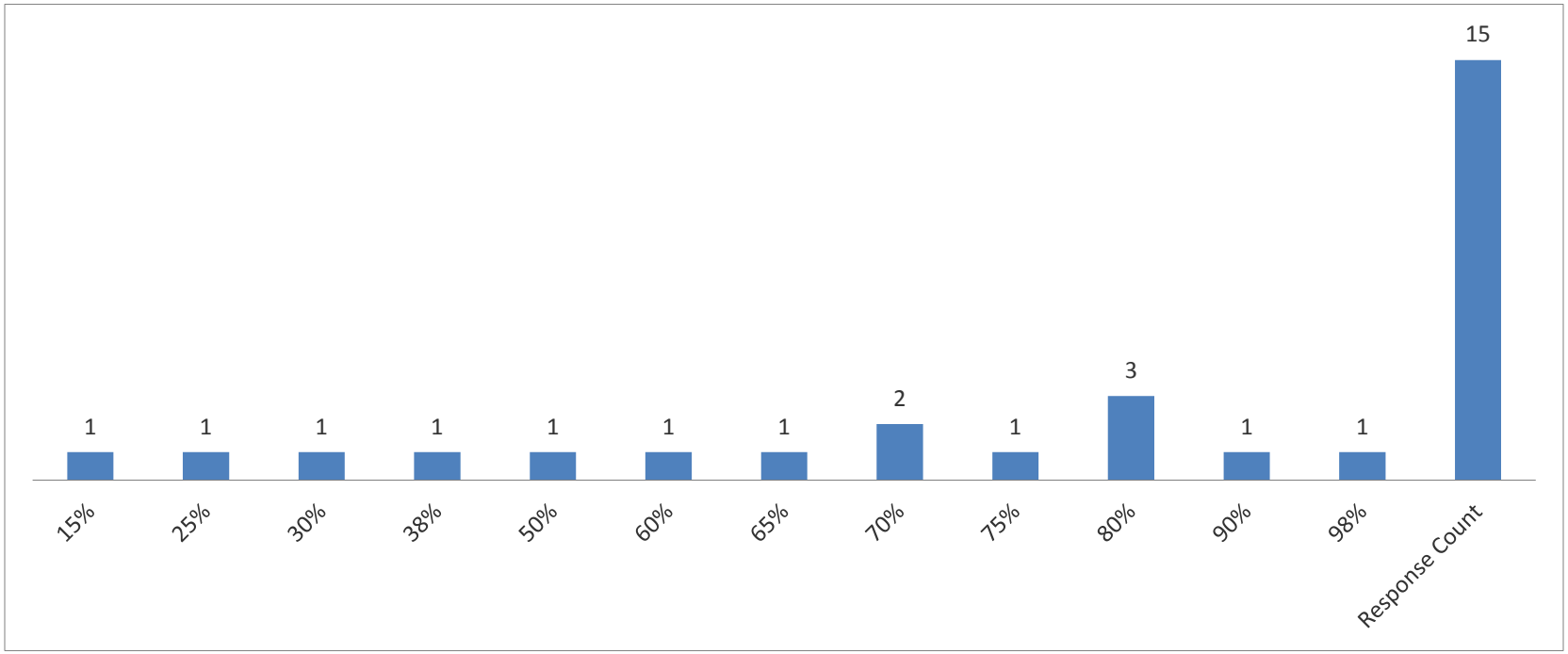


Other comments from NGO respondents:

- Level of racism in country of destination
- Visibility of the fact that the person is a refugee (ex: darker skin)
- Elderly(75+)
- Complex family/ domestic issues

- Single parent homes

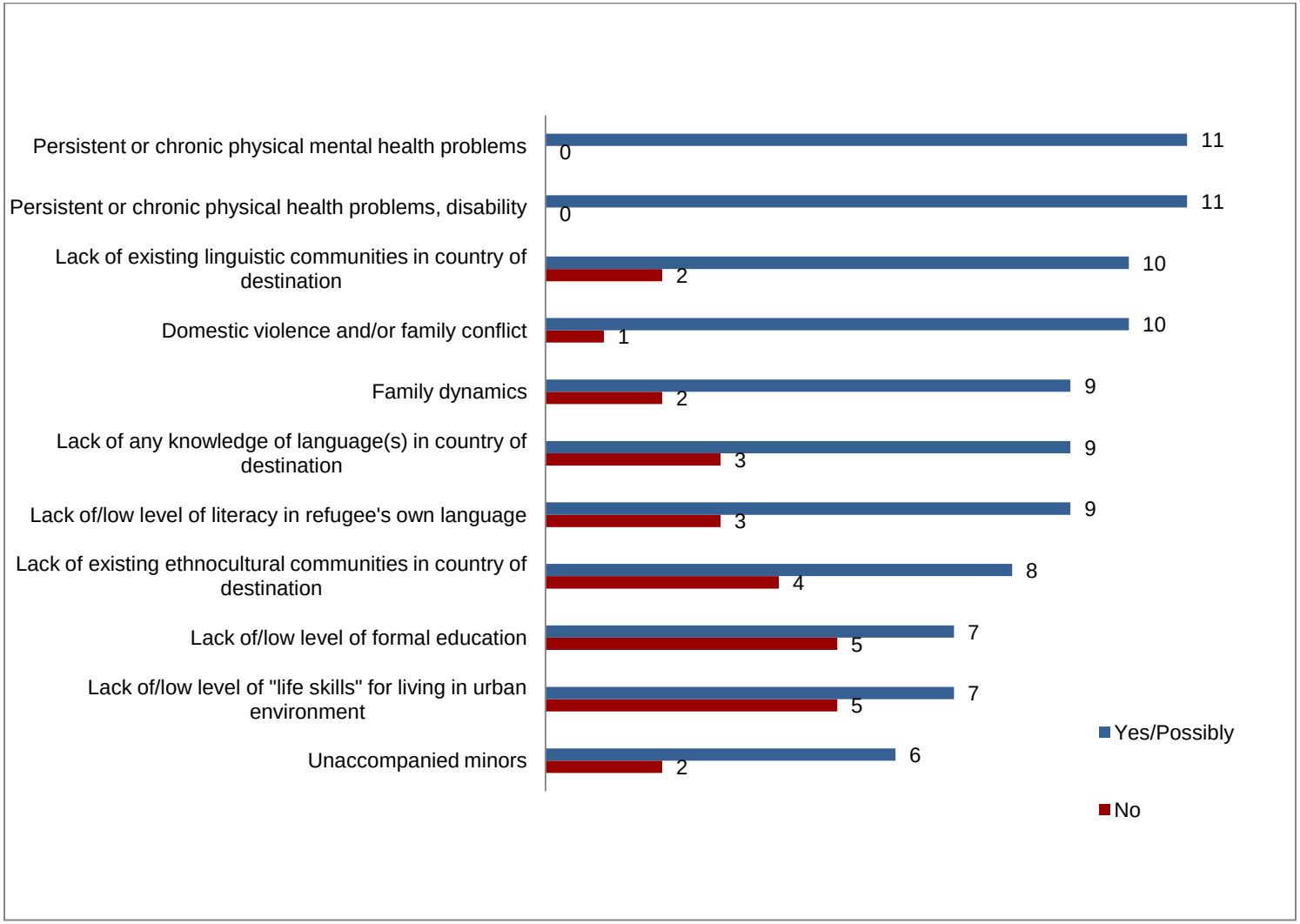
NGOs were asked an additional question that States were not asked: On average sixty one percent (61%) of resettled refugee caseload was estimated by NGO respondents from fifteen (15) states to have high integration needs. The range of resettled refugee cases having high integration needs ranged from a low of fifteen (15%) to as high as ninety-eight (98%).



(b) State survey results

States were provided with the same list (with the exception of one category, namely the lack of familiarity with domestic laws and norms) and asked to indicate whether (a) they deemed a refugee with this condition to be a high integration needs case; and (b) if refugees with these conditions were accepted, and if not why. The results are as follows:

Integration Challenges – High Needs (Yes / No) – State Responses



As noted, states are unanimous in noting that physical and mental health problems are a challenge to successful integration. It is notable that a majority of states indicated that all of the presented integration challenges presented higher needs; at the same time, states did indicate that a high-needs case may often be a combination of factors and that the individual/family capacity and resources are key to becoming self-sufficient. The importance of individual needs assessments and appropriate integration supports is critical to successful integration.

Some states indicate that they do not have policy on what constitutes a higher integration needs case, and most do not impose any restrictions on accepting higher needs cases (although some do consider these factors as part of an ability to integrate assessment, and unaccompanied minors are explicitly not accepted in at least four resettlement states). That said, most states including even those with no limits or policy did identify the fact that integration challenges were present for a significant part of their resettled refugee caseload.

Several states also indicated that capacity considerations may determine whether a case is deemed to be high needs or not. Even within a resettlement state, there will be variance between the supports available at a local/community level and as such the initial placement/destining of refugee cases is a factor in determining initial integration success.

While difficult to estimate, eight states provided estimates as to what percentage of their caseload might be considered high needs based on their perspective and capacity. High integration needs cases ranged from 40-90% of the overall caseload, a significantly high percentage.

(c) NGO and State Perspectives – Similarities and Differences

States were generally slightly more likely to identify a challenge as being higher needs than the NGOs. At the same time, there was state/NGO consensus on the primary integration needs; physical and mental health problems, domestic violence and/or family conflict.

States and NGOs generally report that high-needs cases often do have successful integration outcomes, and that the availability, design and timeliness of integration supports are critical. To that end, there remains ample opportunity to reinforce and strengthen the global capacity for resettlement through (a) better sharing of information on refugee needs to support the delivery of services; and

(b) continuing to develop and share the tools and capacity to adequately meet the needs of refugees at the state/NGO and international level.

5. Tracking And Information Sharing

(a) State tracking of High Needs Cases

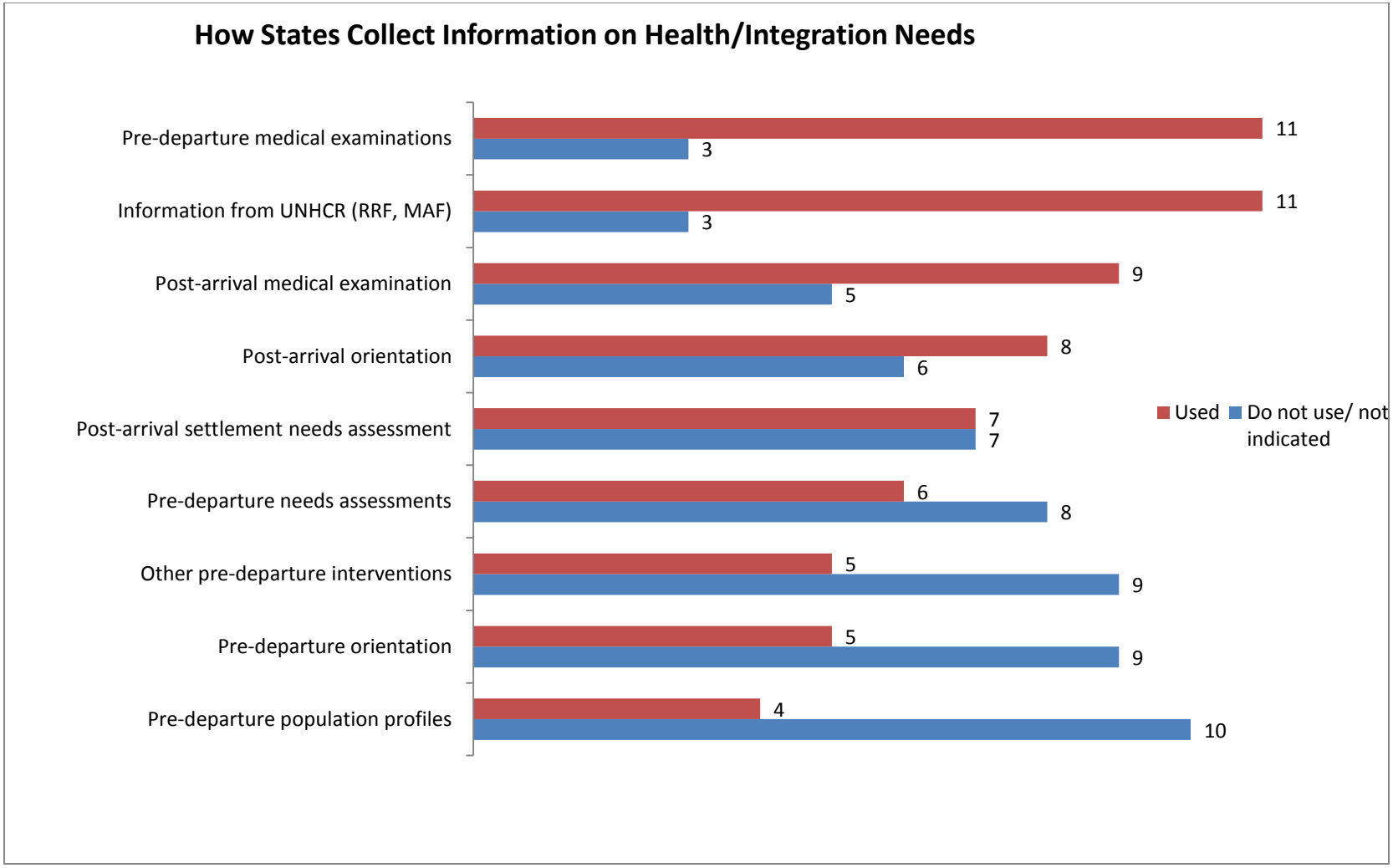
States were also asked to report on whether they tracked the number of high medical and high integration needs cases.

Of the fourteen (14) states that responded, less than half (6/14) systematically track high medical needs cases but to varying degrees. One state captures information on all cases with medical conditions, but no distinction is made between low and high needs cases. The other states vary in terms of what information is collection, e.g., only those cases referred under the UNHCR Medical Needs Referral Category; cases with significant health care costs; cases considered to be part of an annual limit, but not other medical cases; etc.

None of the fourteen (14) responding states report any tracking of higher integration needs cases.

(b) State Information Collection on Refugee Health and Integration Needs

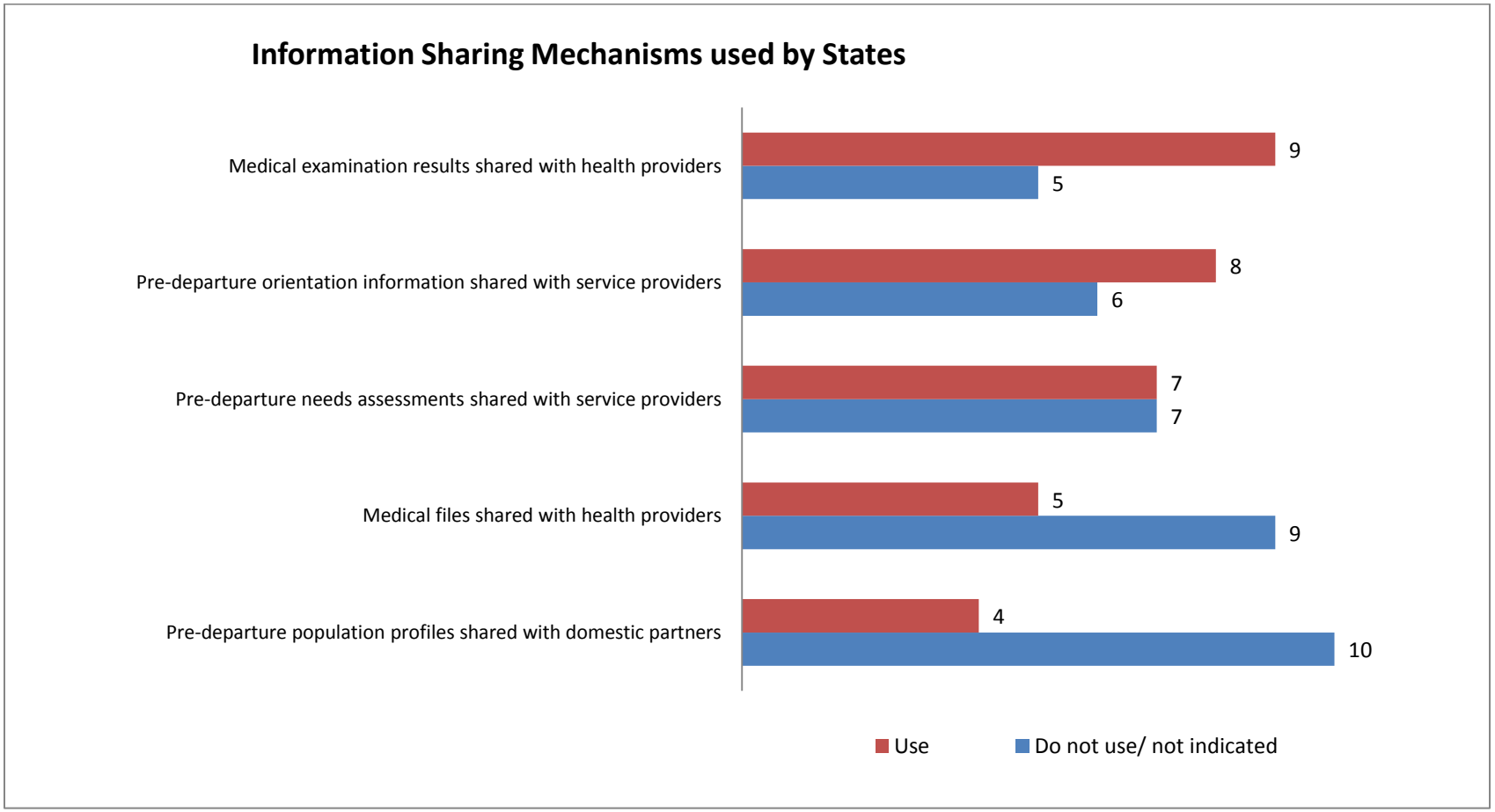
States were asked to identify the various mechanisms through which information on refugee health and integration needs may be collected, either pre-departure or post-arrival. The mechanisms through which states collect such information are as follows:



Other pre-departure interventions used by states include pre-departure medical checks and information collected by states during selection missions, where applicable. The most commonly used methods to collect information by resettlement states are information from the UNHCR (RRF/MAF), along with pre-departure and post-arrival medical examinations.

(c) How states share information on refugee needs

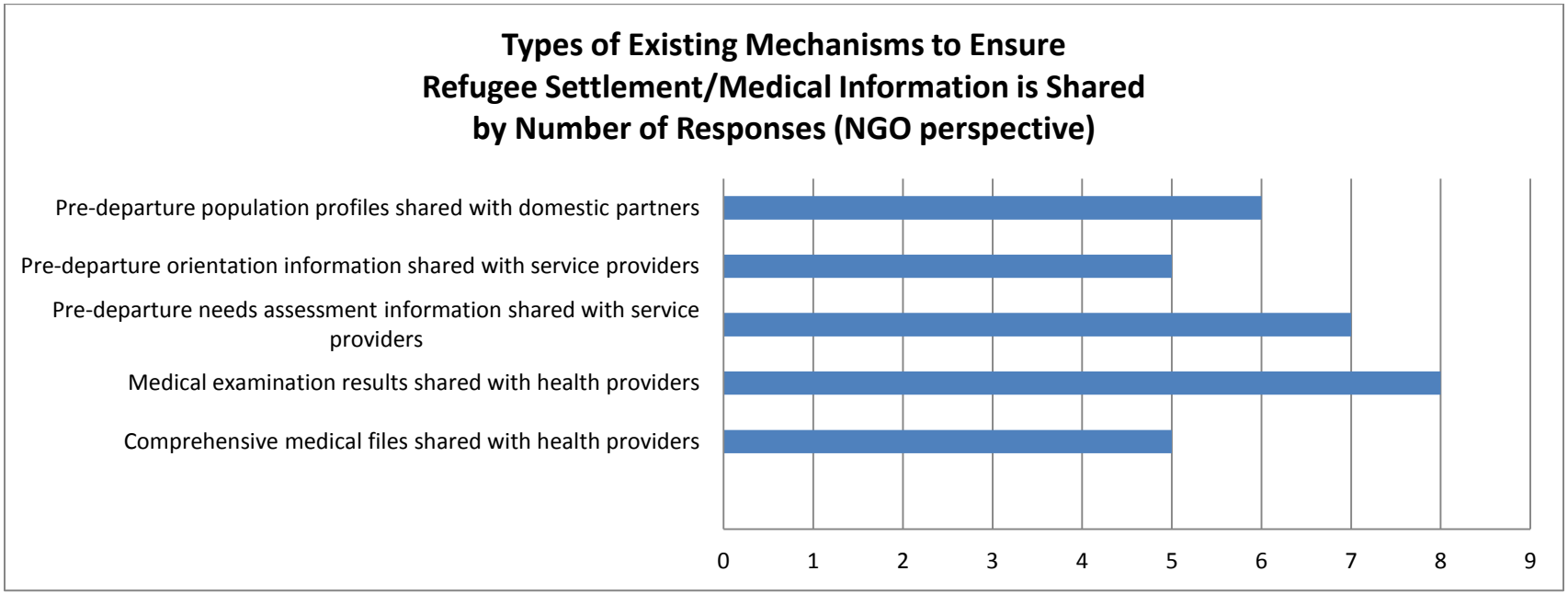
States were also asked to identify which information sharing mechanisms were used to ensure that relevant refugee integration/medical information is shared domestically to help ensure successful integration outcomes. The results are as follows:



The information sharing mechanisms available to states differ significantly, unsurprising given that there are variances in terms of what information is collected as per section 4B above. In addition to the results above, some states have other information sources that are used to share information domestically including case summaries from UNHCR documentation (RRF/MAF), information from field interviews and pre-departure orientation sessions, and other resettlement medical/integration needs information (e.g., Canada's Resettlement Needs Assessment form, USA Medical Condition Form).

(d) How NGOs receive information on refugee needs

What mechanisms exist to ensure that information on refugee settlement/medical information is shared domestically within your country? (Please check all that apply)



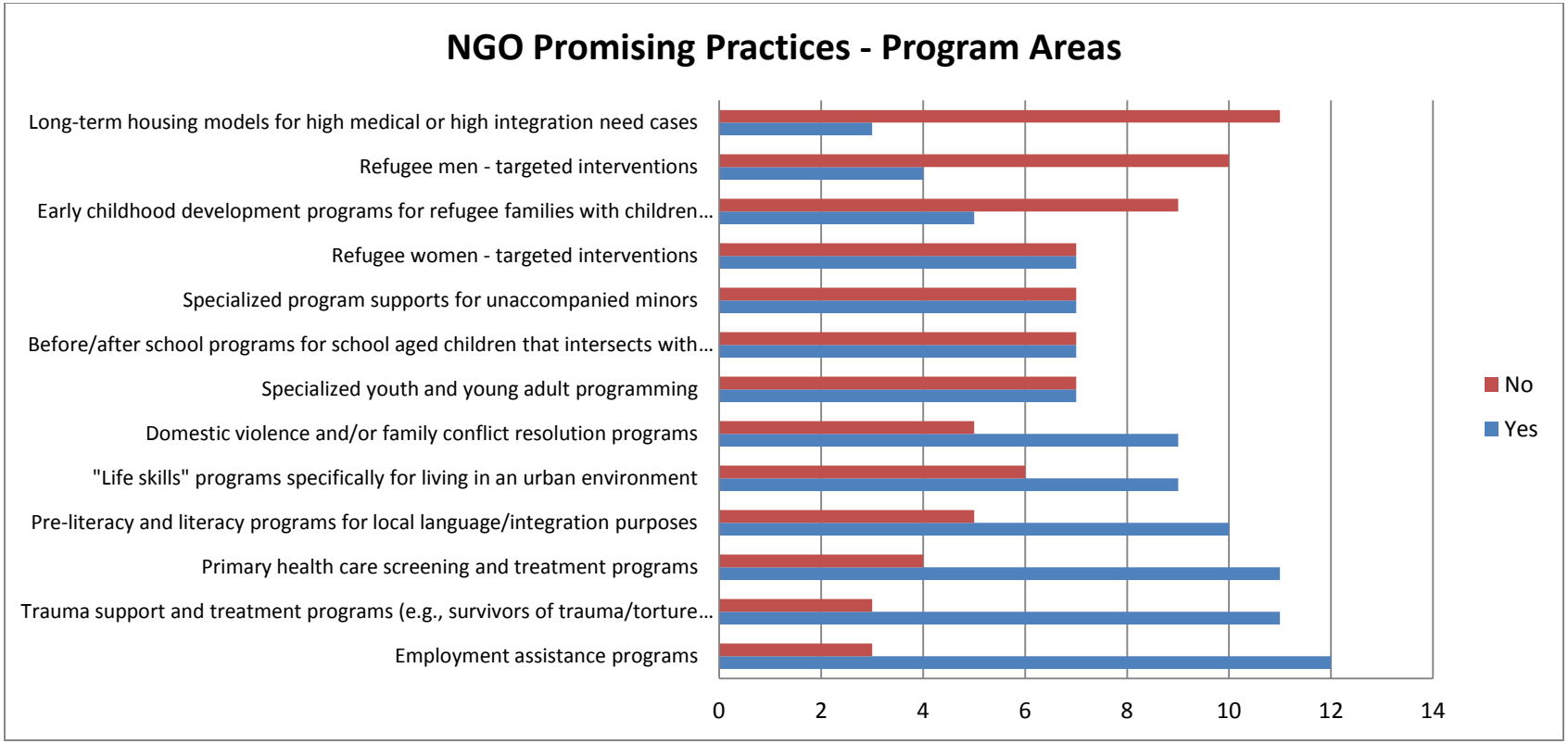
N=10, 5 respondents skipped this question

Other comments from NGO respondents:

- Psychological reports, if applicable and available are also shared with providers
- Unfortunately the civil society or other service providers almost don't get information. The dossiers containing medical information are given to the German states (Länder) but are rarely forwarded or too late.
- Population profiles are done by Center for Applied Linguistics at the start of resettlement of a new population. It may include information on general needs assessment of the group. We also have general information on the type of orientation provided to a group. We don't receive needs-assessment, population profile, and pre-departure orientation per case. The only case specific information we receive is medical examination results. UNHCR resettlement needs information is also made available.
- No mechanisms exist to share such information in Japan, and it was said that almost no information was shared with municipalities to which the resettled refugees are settled after the six-month intensive integration program offered by RHQ, quasi-governmental organization.
- I don't know how medical files are shared. We as NGO receive only basic information.

6. NGO Promising Practices for High Medical/Integration Needs Cases

NGO's were asked as a starting point to help identify, in a cursory way, some integration strategies or practices within their respective country that might be considered promising/innovative in responding to refugees with "high needs medical conditions" and/ or "high integration needs".



Other comments from NGO respondents:

- Programs serving Elderly refugees
- Preventive Health programs
- Refugee garden; micro enterprise, Individual Development Account (matching of personal savings for the purchase of asses or higher education); programming for LGBT cases. Programs targeting accommodation, from initial renting to long-term house-buying. The Finnish Red Cross runs homework support groups in various parts of the country. The groups are lead by Red Cross volunteers.

Conclusion and Next Steps

The vast majority of resettlement states that responded to the survey continue to accept high needs medical condition cases, whether referred under the UNHCR Medical Needs Referral Category or under another submission category. The lack of a common definition as to what constitutes a high needs medical condition case makes it impossible to quantify exact numbers, with ranges estimating from one (1%) to thirty-three (33%) of the overall caseload being considered high medical needs as per state assessments.

The issue of high needs medical condition cases also drew some commonality from within the NGO community. At the time that this survey was conducted thirteen percent (13%) on average identified their current resettled refugee cases as being high need medical cases. From the list of possible medical conditions, NGO's felt the following medical conditions could be clustered to define high need medical cases:

- Autism spectrum disorder
- Developmental delay, including mental retardation
- Impaired vision or blindness
- Malignant neoplasm's (cancers)
- Multiple Sclerosis
- Other neurological conditions causing motor dysfunction
- Parkinson's disease
- Schizophrenia
- Diabetes
- Mental health issues
- Addictions

State results were largely similar, and in fact states were more likely to identify conditions as high needs than NGOs.

Given the findings, it may be worth exploring with the UNHCR whether these types of medical conditions should be flagged as a matter of course when it is known the refugee applicant or a family member has one of these conditions even where the refugee is being referred for other reasons.

On the subject of high integration needs, none of the resettlement states currently restrict numbers of such cases although several may take these into consideration as part of an ability to integrate assessment pre-selection. State respondents generally felt that individual assessments of cases are required, and that the key consideration in meeting high integration needs is to ensure that appropriate support mechanisms are in place pre-departure and/or post-arrival.

While the percentage of current high need medical condition cases were relatively low, NGO respondents felt that, on average, sixty-one percent (61%) could be considered as having high integration needs. The following list below summarizes how the majority of NGO's would categories high integration needs cases:

- Lack of/low level of literacy in resettled refugee's own language
- Lack of/low level of "life skills" for living in urban environment
- Domestic violence and/or family conflict
- Lack of/low level of formal education
- Persistent or chronic mental health problems (e.g., victim of trauma and torture requiring counselling; depression; other)
- Family dynamics (e.g., large single parent families, family breakdown, responsibilities for child care/handling money/other etc.)
- Resettled refugee(s) is/are unaccompanied minors
- Receiving country's lack of existing linguistic communities in country of destination

As with high medical needs cases, state results were largely similar and were on the whole slightly more likely to deem a challenge as being higher need than the NGOs. Several primary needs were clearly identified – physical and mental health problems, and domestic violence and/or family conflict.

States collect information about health and integration needs in a variety of ways, however there appear to be gaps in terms of what pre-arrival information is made available to domestic partners; some NGOs receive information from states while others stated that they don't receive any information or very basic information. Given the view by NGO's of the percentage of high integration need cases being processed for resettlement, this is an area that could be addressed on a consistent basis through the development of

some common global tools that collect key pieces of information. Obtaining and providing key pre-arrival information in an appropriate manner, while maintaining privacy and confidentiality measures, can strengthen the adaptation and integration process of resettled refugees.

While there are many existing innovative and promising practices in place to address the needs of resettled refugees, there appears to be more promising practices in the following program areas:

- Pre literacy and literacy programs – for local language acquisition/integration purposes
- "Life skills" programs specifically for living in an urban environment catering to refugees from protracted refugee situations
- Domestic violence and/or family conflict resolution programs
- Trauma support and treatment programs (e.g., survivors of trauma and torture requiring counselling; chronic depression; other)
- Primary health care screening and treatment programs
- Employment Assistance Programs

The fact that there are a diverse range of NGO self-identified promising practices to assist the needs of high integration need cases should be considered for future learning exchanges with new and emerging resettlement countries as well as for possible future ATCR workshop themes.

Lastly, the findings in this report lead to several questions for future discussion and possible action. Are there practical steps that can be taken to move states, NGO's and UNHCR forward in enhancing the support to "high need medical condition cases" and "high integration need cases"?

1. What could a global integration needs form look like? What questions or pieces of information would it need to include to be useful to the greatest number of states?

2. What questions or pieces of information would it need to include to be useful to the greatest number of NGOs?

3. What questions or pieces of information would it need to include to be useful to the greatest number of resettled refugees? (i.e., while mandatory info about whether or not a person has cancer might be useful to states and NGOs, how many refugees actually have cancer on arrival? Would it make more sense to focus on something like diabetes, heart condition?)

4. What would a global cultural profile look like: what types of information would it need to include to be useful to local authorities and serving providing organizations?

5. What would a global cultural profile look like: what types of information would it need to include to be useful to refugees on arrival?

6. Should common population profiles be developed for all large groups of refugees that would be shared with WGR members as a matter of course? Could the USA website profiles be shared with other countries?

7. Should common health cultural profiles be developed for specific refugee populations? Who would do this and what would be the trigger?

8. Should resettlement states commit to sharing the medical file information with all refugees so that refugees can provide it to health providers on arrival?

ANNEX

(a) List of Respondents

NGO respondents	States respondents
1. Argentina 2. Australia 3. Belgium 4. Canada 5. Chile 6. Denmark 7. Finland 8. Germany 9. Iceland 10. Japan 11. New Zealand 12. Portugal 13. United Kingdom 14. United States of America 15. Uruguay	1. Australia 2. Belgium 3. Brazil 4. Canada 5. Denmark 6. Germany 7. Hungary (responded but did not complete survey – do not resettle high needs cases) 8. Ireland 9. Japan 10. Netherlands 11. New Zealand 12. Norway 13. Portugal 14. Sweden 15. United Kingdom 16. United States of America

(b) Additional Comments to Survey Questions from NGO Respondents

i. NGO Additional Comments on Medical Condition Cases

The following sample comments were provided by NGO's on the list of medical conditions. At this time responses have not been attributed to a specific NGO from a particular state although this information is available.

Comment #1

This reply is based on our direct experience with medical cases to date and therefore only addresses those categories of medical conditions with which we have had any interaction. As a general principle one should keep in mind that each case must be analysed on an individual basis and is dependent upon the particularities of the existing medical condition, stage of progression, etc. Based on our experience on reception and integration of refugees with hepatitis, HIV infection or AIDS, or impaired vision, the medical needs didn't have a special influence on the integration process because the diseases were still early on-set. Concerning "neurological conditions causing motor dysfunction", we have faced more difficulties supporting a young paraplegic girl on her integration process than we have had supporting refugees with the conditions mentioned above. Nevertheless, is important to notice that all medical needs may have a negative impact in the refugees' psyche, which can pose additional challenges to a successful integration.

Comment #2

The impact of the medical condition on someone's ability to integrate will vary considerably across individuals and their ability to communicate in English, education levels, presence of family support in the receiving country. Our organization has had clients arrive with the above listed 'high medical needs', we have been able to link clients with appropriate support mainstream services that assisted the client with their medical needs whilst we supported them throughout settlement period and beyond. Our observations have been that people have been able to integrate into the community, lead promising and satisfactory lives with community support despite their medical conditions. However, some complex medical conditions will impact on the ability to integrate considerably

Comment #3

Many of the above conditions should have an asterisk. We are a national agency resettling all cases through a network of affiliates that have varied resources and thus have different degrees and abilities to work with clients in moving them towards integration. Impaired hearing and vision are not high needs but deafness and blindness would be high needs. With many conditions (e.g. developmental delay, hepatitis, and neurological conditions) it depends on the severity of the disability. We differentiate affiliate sites' ability to serve these cases and help refugees integrate by their ability to work with "mild" cases or "severe" cases, with the latter impacting integration, but the former only mildly impacting integration if at all.

Comment #4

Severity and need for medical attention may change the response to the above question, e.g. cardiac disease can be noted as high needs if it requires open heart surgery shortly after arrival with long term follow up. The longer it takes to address the medical need the longer it will take to integrate the case as resources/client's attention are diverted to addressing the medical needs of the case. This is especially true in cases that are hospitalized at or shortly after arrival. Yes, a medical case isn't necessarily a high integration case.

Comment #5

Hepatitis, HIV, impaired hearing or visions etc. are obviously serious medical problems, but our country's health system can easily cope with such situations. Any kind of mental problem however is a much greater challenge to the health system partly because of the minority background of the refugee.

Comment #6

Even though some resettled refugees had above mentioned conditions and the government knew it, such information was not shared with service providers including receiving municipalities, (even not with the clients themselves) and it caused many problems afterward.

Comment #7

High needs medical conditions are particularly those where the resettled refugee has not been properly diagnosed before arrival. It is vital that prior to resettlement and during the selection mission medical conditions are properly communicated to receiving institutions so they do not worsen in the mean time and make treatment more difficult. Severe mental health problems are considered by us particularly complex to cover.

ii. NGO Additional Comments on High Integration Need Cases

A sample of NGO's comments on the list of integration challenges can be found below. Once again, at this time responses have not been attributed to a specific NGO from a particular state although this information is available.

Comment #1

It is difficult to comment on the severity of health and integration aspects due to the relevance of individual and cultural factors which vary. The level of support required can only be based on a thorough medical psychosocial assessment. Some people with multiple disorders effectively manage their conditions, and then others with a single issue (perceived as manageable by the service provider) cope poorly. Also it is important to note that I have personally assisted clients who have not received formal diagnoses (such as intellectual impairment, social and health anxiety, PTSD etc)

Comment #2

As we are a small country, we get consulted quite thoroughly by the State ministry responsible for resettlement on the ethnic composition of the refugees planned for resettlement. Families from sub-tribes of particular ethnic groups tend to become isolated socially and hence result in high integration needs. Adult literacy and numeracy programmes are not easily available either so it tends to be categorised as a higher needs than low level or lack of English language.

Comment #3

Some of the factors are more the norm than the exception for cases placed into our affiliate sites. We consider working with these aspects part of the normal resettlement process. For example, we have seen at times where there is a very limited base population and linguistic ability to work with in the country of destination, such as was the case with the Bhutanese when they were first resettled. This was taken into account in developing program sites and placing this population, but our affiliates would not consider this making them a high needs case. The percentage of cases with conditions that make them high need often varies with the population resettled. The Congolese are expected to have a high level of trauma cases but may be less than the Burmese for example.

Comment #4

The Danish local authorities are able to handle most of these challenges either on their own or with the help of NGO's such as the Danish Refugee Council.

Comment #5

Japan has so far received only families with children (9 families, 45 individuals in total) from Karen refugees from Mae La Camp (in Thai-Burma border). Thus there are no unaccompanied minors or singles. Those challenges checked "yes" above are the ones JAR considers it necessary to provide additional support, based on the population residing in Japan.

Comment #6

A refugee holding physical characteristics that clearly marks him or her as a refugee, combined with an environment that is hostile to refugees or to a certain group, puts a refugee in a higher level of vulnerability. In some cases, this might mean problems for children to integrate, higher risks of abuse from the authorities, etc.

iii. NGO additional comments on Information Sharing Tools

Six (6) sample responses from NGO's commenting on other tools/means of sharing resettlement need information are as follows.

Comment #1

In HSS we have Case Management Plans, although limited medical information is provided. However, their Health Manifest from DIAC can be obtained.

Comment #2

During the selection procedure, the Portuguese Ministry of Interior shares UNHCR's Resettled Registration Forms (RRFs) with the Portuguese Refugee Council (CPR) as the main settlement service provider who is required to issue a consultative opinion on the individual case submitted for resettlement in accordance to article 35 (1) of Asylum Law 27/2008, 30 June. Upon arrival in the country, such information is then disseminated by CPR to other settlement service providers (health, education and training, housing, etc)

Comment #3

NZ has home assessment forms (for separated children to be reunited with parents OR for partner). Immigration NZ would request Refugee Services (resettlement services provider) to complete the assessments in the community. Immigration NZ would then use this information to plan for the client's optimal arrival.

Comment #4

The amount of information sharing is variable. Health manifests for off-shore cases are very useful and provided to health providers on-shore by service providers. Sometimes information is also provided via a Government Database (Humanitarian Entrants Management System) from off-shore posts regarding "issues" for clients. Health information provision for on-shore cases coming out of detention is given to clients who are expected to inform the service provider, however that doesn't ensure that the service provider will receive the health information. Transitional Care Plans for Community Detention cases are very helpful

Comment #5

The Resettlement Needs Assessment Form is similar to the Significant Medical Condition (SMC) form used to share additional information on medical cases and is helpful tool in preparing for the arrival of a case. The SMC is completed by an overseas medical doctor.

Comment #6

All of the above information is provided to the local authorities, who are responsible for the integration programme. Problems may arise, when the case worker for various reasons do not share the information with other parts of the municipal system. The Danish Immigration Service also offers information meetings for the municipalities together with the Danish Refugee Council. The DRC is in a unique position to offer assistance to the local authorities because we participate in the selection missions and therefore have a greater knowledge of the refugee group.