UNHCR
United Nations High Commissioner for Refugees
Haut Commissariat des Nations Unies pour les réfugiés

Annual Tripartite Consultations on Resettlement
Geneva, 28-30 June 2007

Agenda Item 3j

Information Note: An overview of medical resettlement needs, and the use of "Ten or More" and "Twenty or More" (TOM) programmes

The criteria for resettlement on medical grounds, as outlined in the UNHCR Resettlement Handbook (Chapter 4.4.1), are as follows:

- the health condition is life-threatening;
- without proper treatment, there is a risk of irreversible loss of functions, or the condition is a significant obstacle to leading a normal life;
- adequate treatment is not available in the country of asylum;
- there is a favourable prognosis with treatment in a resettlement country; and
- the refugee consents to resettlement.

Some cases may be submitted for resettlement by UNHCR when treatment is available in the country of asylum, but is prohibitive due to the high costs which are unable to be met by the refugee, UNHCR or other source. UNHCR health spending priorities are to cover basic primary health interventions, such as immunisation, and sufficient funds are not available to cover costly medical interventions.

As a proportion of total resettlement submissions, medical submissions are low. Submissions on medical grounds represented only 2% of the refugees who departed in 2005 and 2006. However, for the refugees concerned, this is often a life-saving intervention.

All traditional resettlement countries accept resettlement submissions on medical grounds in their normal annual intakes requiring interviews. However, there are limitations to UNHCR's ability to meet all medical needs under these programmes, as interview missions may not be scheduled to the refugee's country of asylum, processing times can be lengthy (e.g. Canada and the US) or there may be a ceiling on the number of medical cases or the costs that can be covered by the resettlement country, excluding some types of condition from consideration (e.g. Australia often declines cases owing cost implications).

The TOM programmes, by which refugees are accepted on a dossier basis, have been in place for several years. These places are necessary to meet the needs of refugees where no interview mission is planned for and to ensure decisions are reached within reasonable time owing to the likely deterioration of the refugee's health.

The needs for medical resettlement are great, in particular from the Great Lakes and West and Central Africa, reflecting the low level of healthcare available to refugees in those regions.

The number of Iraqis fleeing their country has escalated during the past year. It is therefore anticipated that the number of refugees requiring resettlement on medical grounds will increase in the Middle East, as medical care is not readily available in Iraq, with many health personnel having fled already. Additionally hospitals and clinics are poorly stocked, with outdated equipment, lack of electricity etc. (IRIN Middle East Report, 31 May, 2007). Due to the violence and use of weapons including incendiary devices, many refugees fleeing to Syria and Iraq have severe physical and/or psychological needs. There are also higher than normal rates of cancer due to the increased use of unsafe products in agriculture and the long-term effects of war on health. Psychological stresses and strains engendered by years of conflict, violence, displacement and uncertainty have weakened people's natural resistance to disease.

While countries in the region have provided support to refugees, their health facilities have limited capacity to absorb all new arrivals. Additionally there are treatments that are not available – for example skin grafts for burns victims. We therefore urge resettlement countries engaged in the Iraqi resettlement programmes to take into account the need to accept medical cases as part of the normal quota.

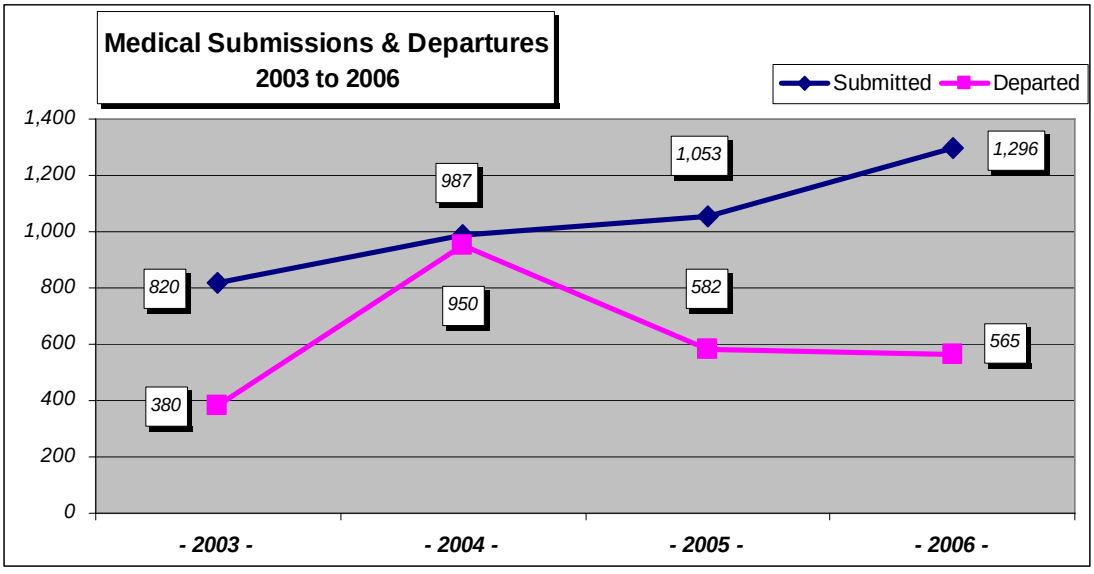
We encourage all resettlement countries to keep available some places for dossier submission as well as under the regular interview mission quota. It is unfortunate that the UK decided to suspend its TOM programme in 2006, and Denmark has indicated that medical places will be primarily reserved for cases identified in the course of missions. While we applaud resettlement policies that do not discriminate on the basis of HIV status, the decision by some resettlement countries to count all persons who are HIV+ as medical cases has effectively decreased the medical places available for other persons, as HIV positive refugees sometimes require resettlement on other grounds (e.g. family reunification, woman-at-risk).

For 2006 and 2007, TOM quotas were as follows:

2006 and 2007 TOM Quota

Country	2006 Places	2007 Places
Denmark	20	17 (reserved for missions)
Netherlands	20	20
Norway	20	20
New Zealand	75. Sub-Quota for HIV+Persons	75. Sub-Quota for HIV+Persons
Finland	Included in Emergency Quota of 75	Included in Emergency Quota of 100

These quotas allocated are not adequate to meet the needs, as illustrated by the gap between submissions and departures from 2003 to 2006 in the graph below. Numbers in submissions include family members of those refugees with a medical condition, but only the person in need of medical treatment counts against the quota.



By the end of May 2007, only two resettlement countries still had places available for TOM submissions. This indicates a need to increase the resettlement quota for medical places

The acceptance rate for medical cases varies greatly. The acceptance rates of medical cases submitted under the various TOM programmes in 2005 and 2006 are as follows:

Country	**Accepted/Submitted 2006**	**2006 Rate**	**2005 Rate**
Denmark	46/66	70%	61%
Finland	109/189	58%	59%
Netherlands	93/268	35%	18%
Norway	63/283	22%	22%
Sweden	21/34	62%	Not applicable
Others	19/177	11%	Not applicable

Often medical cases incur long processing times, and in several instances refugees have died while awaiting decisions or travel processing. There is frequently a long dialogue between resettlement countries and UNHCR with regard to specific medical inquiries. Due to very basic levels of healthcare available in countries of asylum it is often impossible to answer what would appear to be simple inquiries as the diagnostic tools or the expertise needed are simply not available. Additionally, there can be bureaucratic delays, as it is often not clear from the MOU between IOM and the resettlement countries whether certain additional costs can be authorized. Examples are the payment for subsistence allowance for medical escorts, or unusual medical needs, delays in budget authorizations, often leading to the health of the individual deteriorating which ends up increasing the ultimate cost of treatment. IOM and UNHCR are committed to working closely together to clarify the scope of the MOUs in the hope that such clarifications will allow the timely travel of emergency cases.

Resettlement Service
Division of International Protection Service