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SUPPORTING HEALTH COORDINATION, ASSESSMENTS, PLANNING, ACCESS TO HEALTH CARE AND CAPACITY BUILDING IN MEMBER STATES UNDER PARTICULAR MIGRATORY PRESSURE — 717275/SH-CAPAC

COORDINATION FRAMEWORK FOR ADDRESSING THE HEALTH NEEDS OF THE RECENT INFLUX OF REFUGEES, ASYLUM SEEKERS AND OTHER MIGRANTS INTO THE EUROPEAN UNION (EU) COUNTRIES

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User's guide

- The present document aims at supporting individual EU Member States in defining the fundamental elements that ought to be present in a health coordination mechanism for multiple national and international stakeholders. These stakeholders are involved in the response to the health needs of refugees, asylum seekers and other migrants, who are part of the recent influx into the European Union.

- This health coordination framework speaks primarily to national or subnational health authorities. These authorities are responsible for defining an operational strategy to harness the contributions of different actors to the provision of health care and the implementation of public health interventions, addressed to these migrant populations. It is also intended for the different governmental and non-governmental actors, as well as international and civil society organizations, who participate in the national and local efforts, directed at responding to the health needs of these vulnerable populations.

- Flexibility in the application of this health coordination framework is highly recommended. Any ministry/governmental authority can select the parts that are relevant for their country/context and customise them to develop or strengthen their context-specific coordination mechanism.

- The health coordination mechanism aims to ensure that the national and local efforts directed at responding to the health needs of migrant populations fit well into the national health system. It is, however, not the only coordination solution, and may well be part of other forms of (sub)national coordination.

- The health coordination framework was discussed at the SH-CAPAC workshop involving representatives of EU Member States on 23 and 24 February 2016 in Ghent, Belgium and was further discussed at the SH-CAPAC meeting on April 6 2016 in Trnava, Slovakia. Recommendations from the workshop and meeting were integrated in the document. The framework has also been adjusted to the new circumstances of the refugee and migrant flows as well as the developments of the other SH-CAPAC tools. The draft framework was presented during field missions in the second half of 2016 (e.g. Bulgaria, South Aegean, Catalunya Slovakia, Andalusia and Athens) and modified and completed where appropriate. Further amendments may be needed in the future. Revisions will be made publicly available on http://www.easp.es/sh-capac/.

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List of acronyms

BEOC	Basic emergency obstetric care
CD	Communicable disease
CEOC	Comprehensive emergency obstetric care
CESCR	UN Committee on Economic, Social and Cultural Rights
ECDC	European Centre for Disease Prevention and Control
ECHO	European Community Humanitarian Aid Office
EPI	Expanded Programme of Immunization
EU	European Union
HIV	Human immunodeficiency virus
HRH	Human resources for health
IASC	Inter-Agency Standing Committee
ICCPR	International Covenant on Civil and Political Rights
ICESCR	International Covenant on Economic, Social and Cultural Rights
IEC	Information education communication
IFRCRC	International Federation of Red Cross and Red Crescent Societies
IOM	International Organization for Migration
LHA	Local health authority
MdM	Médecins du Monde (Doctors of the World)
MI	Ministry of Interior
MISP	Minimum Initial Service Package
MMA	Ministry of Migration and Asylum
MOH	Ministry of Health
MS	Member State
MSF	Médecins sans Frontières (Doctors without Borders)
NCD	Non-communicable disease
NGO	Non-governmental organization
NHA	National health authority
PHC	Primary health care
PMTCT	Prevention of mother to child transmission
RH	Reproductive health
RHA	Regional health authority
SGBV	Sexual and gender-based violence
SHC	Secondary health care
SRH	Sexual and reproductive health
STI	Sexually transmitted infection
TB	Tuberculosis
THC	Tertiary health care
UCPM	(European) Union Civil Protection Mechanism
UDHR	Universal Declaration of Human Rights
UN	United Nations
UNCT	United Nations Country Team
UNFPA	United Nations Population Fund
UNHCR	United Nations High Commissioner for Refugees
UNICEF	United Nations International Children's Emergency Fund
WASH	Water, sanitation and hygiene
WHO	World Health Organization
WP	Work package

Glossary

➔ **Health coordination framework** is the tool that aims to facilitate the establishment or strengthening of the coordination of the health response to the influx of migrants.

➔ **Health coordination mechanism** is the mechanism set up and lead by the health coordination core team, involving all relevant stakeholders. It is responsible for the various functions of coordinating the health response through the assessment of health needs, strategic and action planning, monitoring and evaluation, advocacy and resource mobilisation.

➔ **Health coordination team** is the core executive team leading the coordination of the health response to the influx of migrants. It is designated by the leading governmental authority/agency providing health care to migrants (from asylum seekers to undocumented migrants).

➔ **Subnational level** refers to the level below the national or central level; it can be the provincial or local municipality level.

1 Why do we need a health coordination framework?

The European Union (EU) is at the heart of an expanding range of increased migration streams. This influx brings different types of migrants who can be categorised according to the phase of the migration trajectory they are in and/or the type of residence status they have at that point. The range includes newly arrived migrants, migrants in transit not claiming asylum, asylum seekers, migrants having been granted refugee or protected status and migrants who become or remain undocumented. Each category of migrants comprises people of different gender and ages, including unaccompanied minors.

In most EU Member States (MS), multiple national and international stakeholders are currently involved in the response to the health needs of refugees, asylum seekers and other migrants who are part of the recent population influx into the European region. Improved coordination of all these stakeholders and actors addressing the migrants' health needs results in a strengthened high-quality and comprehensive health response. This health coordination framework aims at supporting individual EU MS in defining the fundamental elements that ought to be present in the development of such health coordination.

The Universal Declaration of Human Rights (1948) puts the *enjoyment of the highest attainable standard of health* forward as a fundamental right of every human being. The entitlements to health are codified in several international covenants which are ratified by all 28 EU Member States. Moreover, the right to health care is also included in the Charter of Fundamental Rights of the European Union. Finally, the European Directive on Minimum Standards for Reception of Asylum Seekers (2013/33/EU) contains several stipulations on ensuring health care access for asylum seekers (see background document for more details).

1.1 Challenges of the health response to the recent influx of migrants

A mapping of the health care response to the recent influx of refugees, asylum seekers and other migrants in 19 European Union Member States[1] until February 2016 demonstrated that the health response so far remains fragmented. The involvement of many different partners, not all acting in harmony, results in overlapping, duplication and unmet health needs. This is due to the lack of adequate coordination both within a Member State and between Member States, as well as at the European level (see background document for more details on the challenges).

The context requires that prompt action is taken to guarantee health care to all refugees, asylum seekers and other migrants present in the European Union Member States. In order to achieve this, a highly flexible, **coordinated response** that anchors migrants' health in a human rights framework and harnesses all partners, stakeholders and goodwill at national, local and municipal level is required. **Improved coordination of all stakeholders and actors addressing the migrants' health needs results in a strengthened, high-quality and comprehensive health response.**

1.2 The aim of this health coordination framework

This health coordination framework aims to provide individual EU Member States with a **tool for strategic guidance** to establish or strengthen a coordination mechanism. Such a coordination mechanism aligns the

[1] See report: SH-CAPAC. WP1 – Mapping of the health response. March 2016.

health response for migrants with the national health system under the leadership of the Ministry in charge (e.g. Ministry of Health, Ministry of Asylum and Migration, Ministry of Interior…).

To this purpose, the health coordination framework provides basic elements for developing or strengthening a health coordination mechanism that brings together all national and international stakeholders involved in the health response to the recent influx of refugees, asylum seekers and other migrants (Figure 1).

Figure 1: Coordination of the health response

The purpose of the **health coordination mechanism** is to share information, adopt a coordinated approach, establish common objectives, harmonise efforts and use available (human and financial) resources efficiently to ensure access to appropriate integrated health services for these population segments. An essential element in the functioning of the health coordination mechanism is the appointment of a **health coordination team** that coordinates the response of all stakeholders and actors involved.

When Member States apply this health coordination framework, it will guide them in:

1. Establishing a standing coordination mechanism, led by one of the Ministries or authorities in charge of responding to the health needs of (the recent influx of) refugees, asylum seekers and other migrants. *See chapter 2 & chapter 3.2 (1)*

2. Conducting health needs assessments and assessments of the public health response and health care provided to these populations with the participation of the different stakeholders that are part of the coordination mechanism. *See chapter 3.2 (2)*

3. Formulating strategies and action plans (including capacity building, preparedness and contingency planning) to respond to the health needs of these populations with the participation of the different stakeholders of the health coordination mechanism. *See chapter 3.1 (3)*

4. Mobilizing and coordinating the necessary resources to implement the actions needed for an improved health response. *See chapter 3.1 (4)*

5. Monitoring and evaluating the health response to the refugees, asylum seekers and other migrants through consolidation of information collected and periodic reporting. *See chapter 3.1 (5)*

6. Leading the communication and advocacy[2] efforts in support of the health response to these populations. *See chapter 3.1 (6)*

This health coordination framework is part of a set of tools, each addressing one or several of the elements mentioned above. These tools were developed in separate work packages (WP) to which reference is made below (see separate documents on the health system assessment, the development of the action plan, the resource package and the training course).

2 Health coordination mechanism

The health coordination mechanism is activated by the ministries/authorities in charge of responding to the health needs of different groups of migrants. It involves all relevant stakeholders and is led by a health coordination team. The mechanism aligns the various functions of health needs assessment, strategic and action planning, resource mobilisation, monitoring and evaluation, communication and advocacy with the national health system.

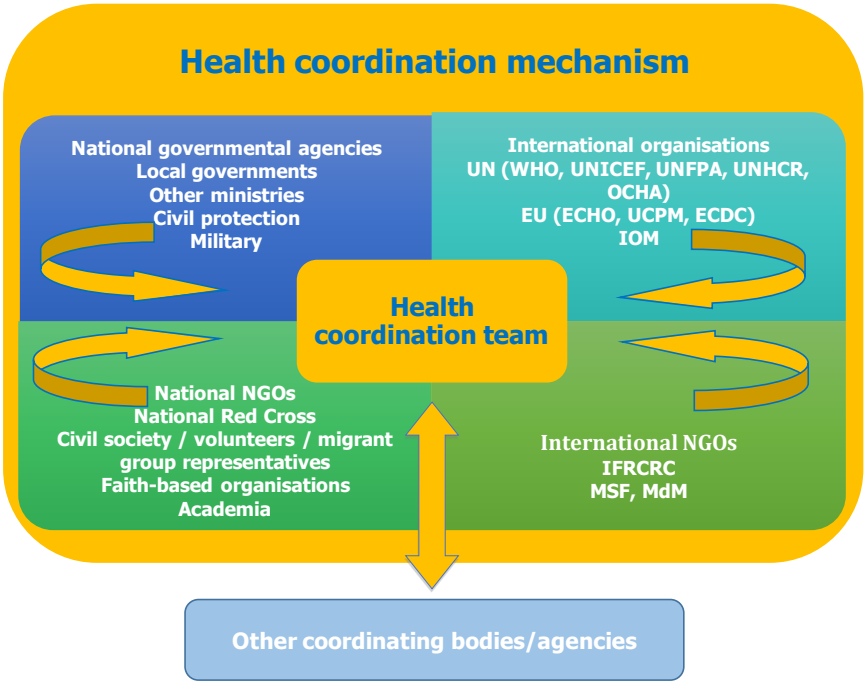
2.1 Who should be part of the health coordination mechanism?

The health coordination mechanism brings together all stakeholders involved in the health response to the recent influx of refugees, asylum seekers and other migrants in order to coordinate their actions in a more efficient way. Figure 2 illustrates the potential partners of the health coordination mechanism, but is by no means exhaustive. The national partners are represented on the left-hand side. Public services are in the left upper quadrant, whilst the lower left quadrant illustrates the non-public sector at national level, including NGOs and civil society. The right-hand side includes the international partners. The UN and EU related organisations are in the upper section and the other international organisations are in the lower portion.

It is highly recommended to encourage a participatory approach and to include representatives of migrant groups in the health coordination mechanism. The efforts of the different actors may thus be more responsive and effective to the (most urgent) needs of the refugees, asylum seekers and migrants.

[2] Advocacy is the deliberate and strategic use of information – by individuals or groups of individuals – to bring about positive change at the local, national and international levels.

Figure 2: Actors to be involved in the health coordination mechanism



2.2 Type of health coordination mechanism

Flexibility. There is no single "one size fits all" approach to the health coordination mechanism. This is because of variations in the context, scale and complexity of the problem across the European countries. In addition, the mechanism must be able to respond to changes in the operating environment. It does so by adjusting requirements, capacity and participation, depending on the national health system and its different levels of involvement/decision making. Health coordination mechanisms can therefore be applied at national level or subnational level, and can focus on internal stakeholders mainly (i.e. different ministries, national agencies, academia…), more on external stakeholders or both.

Importance of subnational coordination. The subnational coordination mechanisms do not necessarily mirror those at national level. They need to be adapted to the specific context i.e. zones of particular operational importance where multiple partners are operating (especially in arrival countries). This subnational coordination should facilitate decentralised decision-making and shorten response time. Moreover, the response has a better chance to be adapted to local circumstances, and allows for close participation with local authorities and partners. The subnational level should report to the national one, which in turn gives the necessary support. It is important to ensure capacity and seniority at the subnational level.

2.3 Activation of the health coordination mechanism

The Ministries/authorities in charge of responding to the health needs of the different migrant groups appoint the health coordination team. They also appoint the team leader/coordinator, who will take responsibility for the coordination of the health response. It is, nevertheless, important to have the Ministry of Health or an equivalent health authority at national or subnational level in the driver's seat, playing a leading

role in the health response. Table 1 shows the steps to take into account, when setting up and managing a successful health coordination team.

Table 1: Enablers for a successful health coordination team

Process	What	How/Remarks
1. Designation of the health coordination team/coordinator	The authorities in charge of responding to the health needs of different migrant groups designate a health coordination team and coordinator for the health coordination mechanism	The coordinator is ideally supported by other technical public health professionals as per context, e.g. an epidemiologist, a health information specialist and a communication specialist
2. Regular successful meetings	The health coordinator □ Chairs the meetings of the health coordination mechanism (co-chairing possible) □ Chooses a suitable venue for the meetings □ Sets realistic agenda, with "smart" objectives □ Hands out information before or during the meetings □ Ensures recording of minutes with action sheets (who is responsible for what) □ Keeps meetings short □ Sets date for the next meeting □ Is open to new partners □ Follows up on former agreements	□ Focus on problem solving/action and not just information sharing among members of the health coordination mechanism □ Consider subgroups for specific issues (vaccination campaign, SGBV, mental health…), which report back to the health coordination mechanism meetings
3. Work with other national and international coordinating entities/working groups	□ Especially important for cross-cutting issues: SRH, SGBV, mental health, WASH… □ Ensure free flow of information □ WHO can liaise with UNCT, if it is part of the health coordination mechanism □ Identifies possible contingencies that could impact on the health needs of the refugees and the required responses (i.e. acute influx)	□ Invite representative(s) to the health coordination mechanism meetings □ Designate someone from the health coordination team to attend the respective meetings, as relevant □ Write a contingency plan detailing the response in terms of services, prepositioning of supplies, resources needed and monitoring and evaluation (see SH-CAPAC action plan) □ Consider simulation exercises
4. Ensure regular feedback to all partners involved	The health coordinator □ Sends out minutes and action sheet within 24-48 hours after the meeting □ Gives regular feedback to the next hierarchical level and other possible partners, who are not part (or only occasionally) of the health coordination mechanism through the production of monitoring reports □ Ensures feedback from the next hierarchical level to the coordination mechanism	□ Designates who takes minutes and circulates them. □ Adopts a simple format/template for the monitoring report with the inclusion of agreed upon indicators (see below)

3 Health coordination team

3.1 Composition of the health coordination team

The health coordination team can be organised at national or subnational level, depending on the (geographical) needs and the (de)centralised health system. At each level, the designated leading authority coordinates the process (e.g. Ministry of Health at national level, regional health authority at subnational level). The health coordination team leads and ensures appropriate linkages with all partners involved. These partners may vary according to the country, context and the level, at which the health coordination mechanism is established.

It is suggested to ensure a core group comprised of:

- Coordinator,
- Health information management and communication expert, and
- Staff member from the health authority with public health experience.

Inclusion of a communication specialist in the health coordination team is desirable, especially at national level or in a prominent hotspot.

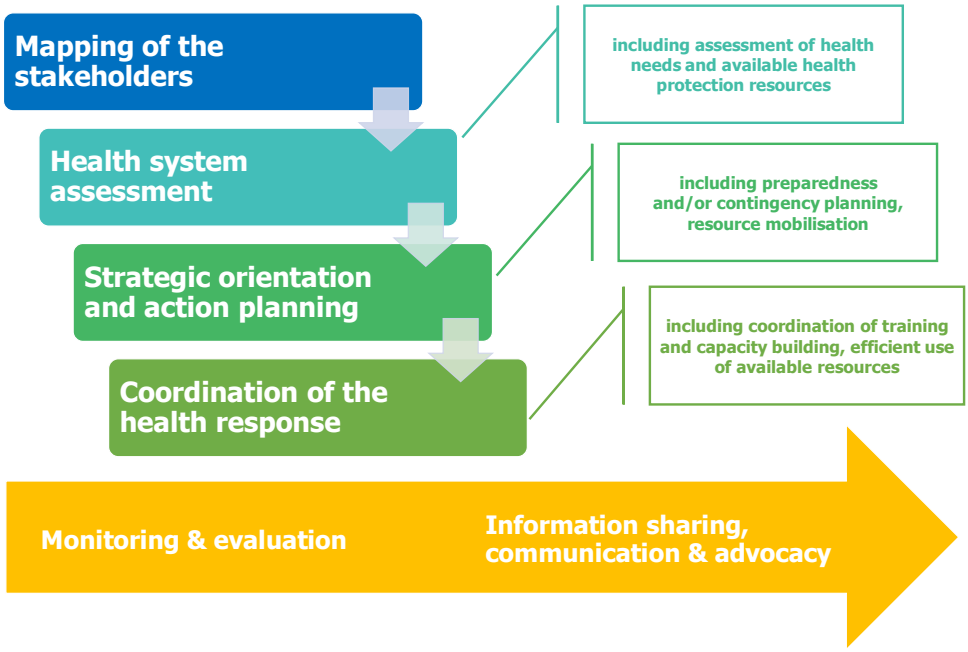
The coordinator is designated by the ministries/authorities in charge of the corresponding level; (s)he is someone with proven leadership skills, knowledge of and experience with migrant crisis and with a public health background. The health information management expert is someone with epidemiological or basic health statistics experience or the staff member/clerk in charge of compiling health data at the local level. An additional staff member with public health experience would be an asset.

Additional persons from the health authority may be called upon to participate in the meeting, depending on the level, contextual needs and dynamics of the situation. An immunisation expert could be called upon for instance, if the need arises for a mass campaign or to inform the various partners of the national routine immunisation norms. At local level, it may be advisable to invite the local hospital director to be part of the core group to ensure smooth referrals and counter referrals.

3.2 Tasks of the health coordination team

The health coordination team is assigned to perform the tasks depicted in Figure 3.

Figure 3: Tasks of the health coordination team



The first four tasks comprise a stepwise process (blue and green boxes). The mapping of the stakeholders to be included in the health coordination mechanism has to be performed first. This is followed – if needed - by a health needs assessment so that strategic orientation and action planning can be conducted. Once the coordination starts, the health coordination team has to work in parallel on the efficient and coordinated health response, monitoring and evaluation, information-sharing, communication and advocacy. The health coordination team has the end responsibility of the latter 'continuous' tasks (yellow arrow). It acts as the gatekeeper of all information generated and gathered by the first four tasks. It is therefore imperative that reporting of the various task achievements is done to the health coordination team in order to avoid fragmentation.

1) Mapping of the stakeholders

The health coordination team maps the main (national and international) stakeholders involved in terms of 'Who is doing What, Where and When'. It then invites them to be part of the health coordination mechanism. The health coordination team should also link with other coordinating bodies or agencies dealing with non-health sectors that have a direct impact on health. These include agencies dealing with water and sanitation and food security, as well as those who have common programmes, such as SGBV, but are not partners of the team. This is important to avoid duplication and ensure complementarities of other stakeholders' efforts.

WHO?	WHAT?	HOW?
Health coordination team	☐ Identify (sub)national and international actors ☐ Map who is doing what and where ☐ Conduct a simplified resource mapping exercise in order to have a rough estimate of the	☐ Gather info through use of simple form or round table talk (especially at local level where resources are scarce) ☐ Consider use of a tool: e.g. ○ WHO assessment

WHO?	WHAT?	HOW?
	available financial and human resources □ Understand their mandates, expectations and constraints □ Gather information, guidelines and tools from stakeholders	

2) Health system assessment

The following elements need to be taken into consideration, when planning a health needs assessment for subsequent strategic orientation and action planning:

1) Access
   - to health services
   - opening hours, especially for women and girls
   - communication (interpreters, pictograms, local facilitators)
2) Staff
   - availability of female and male staff, local staff
   - training in culturally sensitive communication
   - training in specific areas, such as SGBV and psychosocial support
3) Safety and confidentiality
   - private consultation rooms
   - professional confidentiality
   - women and child friendly safe spaces (especially for unaccompanied minors)
   - security personnel
   - provision of legal advice and protection
4) Risk reduction (can be initiated immediately without assessment)
   - WASH: provision of appropriate water and sanitation taking into consideration the gender perspective
   - appropriate lighting in facilities, especially sanitary
   - presence of Minimal Initial Services Package (MISP) at facilities
   - application of SGBV guidelines
5) Environment
   - community awareness/education programmes/public information campaigns
   - use of local field workers

6) Services
   - type of services available, including referrals
   - specific attention to services for reproductive health, including BEOC, SGBV
   - vaccination according to norms [emphasis on measles, mumps, rubella (MMR) and polio]
   - screening for CD as per country of origin
   - surveillance, especially TB
   - psychosocial support
   - care for unaccompanied minors
7) Information management (collect data for action)
   - data collection disaggregated by age and sex

- identification of vulnerable populations
- data analysis at local and central level for decision making
- data management and reporting format
- respect of confidentiality

8) Financial and human resources
   - funding source: where does the funding come from? (e.g. government, UN, EU, NGO, volunteers, etc.)
   - funding mechanism: how is the health care delivery being funded? e.g. envelope (for whole year/project), lump sum amount per asylum seeker/refugee, out of pocket expenditures, third payer mechanism, contingency budget
   - funding amount: amount spent on health care responses in Euros, per year/per month; pledged amount if available
   - human resources for health: number of staff by category/specialty
9) Existence of "what would happen if" scenario (e.g. sudden surge) and level of preparedness.

WHO?	WHAT?	HOW?
Health coordination team with stakeholders (possibly an assessment team is appointed for the purpose of this task)	☐ Needs assessment ☐ Assessment of available health protection resources ☐ Gap analysis and identification	☐ **See guidance provided by the SH-CAPAC health assessment guide**

3) Strategic orientation and action planning

When embarking on strategic planning and development of action plans, attention needs to be paid to:

- Coordination of strategic planning with attention to cross-cutting issues, such as SRH, SGBV, mental health, and filling gaps identified during the health system assessment.
- Development of action plans to respond to the health needs identified.
- Development of preparedness[3] plans to deal with surge capacity. This includes contingency planning; communication strategy, including risk communication and internal communication with call lists including other sectors; coordination with the military; pre-positioning of supplies, fixed or mobile infrastructures.
- Coordination of contingency planning for protracted situations, aiming at adopting a health systems approach.
- Application of standards; ensure use of national policies, norms and standards (support development/revision of guidelines, if needed, using recognised international best practices).
- Resource mobilisation (financial, human resources, supplies).
- Planning of capacity building and training in identified priority areas.
- Strengthening of the national health information system by integrating refugee and migrant health data in the regular health data registration and collection.

[3] Preparedness includes any action, measure, or capacity development that is introduces before an emergency to improve overall effectiveness, efficiency and timeliness of a response and recovery. It builds the advance readiness of country teams and strengthens their ability to respond during a crisis, when conditions deteriorate or new shocks occur. IASC cluster coordination 2015.

WHO?	WHAT?	HOW?
HCT with stakeholders and specific national technical staff	□ Strategic plan □ Action plan □ Preparedness and contingency plan □ Respect of norms and standards □ Capacity building and training plan	□ **For planning: see guidance provided by SH-CAPAC action plan and resource package** □ **For capacity building: see guidance provided by SH-CAPAC resource package and training**

4) Coordination of the health response

To advance health coordination in different types of countries (e.g. countries of first arrival, transit countries, destination countries), it is important to look at the pattern of strengths and weaknesses shown. The following table presents a matrix highlighting the salient aspects of the health response that ought to be put in place to meet the health needs of the different migrant groups. The migrants can be categorised according to the phase of the migration trajectory they are in and/or the type of residence status they have at that point. They range from newly arrived migrants and migrants in transit to asylum seekers, those who have been granted refugee or protected status and those who become or remain undocumented. Each category of migrants comprises people of different gender and ages. They include unaccompanied minors who appear to be particularly vulnerable and deserve special attention (see more in background document). The different types of migrants face different health challenges at the different moments of their passing through or stay. They also have different levels of (entitlement to) access to care that need to be taken into account.

Table 2: Salient aspects of the health response by population segment

Population segment	Location of response	Type of health response	Key actors in the health response	Authority/ coordination
First arrivals and people in transit				
First arrivals	Hotspot/ Registration facility	Initial assessment/triage Acute care Psychological first aid SGBV prevention & response SRH	Governmental agency NGO Volunteers IOM	Lead authority (e.g. MOH/RHA/MI/MMA) with IOM/UNHCR
People in transit	Reception facilities	Acute care Psychological first aid Protection Comprehensive PHC[4], mobile clinics, flexible referral to SHC National and trans-border follow-up SGBV prevention & response SRH	MOH/RHA/designated lead agency (e.g. Ministry of Interior, Ministry of Migration and Asylum, etc.) NGO	Lead authority (e.g. MOH/RHA) with IOM/UNHCR/MI/ MMA
Settling migrants				

[4] Comprehensive PHC: A primary health care based health system is composed of a core set of functional and structural elements that guarantee universal coverage and access to services that are acceptable to the population and that are equity–enhancing. It provides comprehensive, integrated, and appropriate care over time, emphasises health promotion and prevention, and assures first contact care. PAHO/WHO: Renewing PHC, March 2007. In this case, SGBV and psychosocial support should be integrated.

Population segment	Location of response	Type of health response	Key actors in the health response	Authority/ coordination
Asylum seekers	Reception facilities Health centre/hospital	Comprehensive PHC[4], mobile clinics, flexible referral to SHC, SGBV prevention and response, SRH, mental health	MOH/RHA/LHA/ designated lead agency NGO	MOH/RHA/MI/MMA Integration into regular health system initiated
Refugee status granted	Reception facilities Health centre/hospital	Comprehensive PHC[4], flexible referral to SHC, SRH, mental health	MOH/RHA/LHA/ designated lead agency	MOH/RHA Integrated into national health system
Undocumented migrants	GP/Health centre/hospital NGO facility Red Cross facility	Comprehensive PHC[4], referral to SHC, SGBV, mental health	MOH/RHA/LHA NGO Red Cross	MOH/RHA Integrated into national health system
Stranded migrants	Reception/transit facility GP/Health centre/hospital NGO facility Red Cross facility	Comprehensive PHC[4], referral to SHC, SGBV, mental health	MOH/RHA/LHA NGO Red Cross	MOH/RHA Integrated into national health system

In addition, it is important:

1) to ensure the respect and use of national policies, norms and standards[5] and
2) to coordinate training and capacity building in areas identified as priorities; this training should also cater for the mental and physical wellbeing of the health staff and caregivers who are facing various stressful situations.

WHO?	WHAT?	HOW?
Health coordination team with stakeholders and specific national technical staff	□ Health response by population segment with special emphasis on SGBV prevention and response, mental health, comprehensive PHC □ Special attention to unaccompanied minors □ Focus on integration into the national health system	□ **For resource packages: see guidance provided by SH-CAPAC resource package** □ Other SH-CAPAC tools (e.g. online training) could be considered if appropriate □ Ensure that financial and human resources are in line with strategic and action plan of the health response □ Ensure that preparedness and contingency planning is in line with stockpiling of medical supplies, drugs, etc.

5) Monitoring and evaluation

The aim is to collect and consolidate information for coordination purposes and to report on a regular basis. It is a continuous process that uses information received from other teams (e.g. health assessment team) and stakeholders, including regular monitoring and evaluation. For this purpose, it is suggested that an information management and communication specialist is identified from the onset and included in the health coordination team.

[5] I.e. support development/revision of guidelines, if needed, using recognised international best practices).

WHO?	WHAT?	HOW?
Health coordination team	□ Define the minimally required information to be collected, stored and disseminated for the benefit of the health coordination mechanism and other stakeholders □ Collect information from other teams, e.g. health assessment team, and stakeholders to feed into periodic monitoring and evaluation reports □ Regularly update and consolidate the minimally required information □ Focus on information for action that will inform national and decentralised health planning □ Internal feedback (through the periodic monitoring and evaluation reports) to all partners of the health coordination mechanism and to national coordinating body	□ Retrieve relevant information on health status and needs of refugees, asylum seekers and other migrants from national health information system □ If minimally required information is not available in the national information system: (1) collect and analyse data/information received from various teams and stakeholders and/or (2) ask stakeholders to register relevant data □ Produce a M&E report as per agreed format

Data collection and analysis. The information needed for monitoring and evaluation is collected, consolidated and analysed by the health coordination team in a responsible way. The team should only collect what will be used, respect and ensure confidentiality of documents pertaining to individual records.

- *Which data?* In addition to the information obtained from the health needs assessment, there is need for basic information to be updated regularly. Basic information already collected at (sub)national level varies, but data of primary importance are:

  - Number of new arrivals by age group, gender and country of origin.
  - Number residing in registration/reception centre by age group, gender, country of origin.
  - Number of deaths by age and gender with presumed cause.
  - Number of pregnant women.
  - Number of births.
  - Number of unaccompanied minors by age and gender.
  - Number of victims of trafficking.
  - Number of victims of physical, psychological and/or sexual violence.

  Data collected in centres are to be consolidated to obtain a national perspective.

  Additional desirable information as per context and assessment results should be collected and consolidated. This information should preferably be integrated in the existing national health information system. Some data may already be collected as various NGOs focus on specific pathologies like HIV, TB or services like immunisation. Yet, some data are not collected for the national population either. This needs to be taken into consideration, as it may be an opportunity to strengthen the national health information system. To be considered are data regarding:

- *Communicable diseases:*
  - For children < 5 years
    - Number of new cases of gastro-enteritis.
    - Number of new cases of respiratory tract infections.
    - Number of suspected measles.
    - Plus other diseases to be determined by the context.
  - Number of new scabies cases.
  - Number of suspected TB cases.
  - Plus other diseases to be added as per context with request to report any outbreak.
- *Non-communicable diseases:*
  - Number of new persons receiving mental health intervention (or who could be in need of as services may be lacking).
  - Number of new persons treated for cardio-vascular disease.
  - Plus other diseases to be added as per context.
- *Sexual and reproductive health:*
  - Number of new STI.
  - Number of new HIV.
  - Number of new victims of SGBV.
  - Number of new persons receiving treatment for SGBV by age and gender (or *who could be in need of* as services may be lacking).
  - Number of new complicated pregnancies.
- *Health services and needs* (to be determined by context, initial assessment and regular statistical reports pointing to specific needs (i.e. increase in pregnant women or outbreak).
- *Risks.*
- *HRH needs including translators.*
- *Accommodation safety, security.*
- *Status of the activities proposed in the action plan.*
- *Status of the trainings and capacity* building activities.

- *Where to get the data from?* Ideally data should be extracted from the national health information system or consolidated from different data sources with the relevant information (e.g. Red Cross, MSF…). If not available, primary data collection of the minimally required information may be considered. The stakeholder checklist in the health assessment guide may be instrumental in identifying possible data sources.

Periodic reporting. The health coordination team reports periodically to stakeholders and the national migration coordinating body (country specific).

- *When to report?* The health coordination team produces a M&E report at a frequency that is determined by the context and its urgency. In an acute situation, this can be daily and can evolve to weekly or monthly reporting according to the prevailing conditions. The aim of the M&E report is to give a succinct (maximum 2 pages), as precise as possible (given the circumstances) account of the health situation of the migrants.
- *What to report?*

  - Data analysed and consolidated by the health coordination team, including some key indicators (to be agreed on by the HCT and stakeholders) and other information provided by stakeholders;

- Progress reports of stakeholders involved in the various health coordination tasks (assessments, planning, implementation, capacity building);
- Progress made by the health coordination mechanism.

- *How to report*? The report should use a template with agreed structure and level of detail (to be developed by the health coordination team). Information should be presented in a succinct way and can be given in non-technical language if necessary (i.e. for communication to non-technical entities). Data can be presented in table format; graphs can be used to show trends.

Key points of Monitoring and Evaluation:

- ✓ M&E is one of the coordination mechanism's core functions and falls under the health coordination team's responsibility.
- ✓ M&E should be an integral part of the health response strategy and requires a participatory approach from all stakeholders. This will increase the real situation image, especially at subnational level.
- ✓ M&E should be gender-sensitive and be contextualized.
- ✓ M&E should not be delayed to get the perfect fit but should be initiated with a few key indicators agreed upon by the participating stakeholders. The initial list can be refined and extended at a later stage.
- ✓ The HCT should only collect data that will be used.
- ✓ M&E includes initial and possibly repeated assessments but also the monitoring of progress made in the implementation of the strategic plan:
  - Measure of effectiveness: Are we achieving what we had planned. What is our progress? Have any changes occurred in the general context warranting a different approach?
  - Measure of efficiency: are resources used adequately (match between resources and outputs)?
- ✓ The HCT will produce a M&E report at a frequency that is determined by the context and its urgency (see periodic reporting)
- ✓ M&E - especially in protracted situations - warrants quarterly reviews that in addition to the points mentioned are an opportunity to review the functioning of the HCT.

6) Information sharing, communication & advocacy

Adequate communication to internal and external stakeholders is paramount, hence the importance of having a communication specialist in the team.

Communication is aimed at a wider audience, internally (such as line ministries) but also externally at the media and the public. It should be reported in an appropriate language and highlight positive aspects of the interventions that may benefit the general population. This includes risk communication[6].

The information is also aimed at the political level advocating for an integrated health response. This is particularly important in destination countries, as strong evidence needs to be presented to decision makers.

[6] Risk communication is a process of interaction and exchange of information and opinions among individuals, groups and institutions to help everyone understand the risks to which they are exposed and encourage them to participate in minimizing or preventing these risks. Palenchar, M. J., Heath, R. L. (2007). Strategic risk communications: Adding value to society, Public Relations Review, 33(2), p. 121-127.

WHO?	WHAT?	HOW?
Health coordination team, national coordinating body, stakeholders, the media	□ Ensure feedback (e.g. based on the periodic monitoring and evaluation reports) to national coordinating body, other relevant line ministries and stakeholders, including UN and EU □ External communication to media and public (e.g. through website) □ Risk communication □ Highlight advantages to the general population □ Respect confidentiality[7]	□ Importance of having a communication specialist in the team

4 Concluding remarks

The guidelines for a health coordination framework provided above are part of Work Package 1 of the SH-CAPAC project. This health coordination framework incorporates EU Member States' inputs given at the workshop in Ghent on 23-24 February 2016 and feedback from SH-CAPAC partners during the meeting in Trnava on 6 April 2016, the workshops in Copenhagen (May 2016) and Reggio Emilia (June 2016) as well as the country missions (Bulgaria in July 2016, South Aegean and Catalunya in September 2016, Slovakia in October 2016 and Andalusia and Athens in December 2016).

The health coordination framework assumes a dynamic use, considering the nature of the refugee influx. The Member States are encouraged to adapt it to their own needs. This framework is just a first step in organising the health response in a coordinated way under the responsibility and authority of the Ministry in charge. Moreover, it is a first tool of a set of instruments that will help the Member States in implementing the framework. This set consists of an Assessment Guide (WP2 of the SH-CAPAC project), Action plan (WP3), Resource package tool for reducing access barriers (WP4) and Training in culturally-sensitive care (WP5).

This framework offers the potential for inter-country coordination between EU Member States, who are involved in the response to the recent influx of migrants, refugees and asylum seekers.

This health coordination framework should encourage the EU Member States to take action in providing a coordination mechanism for responding to the health needs of the recent influx of refugees, asylum seekers and other migrants into the European Union. The SH-CAPAC team offers technical support until end of December 2016 to establish such a health coordination mechanism and/or to strengthen the current coordination arrangements in the respective countries.

[7] Ensure that health programmes sharing information (including reports of SGBV) within the health sector or with partners in the larger humanitarian community, the media or the public abide by safety and ethical standards.

Annex 1
Report on SH-CAPAC Ghent Workshop

SH-CAPAC Ghent Workshop: Effective health sector coordination for addressing health needs of refugees, asylum seekers and other migrants in EU countries

Minutes
23 February 2016 (Day 1)

The objective of SH-CAPAC project is to support EU Member States under particular migratory pressure in their response to health related challenges. The Ghent workshop brought together the consortium partners, representatives from national governments interested in the SH-CAPAC project, and representatives from EU, UN agencies, IOM, and international NGOs. The workshop primarily focused on defining a framework for effective (sub)national health sector coordination for addressing the needs of the refugees, asylum seekers and other migrant's population in affected countries. In world cafés and discussion groups the workshop participants discussed challenges, gaps and solutions for three groups of migrants: newly arrived migrants, migrants in transit and migrants aiming to stay longer in a country.

Follow this link for the agenda of the workshop & list of participants.

Introduction to the first day of the workshop and Welcome to Ghent University

dr. Ines Keygnaert and Prof. dr. Olivier Degomme, Ghent University – ICRH

On behalf of Ghent University and ICRH, dr. Ines Keygnaert welcomed the participants and explained the purpose and programme of the two-day workshop. Subsequently, Prof Dr Degomme, the Scientific Director of ICRH, welcomed the participants to the city and university of Ghent. He stressed the importance of SH-CAPAC given the health needs and vulnerability of refugees, asylum seekers and migrants, especially in the context of sexual and reproductive health and rights.

Keynote speech – *The need for a common European approach for the protection of SRH and the fight against SGBV in times of migration crisis*

Prof. dr. Petra De Sutter, Head Dept. Reproductive Medicine, University Hospital Ghent; Senator & Parl. Ass., Council of Europe; Vice-chairperson Committee on migration, refugees and displaced person

See PowerPoint presentation.

See full keynote in Annex 1.

Prof. dr. De Sutter started her speech by referring to the refugee crisis of the 1980's, in which many European member states were also hesitant to resettle and relocate refugees. She then showed with recent UN data that 60% of refugees, internally displaced persons and asylum seekers are now women and young girls, with a need for access to essential reproductive health care. She demonstrated how the lack of services and lifesaving interventions, such as obstetric care, results in increased unintended pregnancies and unsafe abortions and in an increase in morbidity and mortality from gender-based

violence and pregnancy-related complications. Yet, men and boys also experience SGBV, but they are seldom recognised as survivors and mostly viewed as perpetrators.

Prof. De Sutter emphasized that we should respond to the disproportionate impact of the refugee crisis on women and children, prioritize funding for their health needs and urgently provide better hygiene, medical assistance at the receiving points and refugee camps and offer women and girls protection from gender based violence and rape. Equally, there should be attention to adolescent reproductive health in terms of funding, access to services, programming and programme evaluation. We should advocate for measures to protect at risk populations and to ensure survivors' access to medical care including: emergency contraception, post exposure prophylaxis to prevent HIV infection and psychosocial counselling. This minimum level of care should be available from the earliest stages of a humanitarian crisis.

In conclusion, Prof. dr. De Sutter referred to the Istanbul Convention and pleaded that it is a common responsibility that every EU Member State ensures:

1. Protection of asylum seekers of concern against SGBV
2. Addressing survival sex as a coping mechanism in situations of displacement
3. Engaging men and boys
4. Providing safe environment and safe access to domestic energy and natural resources
5. Protecting particularly vulnerable persons like persons with disabilities and LGBTI persons from SGBV

Session 1 – *Introduction to the SH-CAPAC project, objectives and goals*

Prof. dr. Daniel López Acuña, Coordinator SH-CAPAC; Adjunct Professor of the Andalusian School of Public Health (EASP)

See PowerPoint presentation.

Prof. dr. López Acuña first gave an overview of the nature and the context of the refugee crisis, stating that this crisis is not only present in Europe, but also in Turkey and Lebanon. Every year, 1 million unauthorized refugees and asylum seekers and 2,5 million legal migrants enter Europe. 60% of the refugees come from Syria, 93% come from the world's top 10 refugee producing countries. The most dominant route is currently arriving in Greece and moving on to Macedonia, Servia and Croatia and afterwards the route depends on the border crossing possibilities. There is a need for rapid humanitarian responses and increased technical assistance. However, responding quickly and efficiently can be complex, resource intensive and socially disruptive. Therefore, he urged the audience to think of public health solutions.

A sound, effective and pragmatic response to address the health needs of refugees and asylum seekers in Europe is required. According to the SH-CAPAC consortium the response should include an agenda for action, coordination and collaboration. The agenda for action should focus on assisting refugees on arrival, strengthening the epidemiological surveillance capacities, immunisation programs, protection of the most vulnerable groups, strengthening the health system capacity, continuity and quality of care, migrant-sensitive health policies and intersectoral collaboration.

The response should focus on communicable and non-communicable diseases. When it comes to communicable diseases, governments should take into account that migrants and refugees are not different from international travellers, but that their living conditions etc. should be addressed. Concerning non-communicable diseases, it is important to identify and tackle gaps in (continuity of) treatment, to take mental health problems, sexual and reproductive health and SGBV into account.

Therefore intersectoral action is needed. Coordination and collaboration is crucial and sharing of information between different actors and policy makers should be intensified. There is a need for trans-border approaches, transnational data with respect of privacy, and portability of health records/cards.

Subsequently, Prof. dr. Daniel López Acuña introduced the SH-CAPAC project objectives and goals to the invited representatives from national governments, EU, UN agencies, IOM and international NGOs. The SH-CAPAC project seeks to address the compounded effect of health needs that require access to regular comprehensive health care and public health. The main objective is to provide support and capacity building to the different EU Member States, which requires a coordination effort and a significant engagement from the member states. The SH-CAPAC consortium exists of 7 universities and started this one-year project on the 1st January 2016. The work packages include the development of a framework, tools for health assessment and action planning, organisation of regional training and workshops and technical assistance. The direct beneficiaries of the support provided by SH-CAPAC are the national and regional health systems (in particular health centres, hospitals, health workers, …) in the 19 EU target countries, the indirect beneficiaries are the 1-2 million migrants and refugees. The outcome is a framework for coordination, an instrument for assessment of health challenges, the implementation of public health responses, resource packages and a framework for training. At the end of 2016 the target countries should have implemented a coordinated response or have strengthened the existing response, gaps will be identified with action plans to address them and the capacity of the health care providers will be increased.

Session 2 – *World Café discussion on project objectives and (un)met needs of the participating Member States*

Dr Ines Keygnaert explained the procedure of having a world café discussion and asked the participants to divide in 5 groups each attending a different table on which a different work package (WP) of the SH-CAPAC project was going to be discussed: health coordination framework (WP1), health assessment (WP2), action plan (WP3), resource package (WP4) and capacity building (WP5). Participants had the opportunity to attend three different tables contributing to the discussion of three work packages of their choice. At the end the main points were presented to the whole group and participants could indicate which work packages were of greatest importance to their country and/or organisations. The discussions are summarized below.

Work package 1: Health coordination framework

Daniel López Acuña & Jackie Gernay (president and notetaker)

The participants of this world café table stated that it is essential for the health coordination framework to recognise that "This is not a migrant crisis; it is a political crisis". They stated that it is important to set priorities, to assess trends and patterns and to learn from the HIV crisis (international coordination), the Malta triumvirate (coordinated registration, screening…) and country experiences in former refugee crises (e.g. Belgium) and to listen to the input from volunteers since they bring positive as well as negative points.

Participants stressed the need for flexibility, for leadership capacity (to coordinate all partners, each with their own agenda), for clarity of focus, aims and outcome of coordination and for cultural mediation. All should look at vulnerabilities, not nationalities and at a political level. Strong political leadership and services should be foreseen. There is a need to coordinate different crises and both positive and negative lessons should be learned from existing coordination mechanisms.

Furthermore, they indicated that there is a risk of being inefficient and time consuming if there is no coordination, leading to overburdened staff. But too heavy coordination could be negative too. Wrong data, double counting, cultural and linguistic barriers and stigmatization should be avoided.

Stakeholders interested in cooperating in the development of this framework are: Romania, Greece, Croatia, Malta, Bulgaria, Portugal, Croatia, WHO, ECDC, UN, Eur-HUMAN project led by University of Crete.

Work package 2: Health assessment

Mette Kristine Torlev & Jeanine Suurmond (president and notetaker)The participants of this world café table discussed the development of the health assessment tool and confirmed that the refinement of existing tools and creation of a standardized tool with the ability to analyse quantitative data are essential and would be very valuable. Health assessment should be apt to respond to changing political aspects (e.g. closing of borders).

Health assessments could reveal that migrants are denied access, that health needs are underdiagnosed or "invisible", or that violations (e.g. rape) are unreported. The health assessment should focus on non-communicable diseases, pregnant women, early detection of vulnerable people, vaccinations and mental health. The focus should not be on public health, but on individual health! There should also be an assessment of the legislative framework and syndromic surveillance. Assessment of the health needs in first arrival countries as Greece is crucial. It should be taken into account that the health assessment will primarily take place in transit countries and will thus be under time constraint.

Interested partners in the development of a health assessment tool are the governments of Romania, Bulgaria, Malta, Greece, and Croatia, and WHO, MF and ECDC,

Work package 3: Action plan

Eva Nemcovska & Alberto Infante (president and notetaker)

The Action Plan should be a step by step manual for the Member States, including lessons learned from others (e.g. Belgium has experiences with the framework) and practical contingency planning. This plan should be flexible and allow actors to do their work. Therefore support from EU (resources, recommendations,…), non-conflicting priorities (IOM, NGOs, local level,…), time for organisation, registration etc., communication (translation, mediation) and correct information (amounts, counting…) are needed. The plan should be adaptable to changing situations and should make use of modern technologies for addressing barriers (e.g. linguistics). Funds should not be the only focus and a spirit of "Think globally, act locally" is crucial.

In the development of this Action Plan imbalance of participation of different states, organisations, … should be avoided. The cooperation of ministries is needed, as is a rebalance of security-health and an accessible drug market. Lack of guidelines on a local level should be avoided too.

Romania, Greece and Slovakia showed interest in the development of an action plan. ECDC, WHO, UN, MSF, and the EUR-HUMAN project led by the University of Crete are also interested.

Work package 4: Resource package

Antonio Chiarenza & Ana Szetela (president and notetaker)

The Resource Package should essentially be a centralisation of resources based on lessons learned from health care professionals and managers. Therefore an exchange/sharing of information is necessary, as is a timely assessment of the needs of health care professionals/field, transit countries, managers and politicians. Guidelines on how to collaborate with NGOs and state agencies have to be included. The different status of migrants (recent arrival, transit, destination) and their different health care needs should be identified. But also materials and strategies to be used to get support (managers, policy level), self-assessment tools, strategies to involve local migrant communities (asking migrants themselves about their needs, the perceived quality) and strategies to cope with media, internal and external communication, … should be part of the Resource Package.

In order to develop this Resource Package, human resources including financial incentives to support the use of the resource package are needed. The consequence of the economic crisis on the mainstream health care system has to be taken into account too, since it may be lacking for the whole country. Further, a tool for needs assessment in a timely way, cross-border information sharing, anticipation of future migrant "hubs" and bypassing "diplomatic" information exchange are also identified as requirements. It should be a package which is useful for different managers and health care professionals (not a single response).

A Resource Package can contribute positively to an improved health response thanks to elimination of chaotic and fragmented actions, reduction of access barriers to health care, more patient-centred care and acceptance of what we are doing for migrants from the society, , more coherent collaborative policies with NGOs, states and health care professionals, increased cross-border collaborations, efficient allocation and use of human and financial resources.

Interested partners in this resource package are the governments of Portugal, Greece, Croatia, Romania, and Slovakia, and MSF, UNFPA and the Eur-HUMAN project led by the University of Crete.

Work package 5: Capacity building

Riitta-Liisa Kolehmainen-Aitken & Lotte De Schrijver (president and notetaker)

Essential for the work package on Capacity Building is the development of a basic, general framework by adopting existing materials and methods and integrating them into a comprehensive package. This package should consist of modules about intercultural competence development, training of specific skills and important issues such as chronical diseases, SGBV, unaccompanied minors, psychological needs and human rights. Capacity Building should include virtual training and an evaluation of the training methods. The consortium should pay attention not to develop a training which is too time consuming since actors in the field are very busy and might not always be easy to motivate. It is a time investment for them.

The training should be integrated in public health training and should be one training for all, but with basic and advanced level (e.g. through modular system). Specific topics should be prioritized and migrant health should not be considered to be an exception. This means that the SH-CAPAC consortium has to look at different target groups and different languages, that the framework should be flexible (rapidly changing situations), that input from migrants is needed and that differences between transit and destination countries are taken into account.

Interested partners in Capacity Building are the governments of Croatia, Greece, Romania, Bulgaria, Portugal, and Malta. UNFPA and the Eur-HUMAN project led by the University of Crete would like to be updated as well.

Session 3 – *Mapping the response to the health needs of refugees, asylum seekers and other migrants in 19 EU Member States*

Presentation

Ainhoa Ruiz Azarola, EASP & Birgit Kerstens, Ghent University – ICRH

See PowerPoint presentation.

SH-CAPAC has been mapping the current response to the health needs of refugees, asylum seekers and other migrants in 19 EU Member States. Information was gathered regarding (1) the existence of a national coordination mechanism for the health response, (2) the kind of first assistance services provided (if any), (3) the characteristics of the health response (Who? What? Where?), and (4) the financial resources available. Information was collected from publicly available documents and complemented with input from contact persons in each of the Member States.

The following observations were made for the four components:

1. Existence of national coordination mechanism of the health response:
   Currently, if existing, the national coordination of the health response is performed at governmental level (by Ministry of Health, Ministry of Interior, Ministry of Foreign Affairs, public institutions) but involves NGOs and professional associations. The degree of coordination provided at governmental level differs between traditional (institutional response already existing) and new destination countries (institutional response in process).

2. First assistance services:
   First assistance takes place in reception and/or registration facilities, coordinated by national, subnational or local governments. IOM and some NGOs are also involved in providing first assistance. In some countries, all migrants are registered and screened. It appears that 1/3 of the 19 European MS integrates first assistance in their existing national health systems and 1/3 does not.

3. Where, what and who?
   -*Where?* It often depends on the legal status of the migrant where (s)he receives health care. Recent arrivals mainly receive health care in facilities managed by government of by the Red Cross, at the point of entry.
   -*What?* Recent arrivals receive primary, secondary and tertiary health care, specialized care for babies and children (NGOs). Asylum seekers get primary, secondary and tertiary health care (exceptions in some countries) in collective reception facilities, emergency rooms, or hospitals, but in some countries access is restricted. When the refugee status is granted, health care takes place at reception facilities and in hospitals (again some countries with access restriction). Undocumented migrants are treated in reception facilities, hospitals and emergency rooms. They receive only urgent medical aid and a restricted access to screening

and treatment. Children have more access to health care. Unaccompanied minors are welcome in specific facilities and hospitals. In some countries unaccompanied minors receive the same care as children of the host country. In other countries there is a lack of access and/or a lack of awareness among health professionals. These minors have a limited choice and receive in some countries "standard" care. In practice, many of them do not have any kind of health access.
-*Who?* Health care is often provided by the Red Cross, IOM, UNHCR, society organisations, volunteers and NGOs.

4. Financial resources:
   Information about financial resources for the health response is often undisclosed or "unavailable". SH-CAPAC only got responses from national governments and most of them only mentioned their own financial resources, so there is probably a lot of missing data from other stakeholders. The consortium partners are aware that there are many stakeholders (government, IOM, UN agencies, EU, NGOs and civil society organisations), using many different sources.

Conclusion & Plenary discussion

Prof. dr. Daniel López Acuña concluded after the presentation that "We are not facing one mechanism, agency, response etc.. We should be critical to emphasize diversity." Participants stressed that there is room for improvement and strengthening of the coordination practices, but experiences and best practices of some of the countries may need to be learned from.

Experience in the different transit countries shows that providing health to migrants, refugees and asylum seekers is not always easy since they want to continue their journey as fast as possible. This may lead both to more and to an underreporting of health problems in this group. It was forwarded that mobile clinics might be a solution?

Furthermore, it was stated that we need to keep in mind that there are three kinds of people affected:

1. Those who just enter EU (specific mood after long travel with specific needs after this trip)
2. People in transit, moving in EU (different dynamics, different health and legal problems)
3. People in destination countries (in camps, who thought this was going to be the final status)

The health needs of migrants in arrival, transit and destination countries are therefore different. Special attention should be given to developing a relation of trust with migrants, refugees and asylum seekers, so that they know that accessing health care is not a threat for their migrant status (professional secrecy, no relation with law enforcement,…). Health care should be disconnected from the police and the legal status of a person. Participation of Ministries is important here. An appropriate legal framework for health care for undocumented migrants is considered crucial.

Session 4 – *Discussion of the working groups: Challenges in coordination of health response*

The participants were divided over three tables and discussed the challenges in coordination of the health response for each group of migrants: the newly arrived migrants, those in transit and the ones aiming to stay longer in the country. Findings were summarised in the plenary session (see below).

Plenary session – Summary findings of session 4 & Wrap up

Table 1: Challenges related to newly arrived migrants

Iain Aitken & Eva Nemcovska (president and notetaker)

New arrivals were mid-February concentrated in Greece, a bit in Italy and Malta and maybe some in Romania and Albania. Therefore the discussion group decided to use Greece as a "case study".

More than half of the migrants are coming through the islands (they stay only approx. 48h on the island) and most of them stop in and around Athens (to gather resources to be able to move on – also approx. 48h). So, it is important to realise that they are moving! They seem to forget all problems (e.g. SGBV, chronic diseases…) as they want to get to their destination despite of everything and they will deal with health problems later.

Primary health care is almost exclusively foreseen by NGOs. Few cases that require hospital care are referred. Care is coordinated at ministry level. Initiatives with academics and civil society organisations failed because of lack of local support (overworked, no staff)). UNHCR offered coordination at local level - particularly on the island – and brought together hospital directors etc. which gave better results. To improve the situation more resources, especially staff, are necessary to allow the Ministry to be involved even more and to coordinate better and provide better care. At the moment Greece is in a difficult economic situation and there is a brain drain amongst the own population. Health camps at the border are also mostly organized by NGOs and Red Cross.

Table 2: Challenges related to migrants in transit

Ines Keygnaert & Antonio Chiarenza (president and notetaker)

The migration routes constantly change . Almost all EU countries have become transit countries, except for the most Northern ones. The big challenge the EU countries are confronted with is dealing with migrants who don't want to stay and are difficult to provide care for. Moreover there is a lack of transnational information transfer and travel per se involves health consequences (e.g. hidden in trucks, long walks on foot, …).

Migrants in transit are not interested to apply for refugee status and are in fact undocumented migrants. This brings another challenge to provide care for this type of migrants, since professionals risk to be sanctioned in certain circumstances.

In this discussion group the representative of Croatia reported on the health care needs of migrants in transit. Only 3.7% of the people arriving receive adequate medical treatment. Nevertheless, there is a well-organized health care system (e.g. medical outpost in camp). Special centres for unaccompanied minors are present. The importance of mobile clinics, which follow people on the move, is stressed. When people get stuck in camps, as in Calais for example, they require special needs. A better coordination of the police, NGOs and local authorities is necessary.

Table 3: Challenges related to people who aim to stay longer

David Ingleby & Mette Kristine Torlev (president and notetaker)

The third group reported that - in countries of arrival - there is attention for (treatment of) mental health issues. Guidelines for this type of care are available (e.g. WHO), but coordination of mental health care

is required. "First line psychologists" might be involved in providing approachable mental health care. There is a need for long term initiatives.

One of the challenges are intercultural issues. There is a need for training of health care professionals and for a long term adaptation of the health care system accordingly (intercultural health education).

When people arrive they lack documents, knowledge about the health system and they don't have medical records. The question came up whether we need to wait with health care until they have legal documents? There is a need for integrated health care (in general), including language and cultural background, a need for early interventions (not just emergency care), for social support, resilience, religion. Access to health care should be promoted and a stronger role of advocacy is necessary.

Notes – 24 February 2016 (Day 2)

Introduction to the second day of the workshop

dr. Ines Keygnaert, Ghent University – ICRH

Dr. Ines Keygnaert welcomed all participants back to the second day of the workshop that is meant to address the Health Coordination Framework in-depth and how this framework can be of best use to the Member States.

Session 1 – *Health coordination framework*

See draft version of the health coordination framework.

Presentation

dr. Ines Keygnaert, Ghent University – ICRH & Jackie Gernay, EASP

See PowerPoint presentation.

The aim of this health coordination framework (HCF) is to provide EU Member States (MS) with strategic guidance in the development of a coordination mechanism for the multiple national and international stakeholders involved in health response. Secondly, the framework wants to support the health or other authority in charge in defining an operational strategy in accordance with international agreements, directives and guidelines putting all governmental and non-governmental organisations and international organisations in line with each other.

The Health Coordination Framework provides a step by step guidance in appointing the health coordination team, in activating and implementing the health coordination mechanism. When Member States apply this health coordination framework, it will help them in:

1. Establishing a standing coordination mechanism, led by the Ministry or authority in charge, for responding to the health needs of (the recent influx of) refugees, asylum seekers and other migrants.

2. Conducting health needs assessments and assessments of the public health response and health care provided to these populations with the participation of the different stakeholders that are part of the coordination mechanism.
3. Formulating strategies and action plans (including preparedness and contingency planning) for responding to the health needs of these populations with the participation of the different stakeholders of the health coordination mechanism.
4. Mobilizing and coordinating the necessary resources to implement the actions needed for an improved health response.
5. Monitoring and evaluating the health response to the refugees, asylum seekers and other migrants.
6. Leading the communication and advocacy[1] efforts in support to the health response to these populations.

Discussion

Prof. dr. Daniel López Acuña repeated that the SH-CAPAC project will provide technical support to those member states requesting it. In that case SH-CAPAC assembles a team of experts and dialogues with existing mechanisms in the country in order to flexibly define which functions can be strengthened. Some countries will require multinational and trans-border approaches and coordination, but not all. SH-CAPAC intends to start by strengthening the national mechanisms and down the road to strengthen the international and trans-border coordination. Since countries have different needs, the same mechanisms will not work in every country. SH-CAPAC needs to be flexible and case-based oriented (not top down). It could be useful to have case studies from actions in other countries or in other situations, not to copy but to generate ideas for other countries.

Participants of the different Member States emphasize that there is a big diversity among the Member States and every effort should be mission-oriented, in real time and with concrete objectives. The approach should be especially tailored to the current situation.

Session 2 Group discussions: *Identification of gaps and solutions in the health coordination framework.*

See presentation of the summary findings in: Session 3 – Plenary consolidation of framework by input of group discussion outcomes.

See ad verbatim description of full group discussions in Annex 2.

Session 3 – Plenary consolidation of framework by input of group discussion outcomes

Table 1: Gaps & solutions related to newly arrived migrants

Jackie Gernay & Antonio Chiarenza (president and notetaker)

There were two countries at the table with recent arrivals: Portugal (only 33 refugees, but have a coordination mechanism in place that is functioning) and Greece (95.000 migrants since the beginning of the year). Greece is facing many challenges, with one of the major challenges being the economic

[1] Advocacy is the deliberate and strategic use of information – by individuals or groups of individuals – to bring about positive change at the local, national and international levels.

crisis in combination with the European pressure to keep the migrants in Turkey or Greece. With the projections for the rest of the year (with the weather getting better) participants stress that this is a time bomb. There is need to think fast. The dynamic nature of migration (especially with closing borders) is going to intensify. Migration repression is going to intensify further and there is worry whether there will be sufficient capacity to deal with the matter, to respond as this requires a lot of coordination.

The fact that Greece has a lot of little islands leads to transportation problems, for referral for example. There are currently not a lot of health facilities and even the local population has to deal with insufficient health care. There is a good coordination group at the national level, which includes scholars, ministries, IOM etc., but the problem is the implementation at the local level. Human resources is one of the problems since 50-60% of the staff has migrated, so it is not only a financial problem. Local coordination is done by UNHCR, reporting to national health authority. Doctors are in these groups, but they have no time to lead these groups.

The table participants brainstormed about possible solutions. One possibility might be to hire retired people. At the moment this is not allowed according to the law. This was done in Portugal with a workaround around legislation. Another option is to look in the migrant population if there are health professionals who could be hired locally. An inter-ministerial group, that is functioning, could create vacancies and look at legislation, instead of only the ministry of health and ministry of finances as is the case at the moment. At local level in Greece, it is necessary to map the stakeholders and make decisions in action taking. At national level there is a need for information management, for external communication (Greece has a negative image) and specific coordination functions. It is also important to create room at national level to look at legislation and flexibility in drugs and vaccine importations.

The framework should be proactive, aimed at being prepared is in humanitarian operations and not only reactive. We should take the lead and propose to the policy makers a framework in a way of contingency planning. Contingency planning/preparedness is different of planning a response. It is putting elements in place when and if the volume intensifies.

Table 2: Gaps & solutions related to migrants in transit

Alberto Infante & Ana Szetela (president and notetaker)

There are two types of transit countries. Countries with a structured procedure (1), with a "corridor" from one border to the other, which are well organized by a "control and command" centre in which the Ministry of Interior has the lead and Ministry of Health has a specific role in health risks of the people included in this movement. Well-established pre-existing social protection is included in an ad hoc body. Other countries are less well organised (2), with migrants that are on the move on their own looking for shelter or food with their own means. They are approached by volunteers of civil society organisations. These opposing models use either a bottom-up or a top-down approach. However, the situation in these countries can evolve from one model to the next.

There is a need to prepare contingency plans. Countries should be prepared (having information (what, where and who), having the contacts, e.g. based on other countries) and have structured coordinating bodies. Apart from this, it is important to communicate at an early stage with the public. Through good health risk communication for example, one can translate confidence to citizens. Stockpiling of resources and installing mobile units and coordination with fixed units are essential too.

It stands out that the models are divers and that we need therefore a divers approach. Centralized models make a lot of sense (given the huge influx), but it has to be a flexible command and control system able to react on differences in regions.

Table 3: Gaps & solutions related to people who aim to stay longer: asylum seekers, refugees, undocumented migrants

Birgit Kerstens & Jeanine Suurmond (president and notetaker)

There is no uniform system in Europe. At the moment we have highly decentralized system in some countries, but highly centralized in others. We need to adopt for every situation.

In destination countries mental health care and secondary care become more important. We should identify the gaps in health care in these destination countries by listening to migrant experiences and include these gaps in policy making. It could also be useful to use testimonies of migrants and how they found access to health care to inform newly arrived migrants about health care outside of the asylum seeking centers. This can also overcome the lack of interpreters/cultural mediators we are often faced with. Plus, in the often hostile host country, these testimonies can give more trust in the health care system. The voices of migrants could be brought to the discussion tables and participating platforms.

Care providers are also often lacking knowledge about procedures among e.g. undocumented migrants. We should keep in mind that the focus and approach for asylum seekers and undocumented migrants are not the same. There should be a coordination framework for stakeholders to support refugees settle in new receiving countries and collaboration with NGO's is necessary. A pre-registration access to care should be installed in order to take care of people with chronic diseases for example.

Closing session

Prof. dr. Daniel López Acuña repeated that the SH-CAPAC project has the possibility to offer technical assistance to individual MS. The work on the health coordination framework would be progressed, with attention for contingency and preparedness planning. The framework should be used to strengthen local initiatives and structures and to develop new ones.

The next meetings of SH-CAPAC workshops are:

- 17-18 May in Copenhagen: workshop for discussing the framework for public health assessment and planning for action.
- 16-17 June in Bologna: WP4 and WP5
- 7-8 July in Granada: training for trainers.

If Member States want to participate, they can contact Daniel López Acuña (SH-CAPAC).

The presentations will be mailed and uploaded to the SH-CAPAC website. Participants were asked to share the info amongst their colleagues.

Extra session –Médecins sans Frontières – Insights in numbers

Meinie Nicolai, President, Médecins sans Frontières Belgium

Meinie Nicolai gave an introduction to the activities of MSF in the context of the refugee crisis (e.g. work in Tunisia with fishermen because they find people in need and corpses and are often traumatized; MSF trains them how to deal with corpses and gives first aid).

A preliminary analysis of medical data from routine OPD consultations in 2015 in Greece and Serbia was presented. The numbers are not to be quoted yet, but publication will follow after in-depth analysis of the data. This preliminary analysis gives an idea that, of all consultations, nearly 1 in 5 was intended

for vulnerable people (children <5 years, pregnant women, unaccompanied minors, elderly persons, disabled persons, single parent). The majority developed symptoms during the trip or after arrival (respiratory tract infections, trauma and wounds (more men than women), gastrointestinal, skin diseases) or were in need of vaccination. Only a few were referred to the hospital, specialized help or mental health professionals; some refused referral. Because of significant life events, mental health problems are present and this mainly in the vulnerable groups. These significant life events include forced displacement, bombing, shelling, threats, family member killed and others. On average 3 significant life events were identified per patient, mostly 2 before trip and 1 after/during.

MSF needs access from authorities before they can start offering assistance. Once access is granted, they look for the place with the highest needs in care and then start to collaborate and coordinate with the authorities. The local situation and initiatives are taken into account. MSF operates with both mobile and fixed medical centres. During their assistance, they also collect data and share this with the authorities. There is attention for psychosocial help too.

Annex 1: Keynote speech – *The need for a common European approach for the protection of SRH and the fight against SGBV in times of migration crisis*

Prof. dr. Petra De Sutter, Head Dept. Reproductive Medicine, University Hospital Ghent; Senator & Parl. Ass., Council of Europe; Vice-chairperson Committee on migration, refugees and displaced person

See PowerPoint presentation.

Ladies and gentlemen,

Dear colleagues,

Thank you for your invitation. As an expert in reproductive health and a co-chair of the Migration Committee of the Council of Europe, it is a big honour to me to introduce this seminar today with a keynote speech about 'The need for a common European approach for the protection of SRH and the fight against SGBV in times of migration crisis'.

I will start by briefly introducing the historical context, give facts and figures about women and girls at risk and suggest some answers: prioritize funding for their health needs and assistance at receiving points and refugee camps, and tackle underreporting of SGBV incidents and psychological counselling.

Then, I will list up the priorities and describe the political initiatives that have been taken, with particular attention for the Istanbul Convention.

Let me take you back in time, first. Back to the 80s. The 1980s saw great socioeconomic change due to advances in technology and the beginning of globalisation. The eighties had many fundamental advances in medicine and biology: the first surrogate pregnancy of an unrelated child in 1986 for example. And it was also the decade for the AIDS epidemic to be recognized.

But the biggest turn of the 80s is that the world population grew tremendously, surpassing the 1970s and later also the 1990s. Some said the population growth of the 80s would be the largest in human history, particularly rapid in a number of African, Middle Eastern, and South Asian countries, with rates of natural increase close to or exceeding 4% annually.

Due to wars and disasters, starting from 1974 through the 1980's, people had to flee. Often, these refugees were not fleeing wars between states, but inter-ethnic conflict in newly independent states. The targeting of civilians as military strategy added to the displacement in many nations, so even 'minor' conflicts could result in a large number of displaced persons.

Whether it was in the Middle East, Asia, Central America or Africa, these conflicts, fuelled by superpower rivalry and aggravated by socio-economic problems within the concerned countries, durable solutions continued to prove a massive challenge for UNHCR, the UN Refugee Agency, in the 80's.

It was a massive challenge indeed, especially because many member states were unwilling to resettle and relocate refugees. Doesn't that sound familiar?

Effective and human resettlement and relocation in Europe is not possible if member states are closing borders, and if every country thinks about its own "safety" instead of unify in a stronger Europe to tackle this crisis.

We tend to forget that history repeats itself: the 80s had to face a big migration challenge, like we have to face an even bigger migration crisis today.

Therefore, I first wanted to contextualize today's crisis. Migration is something of all times, as we know. But the 'bigger' crisis we are facing today, is probably 'bigger' than in the eighties, but not as 'big' at all, because the biggest migration crisis is yet to come. It is almost impossible to get an image of the outrageous number of refugees, amongst whom women and girls are representing a large number, that becomes larger every day. We have no idea. Especially for women and girls.

So, the global refugee crisis is not only a major challenge for governments around the world, it also aggravates another, less visible, but equally disturbing global phenomenon: violence against refugee women. They often suffer "double violence", something we have to denounce.

Let me explain myself: at the beginning of this month of February, the UN reported that more women and children flee to Europe than men: 73% of the people crossing the border of Greece to Macedonia in June 2015 were men, while now 60% of them are women and children.

For the first time since the migration crisis, the number of children has tripled. Three times more children that have to flee and try to encounter a better future in Europe. Three times more children exposed to the risks of the migration routes. Three times more children that could potentially be harmed, on their way to Europe.

More than half of refugees, internally displaced persons and asylum seekers are women and young girls, with a need for access to essential reproductive health care. Displacement increases their need for reproductive health services. The lack of services and lifesaving interventions, such as obstetric care, results in increased unintended pregnancies and unsafe abortions and in an increase in morbidity and mortality from gender-based violence and pregnancy-related complications.

Women and girls represent the most vulnerable group: at risk of sexual violence, including rape and exposed to trauma, malnutrition and disease. The lack of access by women, especially pregnant women, to reproductive health services represents a major health disaster. We know that.

Women and girls are often exposed to SGBV in conflict and displacement settings due to gender norms, inequality, and discrimination. Prevention of sexual violence, services for survivors and access to sexual and reproductive health care is critical in crisis situations when vulnerabilities are drastically increased.

Refugee women have the right to live free from the constant threat of violence and exploitation and survivors must have access to services. Reproductive health is essential for them to maintain their dignity and rebuild their lives.

Many women flee their homes in the North and sub-Saharan Africa and the Middle East to escape war, poverty or a violent family environment, thus embarking on a journey filled with terror. Violence against women during a clandestine journey, or behind the closed doors of detention centres, occurs far too frequently and should be of huge concern to us all.

And even men. While men and boys also experience SGBV, they are seldom recognised as survivors and mostly viewed as perpetrators. Although Age, Gender and Diversity reporting on addressing the needs and concerns of male survivors of SGBV is limited, there is growing recognition across UNHCR operations that more targeted interventions are necessary to also address this challenge.

Although funding for reproductive health in humanitarian appeals have increased since 2002, as you can see on the slide, only 43% of the need was met. The share of total humanitarian assistance also remains low, at only 0.5 per cent in 2014.

Of all the SRH-funding as shown in the largest orange bar on the right:

- *57% included specific proposals for maternal and child health.*
- *About 46% included funding requests to address sexual and gender-based violence,*

- *38% for HIV and sexually transmitted infections,*
- *27% for general reproductive health,*
- *and about 15% for family planning.*

What's missing? Well, there is a marked lack of attention to adolescent reproductive health in terms of funding, access to services, programming and programme evaluation.

That is why I – as a MP of the Council of Europe, vice-chair of the Migration Committee, and president of the Women Working Group of the Socialist Group of the Council of Europe (who deals with human rights and is much larger than the European Union, since it represents 47 countries, including Turkey for example) – …

…I called on Council of Europe member States, especially the countries with most arrivals: Belgium, Bosnia and Herzegovina, Cyprus, France (Calais), Greece, Hungary, Italy, Malta, Serbia, Spain, "the former Yugoslav Republic of Macedonia", Turkey as well as UN agencies and the civil society to:

- *Respond to the disproportionate impact of the refugee crisis on women and children and to prioritize funding for their health needs,*
- *At the receiving points and refugee camps to urgently provide better hygiene, medical assistance and offer women and girls protection from gender based violence and rape.*

We should advocate for measures to protect at risk populations and to ensure survivors' access to medical care including: emergency contraception, postexposure prophylaxis to prevent HIV infection and psychosocial counselling. This minimum level of care should be available from the earliest stages of a humanitarian crisis.

I signed a motion for a resolution (Doc. 13890) to protect refugee women from gender-based violence on the 30th of September and wrote a written declaration (No. 600, Doc. 13898) on the 1st of October last year, because there WAS an urgent need to protect women and children. Five months later I can only say that that urgent need IS even MORE urgent.

It is very urgent because Sexual and Reproductive Health and the fight against Sexual and Gender-based Violence, of course, should be taken seriously.

Many victims do not report cases of SGBV because of the stigma attached. The UNHCR community services have a real challenge with getting refugees to report SGBV incidents, especially rape and domestic abuse. Because when it's not reported, it's neglected like it never happened.

One of the possible ways to tackle this underreporting, is through dialogue with refugee leaders and groups of refugees, explaining the laws and available services and showing that by reporting these issues they can be addressed and things can change. But this is a very long-term work, as we all know.

In addition, UNHCR, with specialist partner agencies, and many NGO's, provide psychological counselling to rape and other SGBV victims. As long as they have enough funding to do that of course.

A few figures to show that this type of work pays off:

- *In 2014, UNHCR was able to make further progress. UNHCR's Operations were able to strengthen engagement of communities in prevention efforts on SGBV as well as identification of children and persons at risk.*
- *UNHCR maintained its high number of output targets that were achieved (two thirds) in SGBV prevention and response in the strategy priority countries, as SGBV core prevention and response services remained the cornerstone of UNHCR's engagement in SGBV.*
- *UNHCR's SGBV reporting and awareness raising led to a doubling of reported incidents in 44 countries between 2012 and 2014.*

- *In 2014, 14,074 incidents of SGBV were reported in 17 out of the 19 strategy priority countries – an increase of more than 100% compared to 2013. The increase of reported incidents does not necessarily demonstrate an increase in SGBV incidents; higher incident reporting is generally recognised to be the result of quality and response services and improved data collection and reporting mechanisms. Progress was also reported towards most of the objectives of the Global Child Protection Framework. UNHCR's operations were able to lift the percentage of impact indicators meeting global standards from 25% to 43%.*
- *Let us not forget that these actions of UNHCR are particularly focused on women coming from Bangladesh, Burkina Faso, Burundi, Chad, Colombia, Ecuador, Egypt, Ethiopia, India, Jordan, Kenya, Lebanon, Malaysia, Niger, Pakistan, Rwanda, Sudan, Uganda and Yemen.*
- *But also from Syria: In the Syrian Arab Republic, SGBV case management for refugees continues to be directly undertaken by UNHCR. Trained staff members are dedicated to assess follow up on the needs of SGBV survivors to ensure adequate access to available services. In addition to referrals, other services provided include monthly financial assistance, urgent cash grants, and community support through trained volunteer's programmes. The operations also support a safe house for women survivors of SGBV that was able to provide services to 37 refugees from different nationalities.*
- *Moreover, the Syrian Arab Republic operation provided approximately 2,500 women with vocational training and awarded a subset of these women with additional income generating grants as part of a self-reliance programme, because women identified access to livelihoods options as key to creating self-reliance and sustainable solutions to improve their lives.*

To sum up, wherever women and girls come from, when they come to Europe, we have to

6. *Protect them of concern against SGBV*
7. *Address survival sex as a coping mechanism in situations of displacement*
8. *Engage men and boys*
9. *Provide safe environment and safe access to domestic energy and natural resources*
10. *Protect particularly vulnerable persons like persons with disabilities and LGBTI persons of concern against SGBV*

These are five priorities, easy to remember, that every member state should keep in mind. It is not a responsibility of first arrival and transit countries (like Bulgaria, Croatia, Greece, Hungary, Italy, Romania, Slovakia, Slovenia) only. It is not a responsibility of traditional destination countries (like Austria, Belgium, Denmark, France, Germany, Malta, Sweden, The Netherlands) or new destination countries (like Portugal, Poland, Spain) only. It is a united responsibility, that goes even beyond the European Union.

These priorities are also addressed in the European Parliament. In November last year, Mary Honeyball from the UK, wrote a report on the situation of women refugees and asylum seekers in the EU. The European Commission agreed with the report, and it should be voted on the 8th of March during the plenary session.

She points out the overpopulation of the detention centres, where violence against refugee women is common; the higher risk there is for refugee girls to be forced to marry, at a very young age, or to have sex to survive. This kind of survival sex has been reported by women and girls, because they argument that it is the only way to pay smugglers that way, to continue their journey to Europe.

In her resolution Honeyball asks for compulsory training, urgent abortion, more money for health care and to forbid detention of pregnant women and women who survived rape and sexual violence. Requests we should support, as our members of the European Parliament, I believe.

Therefore, I would like to remind all of you of the Istanbul Convention, which is a Human Rights convention adopted by the 47 Council of Europe member states, among whom Turkey, Greece, Macedonia and many others. This Istanbul Convention states very clearly that gender-based violence against women may be recognized as a form of persecution and to ensure that the grounds for asylum listed in the 1951 Refugee Convention are interpreted in a gender-sensitive manner. Women and girls should have access to gender-sensitive asylum procedures and support services, as required by the Istanbul Convention. We should adopt relevant texts to provide member States with indications on how to prevent and address discrimination on grounds of sex among asylum seekers in Europe.

This 'Convention on preventing and combating violence against women and domestic violence' of 2011 was the first international convention that explicitly mentioned gender-related persecution. Until now it has only been ratified by 20 states, but there are still 19 countries that have signed it, but not ratified it (Among them are Greece, Macedonia, but also Belgium!).

Even though it is a non-binding treaty, the Istanbul Convention is an important instrument to introduce gender-sensitive procedures, guidelines and support services in the asylum process, as stated in point 3 on this slide. And it can also encourage governments to recognize violence against women as a form of persecution within the meaning of Article 1A of the 1951 Geneva Convention, as stated in point 1 on this slide, for example.

Therefore, I call upon all of you to remind your governments to ratify it, if you haven't done it already.

Finally, I would like to stress one more time the particular attention to the psychological health, stress and traumas of refugee women and girls, that I have mentioned before. The jungle in Calais, the wall in Hungary, the waiting rows at Fedasil here in Brussels, all of these experiences leave important marks in people's minds. We have to make sure that the prioritized funding for health needs of refugee women and girls also contains psychological help.

Thank you.

Annex 2

Umbrella Document (background information)

Annex 3

Country Profiles

Programme co-funded by the EUROPEAN UNION

National coordination of the health care response to refugees, asylum seekers and other migrants: *Working document*

AUSTRIA

READER'S GUIDE:

The SH-CAPAC consortium is conducting a mapping of the European Union Member States' health response to the refugees, asylum seekers and other migrants entering, transiting or staying in their territories.

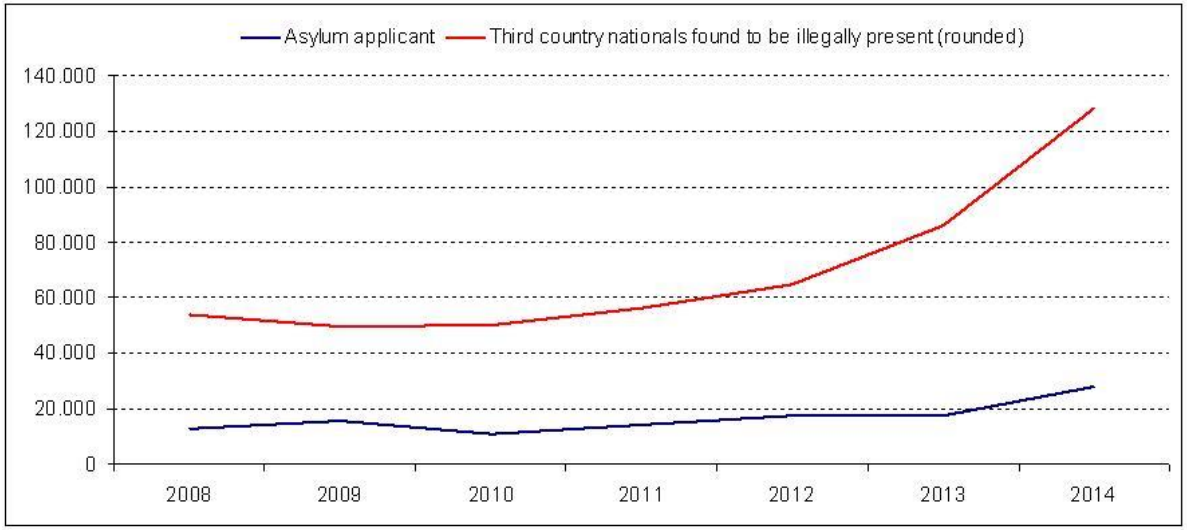
This working document summarizes the latest information on the influx of the different categories (see box 1 on Country Context) and on the coordination of the health care responses (see box 2) in Austria. It also maps the available information on the WHERE-WHAT-WHO of these health care responses (see box 3). This is done for different categories: (1) recent arrivals, (2) people in transit, (3) asylum seekers, (4) refugee status granted persons, (5) undocumented migrants, and where relevant, also for (6) unaccompanied minors. Lastly we would like to map the funding sources for which the Member State's input is appreciated (see box 4 on Funding of health care responses).

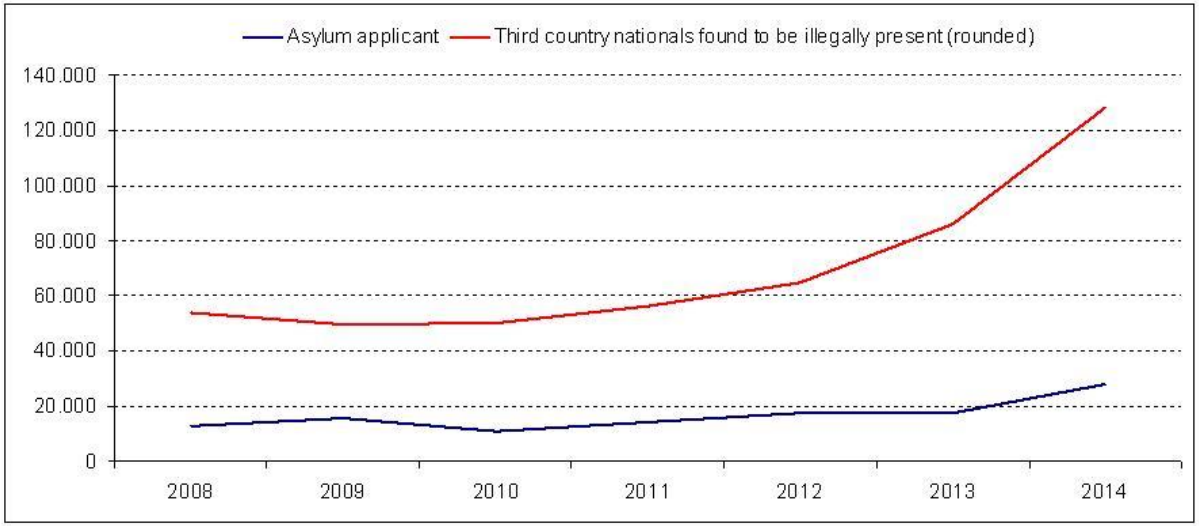
The information already completed below is based on different sources which were consulted online between January 20 and February 8 2016 and which is meant to give a first snapshot. ***We would like to ask you to verify the information, to correct and amend where necessary and to complete where possible.*** *This mapping exercise will help the SH-CAPAC consortium to define a framework for effective health sector coordination for addressing the needs of the refugees, asylum seekers and other migrants in the European Union.* ***Please reply before February 16 2016 to ainhoa.ruiz.easp@juntadeandalucia.es with copy to birgit.kerstens@gmail.com and daniel.lopez.acuna.ext@juntadeandalucia.es.*** *More information on the SH-CAPAC project can be found in the leaflet in attachment and on www.easp.es/sh-capac.*

Sources consulted:

- http://www.unhcr.org/pages/4a02d9346.html
- UNHCR. Refugees/Migrants Emergency Response – Mediterranean
- FRA, European Union Agency for Fundamental Rights. Monthly data collection on the current migration situation in the EU. December 2015 monthly report. 23 November – 31 December 2015. http://fra.europa.eu/sites/default/files/fra_uploads/fra-2016-monthly-compilation-com-update-1_en.pdf

Please provide us with any other sources that you deem appropriate for your country.

1. COUNTRY CONTEXT	
When influx started **(*by year up till 2015, month since 2015*)**	 Eurostat, 2/02/2016.

	 Eurostat, 2/02/2016.
Current number as of Feb 1 ***(AS/ REF/ UDM/ unaccompanied minors)***	A. **Most recent data per category** A total of about 670,000 persons arrived in Austria from 5 September 2015 to 31 December.1 Among them, 153,803 people arrived between 20 November 2015 and 31 December 2015.2 On average, 3,000 to 4,000 persons entered Austria every day.3 A decrease to around 1,000 new arrivals was noted on 23 and 24 December 2015.4 (FRA Monthly review Dec 2015)

Residing in Austria [1]	
Refugees [2]	60,747 Refers to the end of 2014 in the absence of updated data available.
Asylum Seekers [3]	30,900 Refers to the end of 2014 in the absence of updated data available.
Returned Refugees [4]	0
Internally Displaced Persons (IDPs) [5]	0
Returned IDPs [6]	0
Stateless Persons [7]	570
Various [8]	0
Total Population of Concern	92,217
Originating from Austria [1]	
Refugees [2]	9
Asylum Seekers [3]	12
Returned Refugees [4]	0
Internally Displaced Persons (IDPs) [5]	0
Returned IDPs [6]	0
Various [8]	0
Total Population of Concern	21

source: http://www.unhcr.org/cgi-bin/texis/vtx/page?page=49e48e256&submit=GO

B. **Most recent data on total number**:
After re-introduced border controls in EU countries, Austria announced on 20 January 2016 a cap on asylum-seekers and warned that it would take only 37,500 in 2016.

There were hopes that the relocation scheme would result in a more even distribution of asylum seekers across the 28 EU member states. Since the agreements by the European Council in September 2015 to relocate a total of 160,000 asylum seekers from the “front-line” states of Greece and Italy to other EU states over two years, only

414 asylum seekers have been relocated in the past four months.* Austria has recently suspended its participation in the relocation scheme.

*As of 25 January 2016: 14 to Belgium, 140 to Finland, 62 to France, 21 to Germany, 10 to Ireland, 4 to Lithuania, 30 to Luxembourg, 50 to Netherlands, 26 to Portugal, 18 to Spain and 39 to Sweden)

The Austrian Red Cross supports migrants each day at border crossings and major train stations with food, water, non-food items, and **emergency medical services**. The NS also manages transit shelters across the country as well as permanent and temporary facilities. Altogether, some 12,000 Red Cross volunteers and staff have been mobilized since 5 September 2015 (on average 80 staff members and 450 volunteers daily).

source: Information bulletin IFRC Regional Office for Europe Migration response. IFRC. http://www.ifrc.org/docs/Appeals/16/IB6_Migration%20response_Europe_010216.pdf

IOM Austria reports that in 2014, the country received around 28,000 applications for international protection (asylum), a number that was reached this year by the end of June. Kratzmann said projections for this year (2015) are for 80,000 asylum applications. (**Posted:** 08/28/15 IOM-Austria http://www.iom.int/news/iom-latest-austrian-truck-tragedy)

Percentage of F/M/T, age groups and origin

A. **Most recent data per category:**

B. **Most recent data by gender, age group, origin**:

ASYLUM APPLICANT	**2014**
Total	**28.035**
Males	75,8%
Females	24,2%
Less than 18 years	30,2%
18 - 64 years	69,3%
65 years or over	0,5%
Unaccompanied minors (Asylum applicant)	**1.975**
Males	95,2%

Females	4,8%
IRREGULAR MIGRANT	**33.055**
Males	81,4%
Females	18,6%
Less than 18 years	21,4%
18 years or over	78,6%

Source: Eurostat, 02.02.16

The new arrivals still come mainly from Afghanistan, Syria, and Iraq.7 Caritas Styria reported a rising number of people from Pakistan and Northern Africa (Maghreb).8

On average, 250 to 350 asylum applications are filed in Austria every day.10 Persons applying for asylum mainly come from Afghanistan, Syria, Iraq and Iran.11 In November the portion of those requesting asylum in Austria increased considerably with some 20 % of arrivals lodging an asylum claim in Salzburg – in particular, Iraqis, Iranians and Afghans.

(FRA Monthly review Dec 2015)

2. HEALTH CARE RESPONSES			
Please correct or complete the information where possible.			
Health care coordination at national/regional level	A. **Existence of a national coordination mechanism of the health response**: YES/NO B. **Explanation**: *(if yes, please describe how the mechanism works and who participates; if no, please describe why there is no coordination)* The changed constitution, which entered into force on 1 October 2015, has allowed the federal state to set up 3,000 additional reception places without the permission of local mayors.29 The federal government repeatedly made use of the new possibility to establish accommodation facilities in the municipalities (*Durchgriffsrecht*).30 At the end of November, 1,138 of 2,100 Austrian municipalities were housing asylum seekers. This is a considerable increase compared to only 683 municipalities in June.31 Providing shelter to asylum seekers and people in transit continues to be the main challenge in Austria,32 with overstretched reception and accommodation facilities. There are not enough places for asylum seekers.33 More than 4,000 asylum seekers are not taken over by the provinces – which are responsible for the reception of asylum seekers – and they are thus blocking the capacities in the transit quarters.34 About 2,500 of these 4,000 asylum seekers are unaccompanied children.35 (FRA Monthly review dec 2015)		
First entry assistance services			
Response to 'An Agenda for Action' as agreed during the High Level Meeting on Refugee and Migrant Health in Rome in November 2015: *Cross the appropriate 'Yes', 'No' or 'There is no information available' option in the blue boxes. Additional information or sources can be mentioned underneath the box.*			
Integration of the health care services for refugees, asylum seekers end migrants into the existing national health systems	Yes	**x** No	There is no information available
Limit initial screening upon arrival to relevant risk assessment	Yes	No	There is no information available

Non Communicable Diseases included in the provision of services	Yes	No	There is no information available
Active participation and empowerment of the refugees and migrants throughout all stages of health service provision, including design and planning	Yes	No	There is no information available
Training of health professionals involved in the provision of health care	Yes	No	There is no information available

3. WHERE-WHAT-WHO			
Please correct or complete the information where possible.			
Migrant group	**WHERE are they receiving the health care?**	**WHAT type of health care provision are they receiving?**	**WHO is the actor/agency providing the health care?**
(1) Recent arrivals			
(2) People in transit			
(3) Asylum seekers		Asylum seekers receiving basic care (Grundversorgung) also have health insurance and may seek medical advice at any medical doctor or hospital.58 (FRA Monthly Report DEc 2015)	
(4) Refugee status granted			
(5) Undocumented migrants		The Federal State carries out special training on child protection to ensure that due attention is given to the best interests of the child in basic care facilities (Grundversorgung).50 (FRA Monthly Report DEc 2015) Since September 2015, IOM Austria offers legal guardians of UMC in Austria the possibility to conduct a family assessment	

Migrant group	WHERE are they receiving the health care?	WHAT type of health care provision are they receiving?	WHO is the actor/agency providing the health care?
		in the minors' country of origin. IOM can collect current information on the minor's family, their socio-economic situation and living conditions as well as access to education and health care. A family assessment can only be carried out at the request of a legal guardian and the minor and its results remain confidential. In case voluntary return is in the best interest of the child, IOM can ar- 2 range the UMC's return in accordance with IOM standards.	
(6) Unaccompanied minors			

4. FUNDING OF THE HEALTH CARE RESPONSES

Please provide us with any relevant information of funding made available by your country or other partners for health care responses:

- *FUNDING SOURCES: where does the funding come from? e.g. Government, UN agency (UNHCR, IOM, WHO Euro,…), EU, NGO, civil society organisation, faith-based organisation, private organisation, international donor, (public/private) health insurance, other (please specify)*
- *FUNDING MECHANISM: how is the health care delivery being funded? e.g. envelope (for whole year/project), lump sum amount per asylum. seeker/refugee, out-of-pocket expenses, third payer mechanism, emergency/contingency budget.*
- *FUNDING AMOUNT: Give the amount spent on health care responses, in Euros, per year/month; if available also provide the pledged amount.*
- *COMMENTS.*

Migrant group	Funding source	Funding mechanism	Funding amount	Comments
(1) Recent arrivals				
(2) People in transit				
(3) Asylum seekers				
(4) Refugee status granted				
(5) Undocumented migrants				

Programme co-funded by the EUROPEAN UNION

National coordination of the health care response to refugees, asylum seekers and other migrants: *Working document*

BELGIUM

READER'S GUIDE:

The SH-CAPAC consortium is conducting a mapping of the European Union Member States' health response to the refugees, asylum seekers and other migrants entering, transiting or staying in their territories.

This working document summarizes the latest information on the influx of the different categories (see box 1 on Country Context) and on the coordination of the health care responses (see box 2) in Belgium. It also maps the available information on the WHERE-WHAT-WHO of these health care responses (see box 3). This is done for different categories: (1) recent arrivals, (2) people in transit, (3) asylum seekers, (4) refugee status granted persons, (5) undocumented migrants, and where relevant, also for (6) unaccompanied minors. Lastly we would like to map the funding sources for which the Member State's input is appreciated (see box 4 on Funding of health care responses).

The information already completed below is based on different sources which were consulted online between January 20 and February 8 2016 and which is meant to give a first snapshot. ***We would like to ask you to verify the information, to correct and amend where necessary and to complete where possible.*** *This mapping exercise will help the SH-CAPAC consortium to define a framework for effective health sector coordination for addressing the needs of the refugees, asylum seekers and other migrants in the European Union.* ***Please reply before February 16 2016 to ainhoa.ruiz.easp@juntadeandalucia.es with copy to birgit.kerstens@gmail.com and daniel.lopez.acuna.ext@juntadeandalucia.es.*** *More information on the SH-CAPAC project can be found in the leaflet in attachment and on www.easp.es/sh-capac.*

Sources consulted:

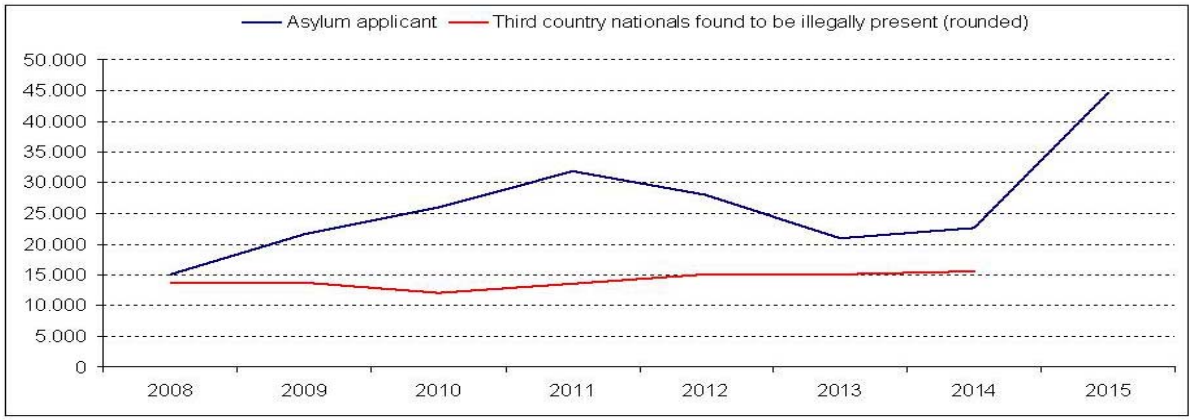
- http://www.unhcr.org/pages/4a02d9346.html
- UNHCR. Refugees/Migrants Emergency Response - Mediterranean
- MdM, Annex 1 (Project proposal 11 ONGS in 8 countries)
- www.fedasil.be
- Roberfroid D., Dauvrin M., Keygnaert I., Desomer A., Kerstens B., Camberlin C., Gysen J., Lorant V., Derluyn I. What health care for undocumented migrants in Belgium?. Health Services Research (HSR) Brussels: Belgian Health Care Knowledge Centre (KCE). 2015. KCE Reports 257. D/2015/10.273/111.
- HUMA. Are undocumented migrants and asylum seekers entitled to access health care in the EU ? A comparative overview in 16 countries. November 2010.

Please provide us with any other sources that you deem appropriate for your country.

1. COUNTRY CONTEXT

When influx started
(by year up till 2015, month since 2015)

Up till beginning of 2015: 2010-2011



Source: Eurostat, 2/2/2016.

Since beginning of 2015: summer 2015
(please complete or correct)

Current number as of Feb 1 ***(AS/ REF/ UDM/ unaccompanied minors)***

A. **Most recent data per category**:

Residing in Belgium	***June 2015***
Refugees	31,115
Asylum Seekers	9,396
Returned Refugees	0
Internally Displaced Persons (IDPs)	0
Returned IDPs	0
Stateless Persons	5,267
Various	0
Total Population of Concern	45,778
Originating from Belgium	
Refugees	76
Asylum Seekers	14

	Returned Refugees: 0 Internally Displaced Persons (IDPs): 0 Returned IDPs: 0 Various: 0 *Total Population of Concern*: 90 Source: http://www.unhcr.org/cgi-bin/texis/vtx/page?page=49e48e2e6&submit=GO B. **Most recent data on total number**: "4,201 asylum applications were registered in Belgium in December 2015, almost the same number as in the previous month (4,199). Among the 1,543 other decisions (decisions on the substance) taken by the CGRS in December, there were 909 decisions to grant refugee status and 186 decisions to grant subsidiary protection. In December 2015, the protection rate therefore amounted to 70.1 % (1,095 positive decisions out of 1,543 decisions on the substance)." (Source: http://www.cgrs.be/en/news/asylum-statistics-december-2015)
Percentage of F/M/T, age groups and origin	A. **Most recent data per category:** **ASYLUM APPLICANT** / **2014** / **2015** **Total** / 22.710 / 44.660 Males / 64,6% / 70,8% Females / 35,4% / 29,2% Less than 18 years / 29,3% / 30,5% 18 - 64 years / 69,7% / 68,8% 65 years or over / 1,0% / 0,7% **Unaccompanied minors (Asylum applicant)** / 475 / 3099* Males / 70,2% / 92,5% Females / 29,8% / 7,5% **IRREGULAR MIGRANT** / 15.540 Males / 85,6% Females / 14,2% Less than 18 years / 4,8% 18 years or over / 94,7%

	Source: Eurostat, 2/02/2016. *This number can still change as not all results of the age determinations were known. B. **Most recent data by gender, age group, origin**: "4,201 asylum applications were registered in Belgium in December 2015, almost the same number as in the previous month (4,199). In December, the main countries of origin of asylum applicants were Afghanistan (1,955 applications, 46.5 %), Syria (718 applications, 17.1 %) and Iraq (335 applications, 8 %). Afghan, Syrian and Iraqi nationals represented 71.2 % of all asylum applicants in Belgium in December 2015. Iran (3.7 %), Russia (2.1 %), Somalia (2.1 %), Guinea (1.9 %), DR Congo (1.7 %), applicants of undetermined nationality (1.6 %) and Albania (1.2 %) complete the top 10 of countries of origin." (Source: http://www.cgrs.be/en/news/asylum-statistics-december-2015)

2. HEALTH CARE RESPONSES	
Please correct or complete the information where possible.	
Health care coordination at national/regional level	A. **Existence of a national coordination mechanism of the health response**: **YES***/NO *(Please complete)* B. **Explanation**: *(if yes, please describe how the mechanism works and who participates; if no, please describe why there is no coordination)* *Yes, partly, Fedasil is responsible for the governmental coordination and for finetuning with NGOs and private partners.
First entry assistance services	"Since August 2015, between 4,000 and 5,500 asylum seekers arrived every month in Belgium, and the federal Belgian government has been unable to register more than 250 new asylum applications per day (and even only 150 new registrations between 27/10/2015 and 02/11/2015). This was due to practical reasons of the building and waiting room.The government always prioritised families, UAM single woman and vulnerable people for registration first . As a result, many single man– up to 1,000 people at one point – had to sleep outside in front of the Foreigners' Office in Brussels, without access to water, food, shelter etc. The government has had to step up its efforts to provide night shelter, especially now that winter is starting. The government started to offer night shelter since the 7th of September 2015 and turned this over into a day centre two weeks after. First offering 500 beds and soon 500 more. This "transit reception facility", operationalized by the Red Cross in Brussels, near the Foreigners' Office, has now a capacity of one thousand threehundred beds. The tent camp has been cleared since the beginning of October, but people waiting to apply for

	asylum still only have access to the transit reception facility, In this transit reception facility basic health care is offered at site. People in need of more care are being forwarded towards health centres in the neighbourhood. For people with a chronical illness contact is sought with the immigration authorities and an asylym application will be conducted the next day. An adjusted centre to the needs of this person will be sought for them by Fedasil. The average length of stay in the transit centre depends on the influx of asylum applicants and outflow in the mainstream reception network, and is currently 5 working days." (MdM, Annex 1)

Response to 'An Agenda for Action' as agreed during the High Level Meeting on Refugee and Migrant Health in Rome in November 2015:
Cross the appropriate 'Yes', 'No' or 'There is no information available' option in the blue boxes. Additional information or sources can be mentioned underneath the box.

Integration of the health care services for refugees, asylum seekers and migrants into the existing national health systems	**YES*** *Yes to large extent	No	There is no information available
Limit initial screening upon arrival to relevant risk assessment	**YES** Yes	No	There is no information available
Non Communicable Diseases included in the provision of services	**YES** Yes	No	There is no information available
Active participation and empowerment of the refugees and migrants throughout all stages of health service provision, including design and planning	Yes	**NO** No	There is no information available
Training of health professionals involved in the provision of health care	**YES*** *Yes but not yet for all pressing health issues related to current asylum influx	No	There is no information available

	3. WHERE-WHAT-WHO		
	Please correct or complete the information where possible.		
Migrant group	**WHERE are they receiving the health care?**	**WHAT type of health care provision are they receiving?**	**WHO is the actor/agency providing the health care?**
(1) Recent arrivals	Pre-registration/transit reception facility Tent camp (cleared since October 2015)	"… people waiting to apply for asylum still only have access to the transit reception facility,." In this transit reception facility basic health care is offered at site. People in need of more care are being forwarded towards health centres. For people with a chronical illness contact with the immigration authorities is sought and a registration will be conducted the next day so that an adjusted centre will be found for them by Fedasil. (MdM, Annex 1) "A centre specialized in mental health as well as a pre-registration ("pré-accueil") centre for those who have not started the procedure for their admission into Belgium". (Source: Information bulletin IFRC Regional Office for Europe Migration response. IFRC. http://www.ifrc.org/docs/Appeals/16/IB6_Migration%20response_Europe_010216.pdf)	Red Cross MdM
(2) People in transit			
(3a) Asylum seekers	'Standard' health care provision	"Once asylum seekers are registered, they are entitled – according to the 2007 law on the reception of asylum seekers and other categories of foreign nationals and stateless people – to health services based on the nomenclature of the National Institute for Health and Disability Insurance (RIZIV-INAMI), with some exceptions. (…) If they do not live in a centre ("no shows"), they must obtain a "payment warranty" ("réquisitoire") before they can receive care and treatment without having to pay. Many healthcare providers are unfamiliar with this complex procedure. Sometimes healthcare providers refuse these patients, fearing that their costs will not be reimbursed." (Source: MdM, Annex 1)	Primary, secondary, tertiary health care providers
(3b) Asylum seekers	92 **collective** centres in total, dd. 2 February 2016 (source: http://fedasil.be/nl/inhoud/alle-opvangcentra; 28 out of 90 are run by Fedasil, others by Rode Kruis Vlaanderen/Croix Rouge Belgique, Caritas International, Samu Social, private sector)	While living in a reception facility, asylum seekers' medical expenses covered by nomenclature (RIZIV/INAMI) + figuring on the +/- list are normally covered by Fedasil (the federal agency for reception of asylum seekers) or one of its reception partners provided that they are proclaimed for within 45 days after the provision for cared at POD integration. (Source: www.fedasil.be)	Fedasil and other reception partners; possibly referrals to health care providers outside of reception facility
(3c) Asylum seekers	Several **'individual'** local reception initiatives organised	While living in an individual reception facility, asylum seekers' medical expenses are normally covered by SPP IS. (Source: Fedasil, Opening van een opvangstructuur	Primary, secondary, tertiary health care

	by municipalities and run by Public Centres for Social welfare and NGOs, e.g. Vluchtelingenwerk Vlaanderen & Ciré	voor asielzoekers).	providers
(4) Refugee status granted	'Standard' health care provision	Entitled to health care as other Belgian residents.	Primary, secondary, tertiary health care providers
(5) Undocumented migrants	'Standard' health care provision (see Royal Decree 12 Dec 1996 on Urgent Medical Aid) - but UM have to fulfil some conditions; discretionary decisions by Public Centres for Social Welfare which enquire if UM is entitled to UMA; sometimes limited free choice of health care provider.	Urgent Medical Aid covers preventive and curative care (but exceptions to the rule). (Source: Roberfroid 2015) "Only a very few number of asylum seekers and undocumented migrants (namely unaccompanied children) can access health care on equal grounds as nationals in regards not only to coverage but also to administrative conditions." (Source: HUMA 2010).	Primary, secondary, tertiary health care providers (Solo health care providers, community health centres, hospitals…)
(6) Unaccompanied minors	Welcome/reception facility for unaccompanied minors (Holsbeek)	See above Asylum seekers - collective reception facilities	Red Cross Belgium

4. FUNDING OF THE HEALTH CARE RESPONSES

Please provide us with any relevant information of funding made available by your country or other partners for health care responses:

- *FUNDING SOURCES: where does the funding come from? e.g. Government, UN agency (UNHCR, IOM, WHO Euro,…), EU, NGO, civil society organisation, faith-based organisation, private organisation, international donor, (public/private) health insurance, other (please specify)*
- *FUNDING MECHANISM: how is the health care delivery being funded? e.g. envelope (for whole year/project), lump sum amount per asylum seeker/refugee, out-of-pocket expenses, third payer mechanism, emergency/contingency budget.*
- *FUNDING AMOUNT: Give the amount spent on health care responses, in Euros, per year/month; if available also provide the pledged amount.*
- *COMMENTS.*

Migrant group	Funding source	Funding mechanism	Funding amount	Comments
(1) Recent arrivals	Belgian government Red Cross			

	MdM			
(2) People in transit				
(3a) Asylum seekers	Belgian government: RIZIV-INAMI	Third payer mechanism (patient pays user fee). Out-of-pocket payments for user fees, some medicines or medical supplies not covered by RIZIV-INAMI and are not figuring on the +/- list of Fedasil		
(3b) Asylum seekers	Belgian government: Fedasil & SPP IS - POD IS (= Federal Public Service of Programmation for Social Integration) for medical expenses	For operational cost of the reception facility: 2 options: (1) reimbursement of actual costs (2) lump sum. Plus: annual financial contribution of € 247,92 per effective shelter. No info on % spent on medical and psychosocial follow-up.		
(3c) Asylum seekers	Belgian government: Fedasil & SPP IS - POD IS (= Federal Public Service of Programmation for Social Integration) for medical expenses	No info on % spent on medical and psychosocial follow-up		
(4) Refugee status granted	Belgian government: RIZIV-INAMI			
(5) Undocumented migrants	Belgian government: SPP IS - POD IS (= Federal Public Service of Programmation for Social Integration)	UM cannot be affiliated to a sickness fund and therefore they are not covered by the legal Belgian health insurance system. In principle cost of health care provided is reimbursed to health care provider. Sometimes out-of-pocket payments for UM (medicines, glasses, protheses,...).		

Programme co-funded by the EUROPEAN UNION

National coordination of the health care response to refugees, asylum seekers and other migrants: *Working document*

BULGARIA

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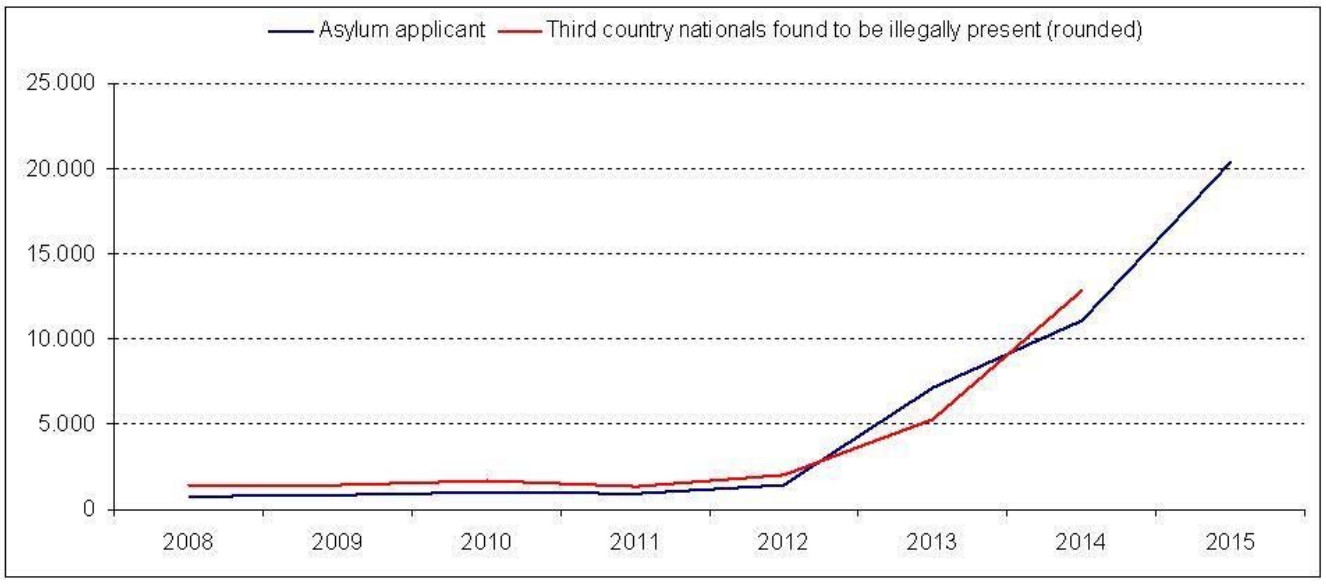
Sources consulted:

- MdM, Médecins du Monde. 8 NGOs for migrants/refugees' health in 11 countries. Project 717307. Annex I (part B), 2016.
- FRA, European Union Agency for Fundamental Rights. Monthly data collection on the current migration situation in the EU. December 2015 monthly report. 23 November – 31 December 2015. http://fra.europa.eu/sites/default/files/fra_uploads/fra-2016-monthly-compilation-com-update-1_en.pdf
- Eurostat, 2/02/2016

- http://www.unhcr.org/cgi-bin/texis/vtx/page?page=49e48db16&submit=GO
- IOM.- Mixed Migration Flows in the Mediterranean and Beyond - 28 January 2016. http://reliefweb.int/sites/reliefweb.int/files/resources/mixed-flows-mediterranean-and-beyond-21-27-january-2016.pdf
- UNHCR_ BULGARIA. http://www.unhcr.org/pages/49e48db16.html

Please provide us with any other sources that you deem appropriate for your country.

1. COUNTRY CONTEXT	
When influx started **(*by year up till 2015, month since 2015*)**	The number of migrants entering Bulgaria is progressively increasing, from 1,025 asylum seekers in 2010 to 12,738 in 2015 (January to September). (…) Authorities have constructed a so-called "offensive barrier" with razor blades (33km), and an additional 130 km long and 4 meters high barrier, planned to be electrified, at the Turkish and Greek border. Moreover, arrests of migrants in Sofia for example with their expulsion to the Republic of Serbia have led to demonstrations, some of which have turned into riots. (MdM, Annex 1)



Eurostat, 2/02/2016

(please complete or correct)

Current number as of Feb 1 ***(AS/ REF/ UDM/ unaccompanied minors)***

A. **Most recent data per category**:

In December, a total of 690 new arrivals were apprehended at the border. (FRA Monthly Review Dec 2015)

Residing in Bulgaria [1]	june 2015
Refugees [2]	11,406 Refers to the end of 2014 in the absence of updated data available.
Asylum Seekers [3]	7,840
Returned Refugees [4]	0
Internally Displaced Persons (IDPs) [5]	0
Returned IDPs [6]	0
Stateless Persons [7]	67
Various [8]	0
Total Population of Concern	18,953
Originating from Bulgaria [1]	
Refugees [2]	1,631
Asylum Seekers [3]	248
Returned Refugees [4]	0
Internally Displaced Persons (IDPs) [5]	0
Returned IDPs [6]	0
Various [8]	1
Total Population of Concern	1,880

source:http://www.unhcr.org/cgi-bin/texis/vtx/page?page=49e48db16&submit=GO

B. **Most recent data on total number**:

	Over the whole year of 2015 Bulgarian authorities apprehended a total of 31,174 migrants and refugees entering, exiting, and within the country. The most prominent nationalities in descending order were Iraqis, Syrians, Afghans, Pakistanis and Iranians (data from January to November 2015). Over the period 01 to 21 January 2016, Bulgarian authorities apprehended 356 irregular migrants and asylum seekers. (IOM.- Mixed Migration Flows in the Mediterranean and Beyond - 28 January 2016)
Percentage of F/M/T, age groups and origin	A. **Most recent data per category:** In December, a total of 690 new arrivals were apprehended at the border. Out of these, 575 persons were apprehended at the green border (189 men, 125 women and 261 children) and 115 persons at border checkpoints (78 men, 12 women and 25 children). The new arrivals were mainly from Iraq, Afghanistan, and Syria, as well as from Pakistan, Somalia, and other countries.70 (FRA Monthly Review Dec 2015). B. **Most recent data by gender, age group, origin**:

ASYLUM APPLICANT	**2014**	**2015**
Total	11.080	20.365
Males	76,9%	79,2%
Females	23,1%	20,9%
Less than 18 years	30,1%	26,9%
18 - 64 years	69,4%	72,7%
65 years or over	0,4%	0,3%
Unaccompanied minors (Asylum applicant)	940	
Males	96,8%	
Females	3,2%	
IRREGULAR MIGRANT	12.870	

Males	84,0%	
Females	16,0%	
Less than 18 years	2,2%	
18 years or over	97,7%	

Source: Eurostat, 2/02/2016.

2. HEALTH CARE RESPONSES	
Please correct or complete the information where possible.	
Health care coordination at national/regional level	A. **Existence of a national coordination mechanism of the health response**: YES/NO *(Please complete)* B. **Explanation**: *(if yes, please describe how the mechanism works and who participates; if no, please describe why there is no coordination)* MdM France has been present in Bulgaria since 2004 (a Roma health mediator programme in Sliven, with a specific focus on sexual and reproductive healthcare), and is recognized on local and national level. MdM has a very good communication with the Ministry of Health, the National Agency for Refugees and other major stakeholders on the topic, even though some links and coordination mechanisms shall need to be strengthened in view of the current crisis (MdM, Annex 1) One of the main currently observed difficulties in Bulgaria is migrants' lack of information concerning where and how to access healthcare. Currently, information is only given inside detention centres. The UNHCR and the Bulgarian State Agency for Refugees (SAR) insist20 on the necessity to improve the information provided: it should be made more accessible and provided in a language understandable for asylum seekers. The Ministry of Health provides basic and specialized healthcare, but does not seem to be able to manage the situation alone, especially outside detention centres, like in the border zones. (UNHCR Observations on the Current Situation of Asylum in Bulgaria, 2014, in MdM, Annex 1)
First entry assistance services	The low occupancy rates at the reception centres of the State Agency for Refugees (SAR) resulted in better living conditions. As of 7 January 2015, the two reception centres based in Sofia (Ovcha Kupel and Voenna Rampa) host a total of 97 persons. The reception centre in Vrazhdebna is still closed as persons to be relocated from Greece and Italy are to be accommodated there. However, no persons were relocated in December 2015.79 The State Agency for Refugees announced that some 80 persons will be relocated by mid-January 2016, but NGOs expressed doubts that people would be willing to do so. The living conditions at the seventh floor of the Ovcha Kupel centre are poor. This is the floor hosting predominantly single men from Afghanistan. They deliberately damaged the building. Volunteers and social workers assumed that stress and frustration were the reasons for such destructive behaviour, although, apparently, relatives in Germany had advised them that if they did damages and filmed these with their mobile

phones, this would prove the bad conditions in Bulgaria and the German authorities would not apply the Dublin Regulation to them.81
The reception centre in Harmanli is being repaired. The works do not affect the living conditions of those accommodated there due to the low occupancy rate.82
Although the inflow of newcomers has decreased in December, the food supply to all centres is delivered according to the forecasted daily inflow of 5,000 persons, possibly leading to waste of food due to poor planning.83
The living conditions in the closed centres managed by the Ministry of the Interior are evaluated as good taking into account the conditions at the receptions centres hosting asylum seekers.84
(FRA Monthly Review Dec 2015)

Migrants accommodated in the open reception centers under SAR (SAR provided data)		Banya	Pastrogor	Ovcha kupel (Sofia)	Vrazhdebna (Sofia)	Voenna rampa (Sofia)	Harmanli	Total
Capacity		70	320	860	370	800	2710	5130
Accommodated migrants	Total	59	120	213	0	135	190	717
	% of used capacity	84%	38%	25%	0%	17%	7%	14%
	Syrian Nationals	31	105	3	0	39	106	284
Accommodated migrants with granted refugee status		0	32	4	0	20	2	58

(IOM.- Mixed Migration Flows in the Mediterranean and Beyond - 28 January 2016)

Response to 'An Agenda for Action' as agreed during the High Level Meeting on Refugee and Migrant Health in Rome in November 2015: *Cross the appropriate 'Yes', 'No' or 'There is no information available' option in the blue boxes. Additional information or sources can be mentioned underneath the box.*			
Integration of the health care services for refugees, asylum seekers end migrants into the existing national health systems	Yes	x No	There is no information available
Limit initial screening upon arrival to relevant risk assessment	Yes	No	There is no information available
Non Communicable Diseases included in the provision of services	Yes	No	There is no information available
Active participation and empowerment of the refugees and migrants throughout all stages of health service provision, including design and planning	Yes	No	There is no information available
Training of health professionals involved in the provision of health care	Yes	No	There is no information available

3. WHERE-WHAT-WHO			
Please correct or complete the information where possible.			
Migrant group	**WHERE are they receiving the health care?**	**WHAT type of health care provision are they receiving?**	**WHO is the actor/agency providing the health care?**
(1) Recent arrivals	The Ministry of Health provides basic and specialized healthcare,		

	but does not seem to be able to manage the situation alone, especially outside detention centres, like in the border zones. (UNHCR Observations on the Current Situation of Asylum in Bulgaria, 2014, in MdM, Annex 1)		
(2) People in transit			
(3) Asylum seekers			
(4) Refugee status granted			
(5) Undocumented migrants	Project "Improving the Quality of Unaccompanied Minor Asylum Seekers' (UAMAS) Guardianship in Central Europe countries" (IOM)		
(6) Unaccompanied minors			

4. FUNDING OF THE HEALTH CARE RESPONSES

Please provide us with any relevant information of funding made available by your country or other partners for health care responses:

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- *FUNDING AMOUNT: Give the amount spent on health care responses, in Euros, per year/month; if available also provide the pledged amount.*
- *COMMENTS.*

Migrant group	Funding source	Funding mechanism	Funding amount	Comments
(1) Recent arrivals				
(2) People in transit				
(3) Asylum seekers				

(4) Refugee status granted				
(5) Undocumented migrants				

National coordination of the health care response to refugees, asylum seekers and other migrants: *Working document*
CROATIA

Programme co-funded by the EUROPEAN UNION

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The information already completed below is based on different sources which were consulted online between January 20 and February 8 2016 and which is meant to give a first snapshot. ***We would like to ask you to verify the information, to correct and amend where necessary and to complete where possible.*** *This mapping exercise will help the SH-CAPAC consortium to define a framework for effective health sector coordination for addressing the needs of the refugees, asylum seekers and other migrants in the European Union.* ***Please reply before February 16 2016 to ainhoa.ruiz.easp@juntadeandalucia.es with copy to birgit.kerstens@gmail.com and daniel.lopez.acuna.ext@juntadeandalucia.es.*** *More information on the SH-CAPAC project can be found in the leaflet in attachment and on www.easp.es/sh-capac.*

Sources consulted:

- UNHCR. 2015 UNHCR subregional operations profile - South-Eastern Europe http://www.unhcr.org/cgi-bin/texis/vtx/page?page=49e48d7d6&submit=GO
- UNHCR. Regional Refugee and Migrant Response Plan. Eastern Mediterranean and Western Balkans Route. 2016.

- MdM, Médecins du Monde. 8 NGOs for migrants/refugees' health in 11 countries. Project 717307. Annex I (part B), 2016.
- FRA, European Union Agency for Fundamental Rights. Monthly data collection on the current migration situation in the EU. December 2015 monthly report. 23 November – 31 December 2015. http://fra.europa.eu/sites/default/files/fra_uploads/fra-2016-monthly-compilation-com-update-1_en.pdf

- *Ministry of Health (Croatia) – Crisis HQ official statistical data registry*
- *Ministry of Interior (Croatia) – National coordination center statistics*

1. COUNTRY CONTEXT

When influx started
(*by year up till 2015, month since 2015*)

Up till beginning of 2015: -
Since beginning of 2015: most recent influx in September 2015 *(as of Sep 16 2015)*
(please complete or correct)

Current number as of Feb 1 ***(AS/ REF/ UDM/ unaccompanied minors)***

A. **Most recent data per category**:

Residing in Croatia	***June 2015***
Refugees	710
Asylum Seekers	90
Returned Refugees	24
Internally Displaced Persons (IDPs)	0
Returned IDPs	0
Stateless Persons	2,886
Various	13,774
Total Population of Concern	*17,484*
Originating from Croatia	
Refugees	33,669 UNHCR has recommended on 4 April 2014 to start the process of cessation of refugee status for refugees from Croatia displaced during the 1991-95 conflict. The Office suggests that cessation enters into effect latest by the end of 2017.

	Asylum Seekers: 460 Returned Refugees: 24 Internally Displaced Persons (IDPs): 0 Returned IDPs: 0 Various: 13,774 *Total Population of Concern*: *47,927* Source: http://www.unhcr.org/cgi-bin/texis/vtx/page?page=49e48d7d6&submit=GOhttp://www.unhcr.org/cgi-bin/texis/vtx/page?page=49e48d7d6&submit=GO http://www.unhcr.org/cgi-bin/texis/vtx/page?page=49e48d7d6&submit=GO B. **Most recent data on total number**: The total number of migrants and asylum seekers that have been registered **since the start of the crisis on 16 September** now totals 650.833, while since the start of 2016 a further 95.072 migrants and asylum seekers have entered the country. (Source: IOM. Flow Monitoring Compilation | 28 January 2016). (Source: Ministry of interior, Republic of Croatia, 15 February 2016.) *the numbers are subject to daily change and increase
Percentage of F/M/T, age groups and origin	A. **Most recent data per category:** **ASYLUM APPLICANT** — **2014** Total: 450 Males: 93,3% Females: 6,7% Less than 18 years: 3,3% 18 - 64 years: 96,7% 65 years or over: 0,0% Unaccompanied minors (Asylum applicant): 10 Males: 100,0% Females: 0,0% **IRREGULAR MIGRANT**: 2.500 Males: 90,4% Females: 9,6% Less than 18 years: 9,4% 18 years or over: 90,6% Source: Eurostat, 2/02/2016.

	B. **Most recent data by gender, age group, origin**: Between 16 September and 31 December 2015, more than 555,000 people had entered Croatia. To date, more than 651,000 people entered the country. A great majority of new arrivals came from Syria, some from Afghanistan and Iran. Between 26 and 31 December 2015, it was noted that the share of elderly men, women and children increased compared to November 2015, when a great majority of arrivals were men between the ages of 18 and 30. (FRA Monthly Review Dec 2015). We have also noticed that since the start of the influx, when the majority of refugees/migrants were men in good health, from November 2015 there has been an increase of people with chronic disease and poor health conditions that were in need of more demanding health care rather than just bruises and muscle pain from traveling and walking.

2. HEALTH CARE RESPONSES	
Please correct or complete the information where possible.	
Health care coordination at national/regional level	A. **Existence of a national coordination mechanism of the health response**: YES *(Please complete)* B. **Explanation**: *(if yes, please describe how the mechanism works and who participates; if no, please describe why there is no coordination)* National coordination, not specifically for health: "The Government of Croatia is responsible for the protection of refugees. The Government is committed to providing safe transit of refugees and migrants, as well as to providing access to the refugee status determination (RSD) procedure to those that express the intention to apply for asylum in Croatia. The Croatian Red Cross Society (CRC) is mandated by the Government of Croatia to coordinate the humanitarian response and assistance by NGOs provided to the refugees and migrants. After the arrival of more than 11,000 people on 17 September alone, the Government established headquarters for the coordination of activities concerning the arrival of refugees and migrants, which task is to ensure a coordinated action by all competent authorities and institutions. It is chaired by the Deputy Prime Minister and the Minister of the Interior, and is empowered to take any related executive decision without further approval or confirmation of the Government. On 20 September, the Government opened a temporary reception centre for migrants in Opatovac where refugees and migrants were registered and accommodated during their transit through Croatia. The center in Opatovac was shut down od November 3rd due to the logistical conditions for the winter reception of people and the ground terrain of the camp equipped with tents and other equipment that was not best suited for bad weather conditions and the transport logistics for the reception and further transport. A better solution was found in the once big industrial and transport center in Slavonski Brod which had concrete and brick built warehouses for all the supplies, enough ground terrain for the establishment of different sectors of the camp (NGO, special facilities for nursing women, field hospital, etc.) With the opening of the WRTC in Slavonski Brod on 3 November, which can accommodate 5,000 people, the Government established an organized system to provide care for refugees and migrants in transit. To minimize exposure to the cold, transport of refugees and migrants is organized free-of-charge by trains and/or buses from Sid in Serbia to the Slavonski Brod transit centre. In the WRTC, refugees and migrants are being registered and subsequently have access to services, such as restoring family links, health protection and emergency treatment; protection of and care for the UASC before they are led to different sectors to wait for boarding the train which will bring them directly to Slovenia. At the WRTC, safety and security, warehousing capacities, as well as regular centre maintenance are provided." (Source: Regional Refugee and Migrant Response Plan, UNHCR, 2016). At the health authorities level, a permanent Crisis headquarters within the Ministry of health is appointed by the minister and it consists of all the high level stakeholders involved within their respective field of work. The HQ convenes regularly and discusses and makes decisions that are implemented in the "field". Daily reports and statistical data are available to the HQ by the statistical ad-hoc department that was established before day 1 with the sole task to be the hub for information

	between the health authorities at the Ministry and the operational level in the field. Daily reports for the HQ are being compiled from the obligatory reports that are received from the health care facilities in charge at any given time. A high level state official from the Ministry and also a member of the Health Crisis HQ is also a member of the Governmental lead HQ that can disperse and deliver the national decisions that are being made from the Governmental level to the Ministry and vice-versa. The Minister of health presides to the Crisis HQ and is in charge of mobilization of medical personell from various part of the country and different medical facilities to rotate the medical teams in the TWC Slavonski Brod, and Opatovac before the closure with. Legal foundations for this mobilization can be found in the Croatian Health protection law that states in one of it's articles that in cases of extraordinary circumstances, disasters and epidemics the Minister is authorized to take all necessary action and activities that include mobilization, organization and distribution of work of medical personell and facilities while the circumstances last. The Croatian Public Health Institute is responsible and in charge of all public health related issues that include the sanitation and epidemiology work. Daily inspections of all sanitation related medical services, including water and food preparing inspections or the communicable disease inspections are on-line and also daily obligatory reports are coming in from the duty officer of the Public Health Institute on the field. No grouping of communicable diseases has been noticed. We have had sporadic cases of varricela and scabies but all have been treated immediately and the infection spread cut. A "situation room" has been established in the Ministry of Health that is operational 24/7 and acts as a hub for all medical care facilities involved and is also the main statistical focal point for Croatian health system. Several lines of communication have been put to work including telephones, e-mail and TETRA have been employed for the situation. Special e-mail addresses have been created for communication with the public, interested individuals and companies that offer assistance or donations in equipment or medicaments or simply wish to participate as medical volunteers. "The Croatian Red Cross is working with the support of a DREF (Disaster Relief Emergency Fund) operation plus substantial support from corporates, public funding and other institutions. The Croatian RC will scale up its response and an Emergency Appeal based on the reassessment of the main emergency needs will be published next week. This Emergency Appeal seeks 2.6 million CHF to respond to the needs of some 175,000 people over the period of six months. The operation will focus on the distribution of food and non-food items (NFIs); protection activities including, screening, referral and psychosocial support, restoring family links (RFL); distribution of hygiene items and National Society capacity building. The operation activities are concentrated at the Slavonski Brod Transit Winter Camp which is the entry point in Croatia where the migrants are received, registered and sheltered" (source: Information bulletin IFRC Regional Office for Europe Migration response. IFRC. http://www.ifrc.org/docs/Appeals/16/IB6_Migration%20response_Europe_010216.pdf).
First entry assistance services	The MdM BE assessment team that visited the region in early October 2015 observed operational services catering for 4,500 people crossing the border daily (Sid/Bapska). However, on 21th October 2015, the temporary closure of the border between Serbia and Croatia led to more than 6,000 people a day arriving and having to wait in open fields for about 24 hours. Health service provision was insufficient and crowd control became difficult (MdM, Annex 1). After the protocol that was signed between the Ministries of Interior from Serbia, Croatia and Slovenia, a direct train link was established between Sid (Serbia) to TWC Slavonski Brod and from there to Slovenia.

	During the reporting period, refugees were transported by trains from the Serbian side of the border (Šid) directly to Slavonski Brod. Between 23 November and 6 December, the camp train station was out of order due to construction works, so refugees were brought to the nearest train station in Garčin and then transported to the camp by buses. Direct railway access to the camp was re-established on 6 December. The transport from the Slavonski Brod camp to the Slovenian border (Dobova) was carried out directly by trains. [Detailed description available, p. 22] (FRA Monthly Review Dec 2015). The TWC Slavonski Brod has it's own rail entry point and inside the camp there is a train "station" to which the train arrives and disembarks the migrants/refugees for their further registration and assistance. A maximum of 10 train wagons + locomotive is able to enter the camp and dock at the "station" due to space limitations of the facility. At first, a total of approximately 1000-1200 people were aboard every train that was arriving at the camp, but due to the Austrian and Slovenian limitations that were announced sometime during December, each train was allowed to carry approximately no more that 900 people at the time for entry into Slovenia.

Response to 'An Agenda for Action' as agreed during the High Level Meeting on Refugee and Migrant Health in Rome in November 2015:
Cross the appropriate 'Yes', 'No' or 'There is no information available' option in the blue boxes. Additional information or sources can be mentioned underneath the box.

Integration of the health care services for refugees, asylum seekers end migrants into the existing national health systems	**Yes** Yes within national legislation regarding asylum seekers and people under special subsidiary protection status	No	There is no information available
Limit initial screening upon arrival to relevant risk assessment	**Yes** Yes a non-discriminatory and non-stigmatizing risk assessment screening and treatment is carried out	No	There is no information available
Non Communicable Diseases included in the provision of services	**Yes (but with limitations)** In the organization and the coordination of the "health care response" to the crisis, Croatia is offering hospital treatment to non-communicable and	No	There is no information available

	chronic diseases to the migrants/refugees and is providing it for example to dialysis patients or children almost daily, but we strongly notice the fact of refusal of health actions because of the need to continue the journey without "being held" in Croatia		
Active participation and empowerment of the refugees and migrants throughout all stages of health service provision, including design and planning	Yes	No	**Not applicable because of the short period of time that the migrants/refugees are staying in Croatia, but taking account of all the specific needs during their stay**
Training of health professionals involved in the provision of health care	Yes	No	**Not applicable because of the short period of time that the migrants/refugees are staying in Croatia, but taking account of all the specific needs during their stay**

3. WHERE-WHAT-WHO
Please correct or complete the information where possible.

Migrant group	WHERE are they receiving the health care?	WHAT type of health care provision are they receiving?	WHO is the actor/agency providing the health care?
(1) Recent arrivals	Slavonski Brod Transit Winter Camp	"The transit center has nine heated containers for babies and children who require special attention." (Regional Refugee and Migrant Response Plan, UNHCR, 2016) "Persons in need of medical assistance were screened for in the registration area and taken to medical containers by the Croatian Red Cross. From 22 November 2015 to 31 December 2015, there were 88 emergency medical interventions, 2017 general practice interventions, 92 hospitalisations and 372 camp infirmary interventions. (The numbers shown have been made available by the MoH Croatia to the Croatia n NGO "Center for peace studies" upon their request in Jan 2016.) In total, since day 1, Sep 16th 2015 6:00 AM, to date (FEB 15th 11:00 AM) there has been **4429** emergency medical interventions, **17877** general practice interventions, 676 hospitalizations and **1167** camp infirmary interventions. The numbers are compiled based on obligatory daily reports that are sent to the Ministry of health and are processed by the statistical team and are	~~The Croatian Red Cross~~ Medical services are organised and provided by the national health system supported by CRC and Magna and other NGO's available for medical care. The whole of the Croatian health system has been employed to meet the challenges of the influx in close collaboration with other state ministries and agencies such as Ministry of Health, Interior, National Rescue and Protection Directorate, Military etc. It is a joint effort of the mentioned to meet the needs of the operation and medical facilities and personell throught the country have been participating in the response. UNICEF, Save the Children and Magna are providing care for children and babies. The health care system is in special state of alert regarding the needs of children and babies, with all necessary supportive roles of children clinics and hospitals and their specific needs. "Currently, twenty-one organizations and NGOs are working in the WTRC. (UN

		official. All acitivities that produced these numbers were made by the Croatian medical system and not by NGO's so it put a lot of strain to the system and we underline the active 24/7 participation and the lead role of the Croatian official medical services in the provision of medical assistance to the affected migrant/refugee population. In total, **24.149** medical services have been made during the crisis to date, which leads to the conclusion that around **3.7 %** of the total number of people in transit through Croatia were seeking and were provided with some kind of medical assistance by the health care system in Croatia. Explanations of the numbers are available per request during the workshop in Ghent and are official statistical data of the Croatian MoH for the influx crisis. NGOs have not had access to the facilities, but the hasty transition raises doubts about the quality of such screening and medical attendance. In close collaboration with NGO's and all other respective governmental bodies involved in the crisis response, including the National Rescue and Rrotection Directorate and the Ministry of Interior, all medical attendance and acitivites were provided by professional and licenced medical doctors, nurses, technitians, EMT personell at the highest level available as would be made to Croatian citizens. The NGO MAGNA continued to provide	agencies, IOs and civil society organizations are allocated winterized containers as office space that enables their permanent presence in the centre and thus, allowing appropriate and timely responses to the protection and humanitarian needs of the people of concern." (Regional Refugee and Migrant Response Plan, UNHCR, 2016)

		specialised medical healthcare for babies and children. On occasions when people were placed in the sectors waiting for the train, people in need of medical attention would only be able to reach a doctor through NGO volunteers who would escort them to the clinic." (FRA Monthly Review Dec 2015). The TWC Slavonski Brod is organized in several sectors in which in every sector there is a medical container or tent as a forward medical outpost of the camp's infirmary clinic. All together, 4 medical centers (3 outposts and 1 infirmary clinic) is available at the TWC at all times 24/7 with medical personell. Due to the overwhelming situations of the influx and the strategically distributed outposts and the infirmary, the national health response has been adequate and in close collaboration with all respective NGO's that provide logistics with escort of assistance seeking migrants/refugees to the medical facilities throught the TWC. IOM interpreters are available upon request to support the migrants and refugees. The interpreters also assist during medical interventions at the centre's infirmary and/or local hospitals. Due to the high demand for this service, IOM will hire additional translators who will also help to increase the translation capacities of the Ministry of the Interior during the registration process.	
(2) People in transit		See above	

(3) Asylum seekers		All asylum seekers (very low numbers – around 25) are being accommodated in pre-established all commodities asylum seeker centers in Croatia and are given all appropriate health care benefits just as Croatian citizens. The fact has been pre-regulated in the Croatian Law of asylum that has been equalised with respective laws of other EU member states during the period of Croatia's negotiation into entry to the EU.	
(4) Refugee status granted		See above	
(5) Undocumented migrants		See "recent arrivals" but since Jan 2016 undocumented migrants are not present due to the new regulations and policies throught the route (FYROM, SRB, CRO, SLO, AUT)	
(6) Unaccompanied minors		All medical services are available	

4. FUNDING OF THE HEALTH CARE RESPONSES

Please provide us with any relevant information of funding made available by your country or other partners for health care responses:

- *FUNDING SOURCES: where does the funding come from? e.g. Government, UN agency (UNHCR, IOM, WHO Euro,…), EU, NGO, civil society organisation, faith-based organisation, private organisation, international donor, (public/private) health insurance, other (please specify)*

  Medical funding is primarily based on the Croatian budget and the budget reserves from which the cost of providing medical assistance (medications, expendables, work force pay, overtime pay, transit of personell cost…etc). A part of the overall cost has been covered by the EU mechanisms for which Croatia has applied through the Ministry of Interior. NGO's and the UN agencies funding is also present for their respective activities within their scope of work and usual line of resources.

- *FUNDING MECHANISM: how is the health care delivery being funded? e.g. envelope (for whole year/project), lump sum amount per asylum seeker/refugee, out-of-pocket expenses, third payer mechanism, emergency/contingency budget.*

  Average monthly cost of medical services that include all of the above mentioned parts are around 237.000 Euro (236.842 to be more exact) , which totals to around 1.185,000 Euro for the period of 5 months since Day 1. Since there has been around 24.149 medical services provided to date, we can say that each has cost 49 euro in average, but the number is very hard to get hold of because some of the medical services involved full-scale hospital treatment and some have covered only sore feet

and bruises so the cost is not the same for the mentioned, but in average, it is around 49 euros per medical assistance. The National Crisis HQ and the Health Crisis HQ have agreed upon the mechanism of funding that would flow through the medical facilities responsible on the field to note and provide full-scale receipts for their services and to send them to the authorized personell of the Ministry of Health for revision and authorization before further reimbursement. After the process of revising and authorizing the receipts, they are passed to the Ministry of Finance – Treasury department for payment and reimbursement of expences back to the respective medical facilities that provided medical assistance on the field.

- *FUNDING AMOUNT: Give the amount spent on health care responses, in Euros, per year/month; if available also provide the pledged amount.*
  237.000 euro per month in average since Sep 16th 2015.
- *COMMENTS.*

Migrant group	Funding source	Funding mechanism	Funding amount	Comments
(1) Recent arrivals				
(2) People in transit				
(3) Asylum seekers				
(4) Refugee status granted				
(5) Undocumented migrants				

Programme co-funded by the EUROPEAN UNION

National coordination of the health care response to refugees, asylum seekers and other migrants: *Working document*

DENMARK

READER'S GUIDE:

The SH-CAPAC consortium is conducting a mapping of the European Union Member States' health response to the refugees, asylum seekers and other migrants entering, transiting or staying in their territories.

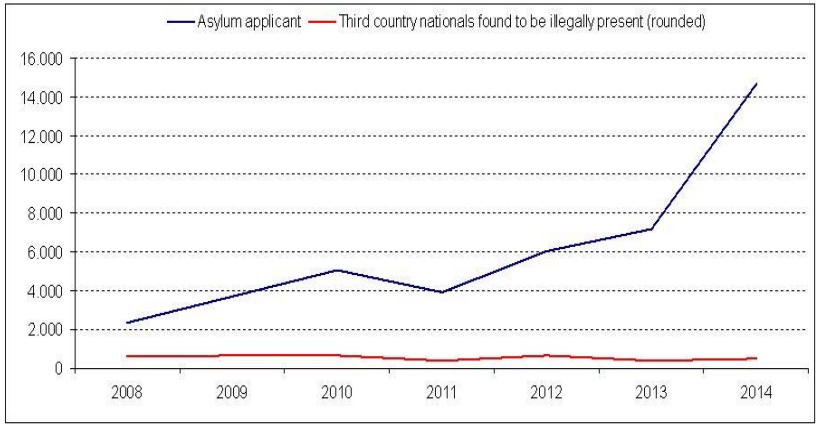
This working document summarizes the latest information on the influx of the different categories (see box 1 on Country Context) and on the coordination of the health care responses (see box 2) in Denmark. It also maps the available information on the WHERE-WHAT-WHO of these health care responses (see box 3). This is done for different categories: (1) recent arrivals, (2) people in transit, (3) asylum seekers, (4) refugee status granted persons, (5) undocumented migrants, and where relevant, also for (6) unaccompanied minors. Lastly we would like to map the funding sources for which the Member State's input is appreciated (see box 4 on Funding of health care responses).

The information already completed below is based on different sources which were consulted online between January 20 and February 8 2016 and which is meant to give a first snapshot. ***We would like to ask you to verify the information, to correct and amend where necessary and to complete where possible.*** *This mapping exercise will help the SH-CAPAC consortium to define a framework for effective health sector coordination for addressing the needs of the refugees, asylum seekers and other migrants in the European Union.* ***Please reply before February 16 2016 to ainhoa.ruiz.easp@juntadeandalucia.es with copy to birgit.kerstens@gmail.com and daniel.lopez.acuna.ext@juntadeandalucia.es.*** *More information on the SH-CAPAC project can be found in the leaflet in attachment and on www.easp.es/sh-capac.*

Sources consulted:

- UNHCR. http://www.unhcr.org/pages/4a02d9346.html
- UNHCR. Refugees/Migrants Emergency Response - Mediterranean
- Information bulletin IFRC Regional Office for Europe Migration response. IFRC. http://www.ifrc.org/docs/Appeals/16/IB6_Migration%20response_Europe_010216.pdf
- Eurostat

Please provide us with any other sources that you deem appropriate for your country.

1. COUNTRY CONTEXT	
When influx started (***by year up till 2015, month since 2015***)	 Eurostat, 2/02/2016 *(please complete or correct)*
Current number as of Feb 1 ***(AS/ REF/ UDM/ unaccompanied minors)***	A. **Most recent data per category**:

Residing in Denmark [1]	As at june 2015
Refugees [2]	17,785 Refers to the end of 2014 in the absence of updated data available.
Asylum Seekers [3]	4,566
Returned Refugees [4]	0
Internally Displaced Persons (IDPs) [5]	0
Returned IDPs [6]	0
Stateless Persons [7]	4,984
Various [8]	0
Total Population of Concern	27,335
Originating from Denmark [1]	
Refugees [2]	11
Asylum Seekers [3]	7
Returned Refugees [4]	0
Internally Displaced Persons (IDPs) [5]	0
Returned IDPs [6]	0
Various [8]	0
Total Population of Concern	18

source:http://www.unhcr.org/cgi-bin/texis/vtx/page?page=49e48e376&submit=GO

B. **Most recent data on total number**:

Percentage of F/M/T, age groups and origin

A. **Most recent data per category:**

ASYLUM APPLICANT	2014
Total	14.680

Source: Eurostat, 2/02/2016.

B. **Most recent data by gender, age group, origin**:

ASYLUM APPLICANT	2014
Total	14.680
Males	75,6%
Females	24,4%
Less than 18 years	20,6%
18 - 64 years	78,7%
65 years or over	0,6%
Unaccompanied minors (Asylum applicant)	815
Males	88,3%
Females	11,7%
IRREGULAR MIGRANT	515
Males	75,7%
Females	24,3%
Less than 18 years	3,9%
18 years or over	97,1%

Source: Eurostat, 2/02/2016.

2. HEALTH CARE RESPONSES			
Please correct or complete the information where possible.			
Health care coordination at national/regional level	A. **Existence of a national coordination mechanism of the health response**: YES/NO *(Please complete)* B. **Explanation**: *(if yes, please describe how the mechanism works and who participates; if no, please describe why there is no coordination)*		
First entry assistance services	The **Danish Red Cross** manages accommodation centres and first reception centres for new arrivals. Services include accommodation, clothes and hygiene parcels, medical and psychological screenings, health care and psychosocial support, RFL, childcare, vocational training, and various volunteer-based activities. In cooperation with the Danish Refugee Council and the Danish Medical Association, the Red Cross is also operating a health clinic for migrants which is run by volunteer doctors and nurses. Approximately 900 staff and 3,000 volunteers provide support to asylum seekers, refugees and migrants. source: Information bulletin IFRC Regional Office for Europe Migration response. IFRC. http://www.ifrc.org/docs/Appeals/16/IB6_Migration%20response_Europe_010216.pdf		
Response to 'An Agenda for Action' as agreed during the High Level Meeting on Refugee and Migrant Health in Rome in November 2015: *Cross the appropriate 'Yes', 'No' or 'There is no information available' option in the blue boxes. Additional information or sources can be mentioned underneath the box.*			
Integration of the health care services for refugees, asylum seekers end migrants into the existing national health systems		x	
	Yes	No	There is no information available
Limit initial screening upon arrival to relevant risk assessment			
	Yes	No	There is no information available
Non Communicable Diseases included in the provision of services			
	Yes	No	There is no information available

Active participation and empowerment of the refugees and migrants throughout all stages of health service provision, including design and planning	Yes	No	There is no information available
Training of health professionals involved in the provision of health care	Yes	No	There is no information available

3. WHERE-WHAT-WHO			
Please correct or complete the information where possible.			
Migrant group	**WHERE are they receiving the health care?**	**WHAT type of health care provision are they receiving?**	**WHO is the actor/agency providing the health care?**
(1) Recent arrivals	The Danish Red Cross manages accommodation centres and first reception centres for new arrivals.	Services include accommodation, clothes and hygiene parcels, medical and psychological screenings, health care and psychosocial support, RFL, childcare, vocational training, and various volunteer-based activities. In cooperation with the Danish Refugee Council and the Danish Medical Association, the Red Cross is also operating a health clinic for migrants which is run by volunteer doctors and nurses. Approximately 900 staff and 3,000 volunteers provide support to asylum seekers, refugees and migrants. RC does not officially provide health care (besides acute first aid) until someone seeks asylum … i.e. people not seeking asylum (because they cannot or do not want to) are not entitled to these services and cares. Volunteers (including RC volunteers) provide some of the services.	The Danish Red Cross Danish Refugee Council The Danish Medical Association, The Red Cross is also operating a health clinic for migrants which is run by volunteer doctors and nurses.
(2) People in transit			
(3) Asylum seekers			

Migrant group	WHERE are they receiving the health care?	WHAT type of health care provision are they receiving?	WHO is the actor/agency providing the health care?
(4) Refugee status granted		When refugee status is granted, they are relocated to a municipality – here the municipality is obliged to offer a 'health exam/health check' that is more extensive than the one offered in the asylum centres. It is voluntary for the refugee to accept the offer of a health exam	
(5) Undocumented migrants			
(6) Unaccompanied minors			

4. FUNDING OF THE HEALTH CARE RESPONSES

Please provide us with any relevant information of funding made available by your country or other partners for health care responses:

- *FUNDING SOURCES: where does the funding come from? e.g. Government, UN agency (UNHCR, IOM, WHO Euro,…), EU, NGO, civil society organisation, faith-based organisation, private organisation, international donor, (public/private) health insurance, other (please specify)*
- *FUNDING MECHANISM: how is the health care delivery being funded? e.g. envelope (for whole year/project), lump sum amount per asylum. seeker/refugee, out-of-pocket expenses, third payer mechanism, emergency/contingency budget.*
- *FUNDING AMOUNT: Give the amount spent on health care responses, in Euros, per year/month; if available also provide the pledged amount.*
- *COMMENTS.*

Migrant group	Funding source	Funding mechanism	Funding amount	Comments
(1) Recent arrivals				
(2) People in transit				
(3) Asylum seekers				
(4) Refugee status granted				
(5) Undocumented migrants				

Programme co-funded by the EUROPEAN UNION

National coordination of the health care response to refugees, asylum seekers and other migrants: *Working document*

FRANCE

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This working document summarizes the latest information on the influx of the different categories (see box 1 on Country Context) and on the coordination of the health care responses (see box 2) in France. It also maps the available information on the WHERE-WHAT-WHO of these health care responses (see box 3). This is done for different categories: (1) recent arrivals, (2) people in transit, (3) asylum seekers, (4) refugee status granted persons, (5) undocumented migrants, and where relevant, also for (6) unaccompanied minors. Lastly we would like to map the funding sources for which the Member State's input is appreciated (see box 4 on Funding of health care responses).

The information already completed below is based on different sources which were consulted online between January 20 and February 8 2016 and which is meant to give a first snapshot. ***We would like to ask you to verify the information, to correct and amend where necessary and to complete where possible.*** *This mapping exercise will help the SH-CAPAC consortium to define a framework for effective health sector coordination for addressing the needs of the refugees, asylum seekers and other migrants in the European Union.* ***Please reply before February 16 2016 to ainhoa.ruiz.easp@juntadeandalucia.es with copy to birgit.kerstens@gmail.com and daniel.lopez.acuna.ext@juntadeandalucia.es.*** *More information on the SH-CAPAC project can be found in the leaflet in attachment and on www.easp.es/sh-capac.*

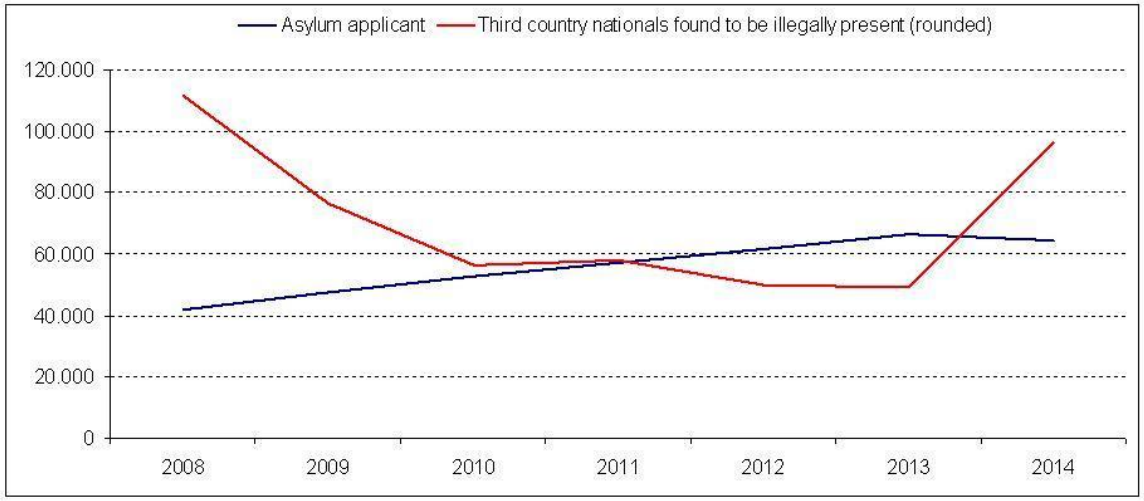
Sources consulted:

- MdM, Médecins du Monde. 8 NGOs for migrants/refugees' health in 11 countries. Project 717307. Annex I (part B), 2016.
- UNHCR. 2015 UNHCR subregional operations profile - Northern, Western, Central and Southern Europe. France. http://www.unhcr.org/cgi-bin/texis/vtx/page?page=49e48e571e&submit=GO
- IFRC. http://www.ifrc.org/docs/Appeals/16/IB6_Migration%20response_Europe_010216.pdf
- French Government oficial website. http://www.gouvernement.fr/en/composition-of-the-government

- Eurostat

Please provide us with any other sources that you deem appropriate for your country.

1. COUNTRY CONTEXT

When influx started **(*by year up till 2015, month since 2015*)**	 Eurostat, 2/02/2016. *(please complete or correct)*
Current number as of Feb 1 ***(AS/ REF/ UDM/ unaccompanied minors)***	A. **Most recent data per category**: In September 2015, the UNHCR estimated that more than 440,000 migrants and refugees arrived in Europe. (MdM, Annex 1)

Calais: More than 6,000 people currently live in slums with no sanitation nor access to drinking water, food, or healthcare. (MdM, Annex 1)

Residing in France [1]	As at june 2015
Refugees [2]	264,972
Asylum Seekers [3]	53,827
Returned Refugees [4]	0
Internally Displaced Persons (IDPs) [5]	0
Returned IDPs [6]	0
Stateless Persons [7]	1,290
Various [8]	0
Total Population of Concern	320,089
Originating from France [1]	
Refugees [2]	93
Asylum Seekers [3]	62
Returned Refugees [4]	0
Internally Displaced Persons (IDPs) [5]	0
Returned IDPs [6]	0
Various [8]	0
Total Population of Concern	155

source: http://www.unhcr.org/cgi-bin/texis/vtx/page?page=49e48e571e&submit=GO

B. **Most recent data on total number**:

Percentage of F/M/T, age groups and origin

A. **Most recent data per category:**

In September 2015, the UNHCR estimated that more than 440,000 migrants and refugees arrived in Europe. Among them, 1 in 4 were children, many arriving with their families but a significant number unaccompanied.

According to the IOM, out of 170,000 migrants arriving by boat in Italy from Libya, more than 13,000 were unaccompanied minors. In 2014, 13.8% (3,711) of the patients seen in the MdM clinics throughout France were minors, and approximately 10% among them were **unaccompanied minors** (hereafter UM). The number of UM seen multiplied four-fold since 2011. (MdM, Annex 1)
In 2013, 50 minors requested care in the MdM Paris health clinic; this number increased to 150 in 2014 and 121 during the first 6 months of 2015. (…) In 2016, the number of minors who will be referred to MdM will likely double. The target group is expected to be around 400 to 480 minors. (MdM, Annex 1)
Since 2013, the city of Caen has seen a strong increase in the number of asylum seekers and the number of UMs has increased too. The department received 170 UMs in 2014/2015 as compared to 75 in 2013/2014. (MdM, Annex 1)

ASYLUM APPLICANT	**2014**
Total	64.310

Source: Eurostat, 2/02/2016.

B. **Most recent data by gender, age group, origin**:

ASYLUM APPLICANT	**2014**
Total	64.310
Males	61,8%
Females	38,2%
Less than 18 years	21,7%
18 - 64 years	77,1%
65 years or over	1,2%
Unaccompanied minors (Asylum applicant)	270
Males	66,7%
Females	35,2%
IRREGULAR MIGRANT	96.375

Males	89,8%
Females	10,2%
Less than 18 years	5,4%
18 years or over	94,6%

Source: Eurostat, 2/02/2016.

2. HEALTH CARE RESPONSES	
Please correct or complete the information where possible.	
Health care coordination at national/regional level	A. **Existence of a national coordination mechanism of the health response**: YES/NO *(Please complete)* B. **Explanation**: *(if yes, please describe how the mechanism works and who participates; if no, please describe why there is no coordination)* Calais: Given the fact that the government took no specific measures with a specific timeline for implementation, MdM had to introduce (on 26/10/2015), together with the NGO Secours Catholique (Caritas) an emergency court procedure (référé). Following the hearing, the Lille tribunal ordered authorities to put 10 supplementary access points for drinking water, 50 toilets, a garbage collecting system; to organise a large clean-up of the site, to create access routes to the camp so that emergency units can reach the people and also, to identify all unaccompanied minors in order to get them under State minors protection. (MdM, Annex 1) Due to the system's deficiencies in the care of UM, the MdM teams have reported an increasing number of UMs requesting healthcare in the various MdM programmes. In 2013, 50 minors requested care in the MdM Paris health clinic; this number increased to 150 in 2014 and 121 during the first 6 months of 2015. (…) MdM has already met with the local health authorities (and the departmental *Direction de l'Action Sociale, de l'Enfance et de la Santé* or DASES) to raise awareness on the specific problems UM face and propose areas for improvement. (MdM, Annex 1) The director of children and family services from the Direction de l'Aide Sociale à l'Enfance (a Departmental Council) recognized that problems exist in the system. On the issue of access to care for UMs, the Director conceded that the system in place is unsatisfactory and appeared open to discussing areas for improvement. He recognized that the social actors who receive UMs are not necessarily cognizant of the various issues affecting UMs, including physical and psychological trauma. He also referred to the abusive practices of the Primary Health Insurance Fund with regards to entitlements for health coverage. In 2015, MdM France conducted a three month exploratory mission to determine (MdM, Annex 1) The British Red Cross worked with the **French Red Cross** to send an emergency relief convoy to deliver aid to refugees, migrants and asylum seekers in **Grand-Synthe camp**, northern France, and four smaller satellite camps in December. The emergency relief convoy included supplies for up to 3,000 people, including rain ponchos, blankets, scarves, gloves and hats, toiletries and information about asylum. The **British Red Cross** continues to provide its regular support to refugees and asylum seekers including newly arrived migrants. This includes the provision of food and non-food items,

	emergency cash and support in cultural integration, as well as support to people going through the family reunion process. The British Red Cross is also involved in helping to provide reception and support services in a number of areas taking part in the first phase of the Syrian Resettlement Programme. source: Information bulletin IFRC Regional Office for Europe Migration response. IFRC. http://www.ifrc.org/docs/Appeals/16/IB6_Migration%20response_Europe_010216.pdf http://www.gouvernement.fr/en/composition-of-the-government The Government intends to pursue its existing course of action and provide solutions that meet the challenge presented by refugees, which is a Europe-wide challenge. This course of action primarily involves adapting national tools to this migration crisis: ● with the **reform of the asylum system**, initiated by the Act of July 2015, which reduces the time frames for examining asylum applications, improves the welcome asylum-seekers receive and better distributes them across the country, and reinforces their rights through the transposition of European standards; ● with a **"migrant plan"** for the creation of 11,000 places. This includes an important section on fighting illegal economic immigration and people smuggling networks. This course of action also involves seeking a balanced European solution designed to: ● manage flows of migrants by **distinguishing**, in 'frontline' countries,**between those in need of protection**, who should be distributed across the Union by means of a relocation mechanism in order to lighten the burden on frontline States, **and economic migrants**, who should be returned with dignity to their home country. This is the intended purpose of identification and registration centres ('hot spots'), which must be set up in these countries by the end of the year; ● better **control the Union's external border** by supporting those countries faced with a mass influx of migrants. This is the role of Frontex, the duties of which may eventually be incorporated into a European border protection system; ● more effectively **fight illegal immigration networks**, notably by strengthening European police cooperation. These issues, and the Commission's proposed distribution of 120,000 asylum-seekers from frontline countries (Italy, Greece and Hungary) in particular, were debated at the Extraordinary Council of Justice and Home Affairs Ministers on 14 September; **in two years, France will be urged to take 24,000 people** clearly in need of protection, **in addition to the 6,750 people** that it agreed to take last July in the framework of the initial decision to relocate refugees in Europe.

	This relocation will be governed by the strict conditions outlined above.Bernard Cazeneuve felt that good progress had been made during this extraordinary Council of Justice and Home Affairs Ministers, and that progress now needs to be made with regard to relocating refugees. Responsibility for their reception cannot fall on just five EU countries, as solidarity is not divisible. Furthermore, **as a voluntary gesture of solidarity towards Germany, France is arranging to immediately host, in France, 1,000 people** from Syria, Iraq and Eritrea, arriving from Bavaria and clearly in need of protection. With this in mind, the Minister for the Interior has invited French mayors to attend a meeting on Saturday 12 September aimed at coordinating regional authorities' hosting initiatives with existing systems. Finally, this course of action involves **developing a joint solution with the home and transit countries.** France is responding to the humanitarian emergency by **providing vital resources for the United Nations agencies and non-government organisations** working in the camps in the countries neighbouring Syria. Humanitarian needs are increasing on the European continent, too. The fight against criminal migrant trafficking networks operating from the southern banks of the Mediterranean must also continue. Initial solutions have been provided in the central Mediterranean region. Furthermore, the ability of partner countries to monitor and manage borders, particularly where the Sahel countries are concerned, must be improved. Finally, the EU-Africa Summit in Valletta on 11 and 12 November must help establish a renewed partnership with the African countries. In order to move forward, the summit must take into account the concerns of the African partners with a view to better managing migration flows. **AN ACTION PLAN FOR VICTIMS OF ETHNIC OR RELIGIOUS VIOLENCE IN THE MIDDLE EAST** A conference on victims of ethnic or religious violence in the Middle East was held in Paris on 8 September. An action plan was drawn up in response to the humanitarian emergency in refugee camps in Turkey, Lebanon and Jordan in order to strengthen judicial cooperation and prevent terrorists from going unpunished. We will not let the ancient diversity of the Middle East disappear without taking action. To this end, **France has agreed to pay the first €25m.** Other funding will then follow: ● €10m will go into an emergency fund for bomb disposal, housing, rehabilitation and judicial cooperation initiatives, notably to prevent terrorists from going unpunished; ● €15m mobilised by the French Development Agency (AFD) will contribute to funding refugee camps and supporting countries that take in refugees, including Lebanon, Jordan, Turkey and Iraq. **INTER-MINISTERIAL MEETING ON THE HOSTING OF SYRIAN AND IRAQI REFUGEES**

	The Prime Minister chaired a meeting attended by all ministers affected by the hosting of Syrian and Iraqi refugees on 9 September. The ministers outlined the nature and scope of the support that each of their ministries is lending to the preparation, organisation and smooth running of hosting operations. This concerns the immediate hosting of a thousand people currently located in Germany, as well as the scheduled settlement of new refugees over the course of the next two years. Furthermore, Bernard Cazeneuve hosted a national mobilisation meeting on 12 September involving all mayors of towns that are willing to help with hosting these refugees in partnership with the State. The inter-ministerial meeting outlined the financial support measures that the State will offer for municipalities willing to participate. **Calais: responsibility, humanity and State involvement** - **The Jules Ferry day reception centre opened in January 2015** to provide a real humanitarian welcome for migrants in Calais. The centre provides somewhere for migrants to eat, wash and access medical care if need be and is funded by the State at €13 million a year, €3.7 million of which come from European funds. http://www.gouvernement.fr/en/refugees-we-must-act-in-accordance-with-the-principles-of-humanity-solidarity-responsibility-and?55pushSuggestion=Teaser **Additional resources will be allocated to solidarity initiatives**, with a total of **€279m** earmarked for initial reception, emergency accommodation and lump-sum payments to municipalities between now and the end of 2016. This funding will also finance additional staffing for the French Office for the Protection of Refugees and Stateless People (OFPRA), the French Immigration and Integration Office (OFII) and the Ministry of Education.
First entry assistance services	

Response to 'An Agenda for Action' as agreed during the High Level Meeting on Refugee and Migrant Health in Rome in November 2015:
Cross the appropriate 'Yes', 'No' or 'There is no information available' option in the blue boxes. Additional information or sources can be mentioned underneath the box.

Integration of the health care services for refugees, asylum seekers end migrants into the existing national health systems	Yes	x No	There is no information available
Limit initial screening upon arrival to relevant risk assessment	Yes	No	There is no information available
Non Communicable Diseases included in the provision of services	Yes	No	There is no information available
Active participation and empowerment of the refugees and migrants throughout all stages of health service provision, including design and planning	Yes	No	There is no information available
Training of health professionals involved in the provision of health care	Yes	No	There is no information available

3. WHERE-WHAT-WHO
Please correct or complete the information where possible.

Migrant group	WHERE are they receiving the health care?	WHAT type of health care provision are they receiving?	WHO is the actor/agency providing the health care?
(1) Recent arrivals			
(2) People in transit			
(3) Asylum seekers			
(4) Refugee status granted			
(5) Undocumented migrants			

(6) Unaccompanied minors	Although UM who clearly seem minor get access to specialised reception centres right away, the majority of UM seeking assistance from administrative and legal entities in charge of children at risk are left without support and in administrative limbo. Firstly, young migrants between the ages of 16 and 18 are often only given shelter (e.g. a basic hotel room) without their other needs being taken care of (no social or legal assistance, no access to education, no specific protection), awaiting their age assessment. Secondly, the age-determination system currently in place is questionable in terms of accuracy and reliability. As a result, many minors/young migrants are left without shelter or any access to healthcare once their age assessment turns out negative. On the one hand, unaccompanied minors are legally entitled to healthcare through the health system as the children of nationals or authorised residents. On the other hand, undocumented individuals who have been resident for more than three months in France and whose resources are less than €720 per month are		

	entitled to AME (Aide Médicale d'Etat), i.e. full healthcare coverage. These young people are neither considered adult undocumented migrants, neither unaccompanied minors. In practice, many young migrants had not received any kind of health assessment or access to physical or mental healthcare before going to MdM. Furthermore, prosecutions have been often reported against youth who have been declared adults. (MdM, Annex 1) 'Older' UMs (between 15 to 18 years old) can sometimes stay in a shelter awaiting the processing of their asylum claim for up to eight months. **During this time they have no access to education, social or legal assistance, nor to any kind of health assessment or care.** There are no health professionals in the teams responsible for providing shelter, and these teams lack knowledge and information about health prevention, especially concerning infectious diseases. External health professionals are often		

	misinformed about children's entitlement to care (MdM, Annex 1)		

4. FUNDING OF THE HEALTH CARE RESPONSES				
Please provide us with any relevant information of funding made available by your country or other partners for health care responses: ▪ *FUNDING SOURCES: where does the funding come from? e.g. Government, UN agency (UNHCR, IOM, WHO Euro,…), EU, NGO, civil society organisation, faith-based organisation, private organisation, international donor, (public/private) health insurance, other (please specify)* ▪ *FUNDING MECHANISM: how is the health care delivery being funded? e.g. envelope (for whole year/project), lump sum amount per asylum. seeker/refugee, out-of-pocket expenses, third payer mechanism, emergency/contingency budget.* ▪ *FUNDING AMOUNT: Give the amount spent on health care responses, in Euros, per year/month; if available also provide the pledged amount.* ▪ *COMMENTS.*				
Migrant group	**Funding source**	**Funding mechanism**	**Funding amount**	**Comments**
(1) Recent arrivals				
(2) People in transit				
(3) Asylum seekers				
(4) Refugee status granted				
(5) Undocumented migrants				

Programme co-funded by the EUROPEAN UNION

National coordination of the health care response to refugees, asylum seekers and other migrants: *Working document*

GERMANY

READER'S GUIDE:

The SH-CAPAC consortium is conducting a mapping of the European Union Member States' health response to the refugees, asylum seekers and other migrants entering, transiting or staying in their territories.

This working document summarizes the latest information on the influx of the different categories (see box 1 on Country Context) and on the coordination of the health care responses (see box 2) in Germany. It also maps the available information on the WHERE-WHAT-WHO of these health care responses (see box 3). This is done for different categories: (1) recent arrivals, (2) people in transit, (3) asylum seekers, (4) refugee status granted persons, (5) undocumented migrants, and where relevant, also for (6) unaccompanied minors. Lastly we would like to map the funding sources for which the Member State's input is appreciated (see box 4 on Funding of health care responses).

The information already completed below is based on different sources which were consulted online between January 20 and February 8 2016 and which is meant to give a first snapshot. ***We would like to ask you to verify the information, to correct and amend where necessary and to complete where possible.*** *This mapping exercise will help the SH-CAPAC consortium to define a framework for effective health sector coordination for addressing the needs of the refugees, asylum seekers and other migrants in the European Union.* ***Please reply before February 16 2016 to ainhoa.ruiz.easp@juntadeandalucia.es with copy to birgit.kerstens@gmail.com and daniel.lopez.acuna.ext@juntadeandalucia.es.*** *More information on the SH-CAPAC project can be found in the leaflet in attachment and on www.easp.es/sh-capac.*

Sources consulted:

- BAMF, Bundesamt für Migration und Flüchtlinge (2015). Prognoseschreiben, 20.08.2015. http://www.bamf.de/SharedDocs/Anlagen/DE/Downloads/Infothek/DasBAMF/2015-08-20-prognoseschreiben-asylantraege.pdf?__blob=publicationFile
- BAMF, Bundesamt für Migration und Flüchtlinge (2016). Asylgeschäftsstatistik 12/2015, 06.01.2016. http://www.bamf.de/SharedDocs/Meldungen/DE/2016/201610106-asylgeschaeftsstatistik-dezember.html?nn=1367522
- Bundesministerium für Gesundheit (2015). Verbesserung der medizinischen Versorgung von Flüchtlingen. http://www.bmg.bund.de/ministerium/meldungen/2015/bund-laender-vereinbarungen.html
- Die Bundesregierung (2015). http://dip21.bundestag.de/dip21/btd/18/038/ 1803850.pdf
- European Commission (2016). Member states' Support to Emergency Relocation Mechanism. http://ec.europa.eu/dgs/home-affairs/what-we-do/policies/european-agenda-migration/press-material/docs/state_of_play_-_relocation_en.pdf

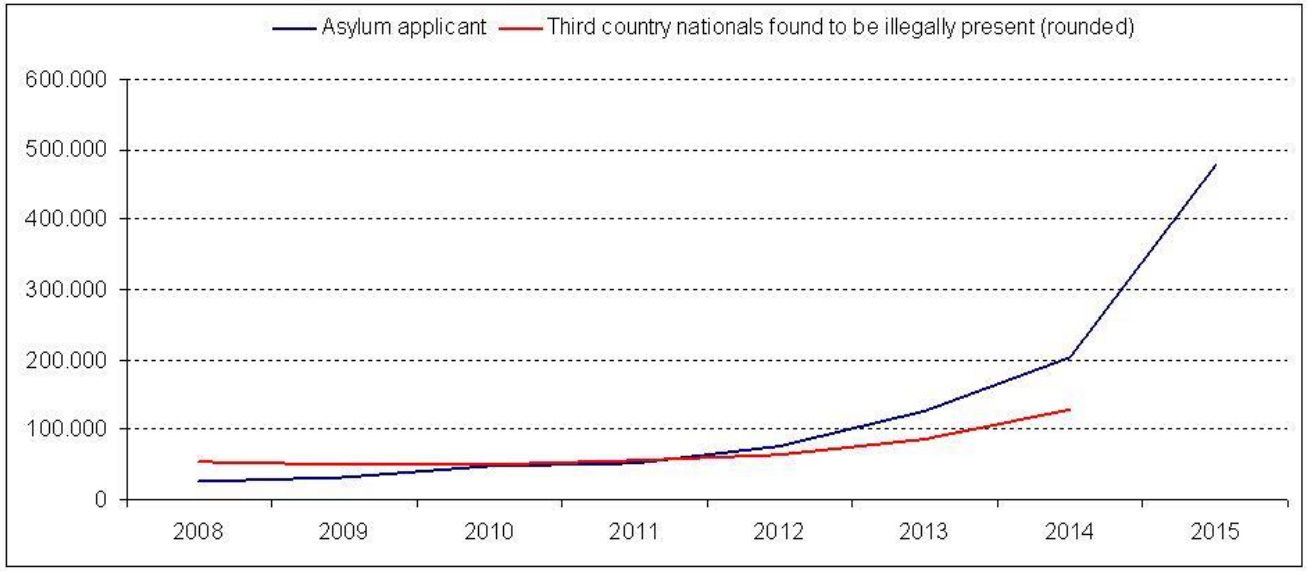
- EUROSTAT (2016). Statistics 02/02/2016. http://ec.europa.eu/eurostat
- FRA, European Union Agency for Fundamental Rights (2015). Monthly data collection on the current migration situation in the EU. December 2015 monthly report. 23 November – 31 December 2015. http://fra.europa.eu/sites/default/files/fra_uploads/fra-2016-monthly-compilation-com-update-1_en.pdf
- IFRC, International Federation of Red Cross and Red Crescent Societies (2016). Information Bulletin IFRC Regional Office for Europe Migration response. http://www.ifrc.org/docs/Appeals/16/IB6_Migration%20response_Europe_010216.pdf
- IOM, International Organization for Migration, Global Migration Data Analysis Centre (2016). Migration, asylum and refugees in Germany: Understanding the data. Data Briefing Series, Issue No. 1, January 2016. https://www.iom.int/sites/default/files/country/docs/Germany/Germany-Data-Briefing-1Jan2016.pdf
- MdM, Médecins du Monde (2016). 8 NGOs for migrants/refugees' health in 11 countries. Project 717307. Annex I (part B).
- UNHCR, The UN Refugee Agency (2015). 2015 UNHCR subregional operation profile – Northern, Western, Central and Southern Europe - Germany. http://www.unhcr.org/cgi-bin/texis/vtx/page?page=49e48e5f6&submit=GO

Please provide us with any other sources that you deem appropriate for your country.

1. COUNTRY CONTEXT

When influx started
(*by year up till 2015, month since 2015*)

(please complete or correct)



	(Eurostat 2016)
Current number as of Feb 1 ***(AS/ REF/ UDM/ unaccompanied minors)***	A. **Most recent data per category**:

Residing in Germany [1]	at June 2015
Refugees [2]	250,299
Asylum Seekers [3]	311,551
Returned Refugees [4]	0
Internally Displaced Persons (IDPs) [5]	0
Returned IDPs [6]	0
Stateless Persons [7]	11,978
Various [8]	0
Total Population of Concern	573,828
Originating from Germany [1]	
Refugees [2]	174
Asylum Seekers [3]	87
Returned Refugees [4]	0
Internally Displaced Persons (IDPs) [5]	0
Returned IDPs [6]	0
Various [8]	2
Total Population of Concern	263

(UNHCR 2016)

Since the start of the refugee crisis in September 2015, there has been a tremendous increase in migrants and refugees passing through or applying for asylum in Munich. In 2015, 800,000 refugees are expected to apply for asylum in Germany So far, most of the migrants choose to take the Balkan route, crossing the Austrian-German border, aiming to apply for asylum in Germany, Scandinavia or The Netherlands. A total of 362,153 asylum seekers have already been registered in Germany in 201523. Bavaria, as one of the biggest federal states in Germany, already registered 54,412 asylum seekers (until end of October) (MdM 2016)

The gap between the figures of expected asylum seekers (800,000) and actual registered persons until end of October (362,153 applications) is a result of the fact that the formal application process is often delayed. Hence

there is a difference between registered asylum seekers (in the official EASY System of the respective Ministry "Bundesamt für Migration und Flüchtlinge-BAMF") and the formally registered asylum applications. The BAMF reports 758.000 persons registered in EASY for January to October 2015 (MdM 2016)

Some 127,000 new arrivals of people seeking international protection were registered in December 2015, among them mostly people from Syria, Iraq, Afghanistan, Iran and Morocco. In November, there were over 206,000 registrations. (FRA 2015)

ASYLUM APPLICANT	**2014**	**2015**
Total	**202.645**	**476.510**
Males	65,4%	68,3%
Females	34,5%	31,5%
Less than 18 years	31,6%	31,1%
18 - 64 years	67,6%	68,3%
65 years or over	0,8%	0,6%
Unaccompanied minors (Asylum applicant)	**4.400**	
Males	86,0%	
Females	13,5%	
IRREGULAR MIGRANT	**128.290**	
Males	74,2%	
Females	25,8%	
Less than 18 years	14,0%	
18 years or over	86,0%	

(Eurostat 2016)

On 31 July 2015, BAMF had counted 218,221 asylum applications (first and subsequent applications) whilst 309,075 people had already registered in EASY.
(BAMF 2015; IOM 2016)

The EU scheme, within which 4,237 places have been made available by 17 EU Member States, has so far only resulted in the relocation of 272 persons. Of these, Germany has made 40 places available, with 11 people relocated from Italy and 10 from Greece.
(European Commission 2016; IOM 2016)

<table>
<tr><td></td><td>In context:
- 4,237 places have been made available in total by 17 EU Member States.
- 190 people have been located from Italy, of a target 39,600.
- 82 people have been relocated from Greece, of a target 66,400.
- 97,982 places remain to be allocated, of an initial 98,256 places.
- 7,744 of the 40,000 decision and 54,000 of the 120,000 decision remain to be allocated.
By the end of November, Germany handmade 41,217? Dublin requests', with peaks in January (4,405, of which 3,117were based on EURODAC matches) and July (4,839, of which 3,803were based on EURODAC matches).13 In comparison, throughout 2014, 35,100 requests had been made to other Member States, and around 4,800 people were transferred.
(Die Bundesregierung 2015; IOM 2016)

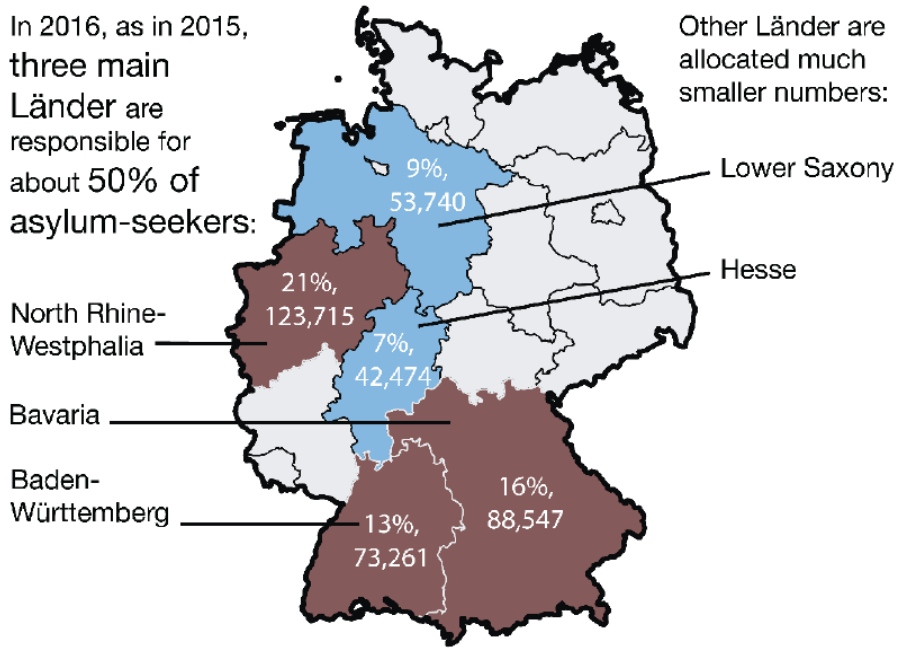
B. Most recent data on total number:</td></tr>
<tr><td>Percentage of F/M/T, age groups and origin</td><td>A. Most recent data per category:
B. Most recent data by gender, age group, origin:

<table><tr><th>Main third countries of origin</th><th>December 2015</th><th>November 2015</th></tr><tr><td>1. Syria</td><td>44,522</td><td>97,463</td></tr><tr><td>2. Iraq</td><td>28,319</td><td>24,678</td></tr><tr><td>3. Afghanistan</td><td>26,506</td><td>44,846</td></tr><tr><td>4. Iran</td><td>7,464</td><td>10,080</td></tr><tr><td>5. Morocco</td><td>7,464</td><td>2,690</td></tr><tr><td>Total number of registrations:</td><td>127,320</td><td>206,101</td></tr></table>
The registration figures can only give an indication of the overall number of new arrivals since they do not include the unknown number of non-registered persons who are either on their way to other (German federal) states or still waiting for their registration procedure. Secondly, an unknown number of double and incorrect registrations may be included and, thirdly, persons registered who immediately left Germany to reach another state (e.g. Sweden) may also be included in the system.</td></tr>
</table>

	Some 46,730 asylum applications were submitted in the month of December 2015.128 In November, 55,950 asylum applications were submitted. Approximately a third of all asylum applications in 2015 were submitted by children129 and another third by women.130 Some 14,439 unaccompanied children applied for asylum in 2015, amounting to about 3 %. The Federal Office for Migration and Refugees (BAMF) does not have data concerning the share of families or other vulnerable groups. (FRA 2015) **Main countries of origin registered in EASY, Jan-Dec 2015** Syria 428.468 Afghanistan 154.064 Iraq 121.662 Albania 69.426 Kosovo (UN 244/99) 33.049 (BAMF 2016)

2. HEALTH CARE RESPONSES	
Please correct or complete the information where possible.	
Health care coordination at national/regional level	A. **Existence of a national coordination mechanism of the health response**: YES/NO *(Please complete)* B. **Explanation**: *(if yes, please describe how the mechanism works and who participates; if no, please describe why there is no coordination)* After registration, asylum seekers have access to accommodation and are also entitled to healthcare services through the Asylum Seekers Benefits Act. They have to apply for a health insurance certificate ("Krankenschein") at the social assistance office. However, it should be noted that, as for all other asylum seekers, there are many restrictions to access healthcare in Germany during the first 15 months of presence24. Furthermore, social services such as Caritas, the Housing and Migration Office and the Department of Health and Environment of the city in Munich report that this process is increasingly time-consuming since the amount of applications has increased. It is usually up to these social services to organize interpreters and make doctors' appointments (Legal report on access to healthcare in 12 countries, June 2015. Macherey A-L., Vanbiervliet F., Simonnot N.; MdM, Annex 1) **The German Red Cross** has been highly active in the operation of emergency accommodation centres and provision of aid services to migrants at national level, running more than 470 emergency accommodation centres. More than 20,000 Red Cross volunteers and staff are working on the operation, providing a variety of services to vulnerable migrants: medical assistance, psychosocial support, family tracing services and assistance in the asylum procedure, among other. As auxiliary to the German federal authorities, the NS is tasked with setting up and operating two camps in Bavaria. The camps have received in-kind and operational support by NS of Denmark, Finland, Canada, USA, the Netherlands, Norway, Sweden and Switzerland as well as the ICRC, making this the first German Red Cross relief operation with coordinated international support within Germany in recent history. The NS is also carrying out social inclusion programs across the country, piloting a volunteer program for refugees and migrants and providing a variety of information products in relevant language outputs. (IRFC 2016) Improvement of health care for refugees, established in a bill for accelerating the asylum process (Entwurfs des Asylverfahrensbeschleunigungsgesetzes), agreement of the federal states and federal government, September 24, 2015: • Electronic health care card: facilitation of the implementation process in the federal states • Vaccination: Acceleration of the vaccination process, information: Robert-Koch-Institut. • Psychotherapeutic treatment for post-traumatic stress • Basic medical care in the reception centres: with the support of refugees with medical training (Bundesministerium für Gesundheit 2015)

First entry assistance services	The reception capacity varies from federal state to federal state. In north German states such as Schleswig-Holstein, Mecklenburg-Western Pomerania and Lower Saxony the situation improved during the reporting period. Emergency shelters are currently not needed as the decentralised accommodation of persons in need of international protection has been well organised. On the other hand, in Berlin, many new mass reception centres and emergency shelters (e.g. gyms) were established. In the airport hall of the former airport Berlin-Tempelhof thousands of asylum seekers had to wait for weeks until showers were installed. Also the living conditions vary strongly from accommodation centre to accommodation centre. The bigger the accommodation centres are, the worse the sanitary conditions as well as the kitchen conditions. In many large accommodation centres people refused to cook due to this reason. In general, enough water and food can be provided to the inhabitants. Some problems occurred when asylum seekers refused to drink clean water from the pipe as they were not used to this, insisting on bottled water. In some gyms and air halls, which were used as emergency shelters, heating systems temporarily failed. These problems, however, could quickly be solved.144 (…) In many reception centres, it still takes too long until first medical examination takes place. A high risk of infection exists in many accommodation centres. (FRA 2015)



(IOM 2016)

Response to 'An Agenda for Action' as agreed during the High Level Meeting on Refugee and Migrant Health in Rome in November 2015: *Cross the appropriate 'Yes', 'No' or 'There is no information available' option in the blue boxes. Additional information or sources can be mentioned underneath the box.*			
Integration of the health care services for refugees, asylum seekers end migrants into the existing national health systems	Yes	No	There is no information available
Limit initial screening upon arrival to relevant risk assessment	Yes	No	There is no information available
Non Communicable Diseases included in the provision of services			

	Yes	No	There is no information available
Active participation and empowerment of the refugees and migrants throughout all stages of health service provision, including design and planning	Yes	No	There is no information available
Training of health professionals involved in the provision of health care	Yes	No	There is no information available

3. WHERE-WHAT-WHO			
Please correct or complete the information where possible.			
Migrant group	**WHERE are they receiving the health care?**	**WHAT type of health care provision are they receiving?**	**WHO is the actor/agency providing the health care?**
(1) Recent arrivals		Access to health care restricted (MdM legal report on access to healthcare in 12 countries,in MdM 2016) Emergency accommodation centres and provision of aid services to migrants.	German Red Cross The camps have received in-kind and operational support by NS of Denmark, Finland, Canada, USA, the Netherlands, Norway, Sweden and Switzerland as well as the ICRC
(2) People in transit	About 200 refugees mainly from Syria, Eritrea and Afghanistan are daily passing through the central bus station of Munich. They intend to continue their route and do not register in Munich. So they are not recognised as asylum seekers but as undocumented migrants. This means that they do not have access to the regular health services as registered migrants do.		

Migrant group	WHERE are they receiving the health care?	WHAT type of health care provision are they receiving?	WHO is the actor/agency providing the health care?
	Ärzte der Welt has a needs assessment in Munich during a pilot phase and identified the following health needs: respiratory problems (flue, cough, and headaches), gastro-intestinal diseases, dermatological problems and wounds, sleeping disorders, exhaustion, needs for psychological support, and no access to medication for chronic diseases. Most people with chronic conditions do not have health booklets. (MdM 2016) emergency accommodation centres and provision of aid services to migrants at national level, running more than 470 emergency accommodation centres. medical assistance, psychosocial support, family tracing services and assistance in the asylum procedure, among other (IFRC 2016) As auxiliary to the German federal authorities, the NS is tasked with setting up and operating two camps in Bavaria.		
(3) Asylum seekers	Access to health care restricted (MdM legal report on access to		

Migrant group	WHERE are they receiving the health care?	WHAT type of health care provision are they receiving?	WHO is the actor/agency providing the health care?
	healthcare in 12 countries,in MdM 2016) medical assistance, psychosocial support, family tracing services and assistance in the asylum procedure, among other		
(4) Refugee status granted	Access to health care restricted (MdM legal report on access to healthcare in 12 countries,in MdM Annex 1) After registration, asylum seekers have access to accommodation and are also entitled to healthcare services through the Asylum Seekers Benefits Act. They have to apply for a health insurance certificate ("Krankenschein") at the social assistance office. However, it should be noted that, as for all other asylum seekers, there are many restrictions to access healthcare in Germany during the first 15 months of presence (Legal report on access to healthcare in 12 countries, June 2015. Macherey A-L., Vanbiervliet F., Simonnot N.; MdM 2016)		
(5) Undocumented migrants	Cost of restricting access to screening and treatment(FRA "Cost of exclusion from healthcare – The		

Migrant group	WHERE are they receiving the health care?	WHAT type of health care provision are they receiving?	WHO is the actor/agency providing the health care?
	case of migrants in an irregular situation" (MdM 2016)		
(6) Unaccompanied minors			

4. FUNDING OF THE HEALTH CARE RESPONSES
Please provide us with any relevant information of funding made available by your country or other partners for health care responses: ▪ *FUNDING SOURCES: where does the funding come from? e.g. Government, UN agency (UNHCR, IOM, WHO Euro,…), EU, NGO, civil society organisation, faith-based organisation, private organisation, international donor, (public/private) health insurance, other (please specify)* ▪ *FUNDING MECHANISM: how is the health care delivery being funded? e.g. envelope (for whole year/project), lump sum amount per asylum. seeker/refugee, out-of-pocket expenses, third payer mechanism, emergency/contingency budget.* ▪ *FUNDING AMOUNT: Give the amount spent on health care responses, in Euros, per year/month; if available also provide the pledged amount.* ▪ *COMMENTS.*

Migrant group	Funding source	Funding mechanism	Funding amount	Comments
(1) Recent arrivals				
(2) People in transit				
(3) Asylum seekers				
(4) Refugee status granted				
(5) Undocumented migrants				

Programme co-funded by the EUROPEAN UNION

National coordination of the health care response to refugees, asylum seekers and other migrants: *Working document*
GREECE

READER'S GUIDE:

The SH-CAPAC consortium is conducting a mapping of the European Union Member States' health response to the refugees, asylum seekers and other migrants entering, transiting or staying in their territories.

This working document summarizes the latest information on the influx of the different categories (see box 1 on Country Context) and on the coordination of the health care responses (see box 2) in Greece. It also maps the available information on the WHERE-WHAT-WHO of these health care responses (see box 3). This is done for different categories: (1) recent arrivals, (2) people in transit, (3) asylum seekers, (4) refugee status granted persons, (5) undocumented migrants, and where relevant, also for (6) unaccompanied minors. Lastly we would like to map the funding sources for which the Member State's input is appreciated (see box 4 on Funding of health care responses).

The information already completed below is based on different sources which were consulted online between January 20 and February 8 2016 and which is meant to give a first snapshot. ***We would like to ask you to verify the information, to correct and amend where necessary and to complete where possible.*** *This mapping exercise will help the SH-CAPAC consortium to define a framework for effective health sector coordination for addressing the needs of the refugees, asylum seekers and other migrants in the European Union.* ***Please reply before February 16 2016 to ainhoa.ruiz.easp@juntadeandalucia.es with copy to birgit.kerstens@gmail.com and daniel.lopez.acuna.ext@juntadeandalucia.es.*** *More information on the SH-CAPAC project can be found in the leaflet in attachment and on www.easp.es/sh-capac.*

Sources consulted:

- Information bulletin IFRC Regional Office for Europe Migration response. IFRC. http://www.ifrc.org/docs/Appeals/16/IB6_Migration%20response_Europe_010216.pdf

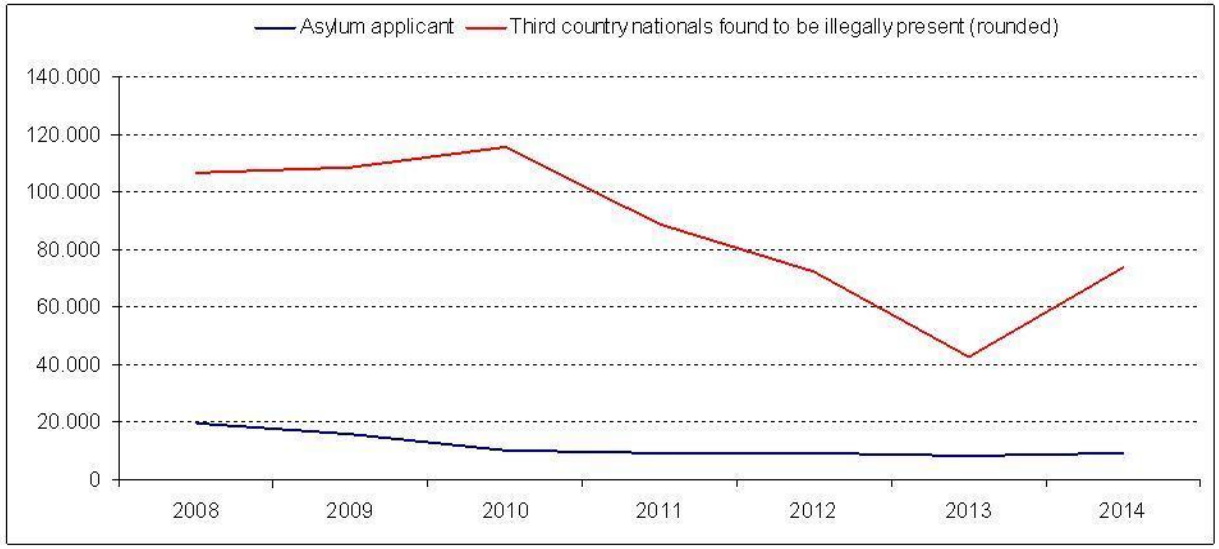
- Eurostat
- UNHCR. Refugees/Migrants Emergency Response - Mediterranean http://data.unhcr.org/mediterranean/country.php?id=83
  - 2015 UNHCR subregional operations profile - Northern, Western, Central and Southern Europe http://www.unhcr.org/cgi-bin/texis/vtx/page?page=49e48e726&submit=GO
- REGIONAL REFUGEE AND MIGRANT RESPONSE PLAN FOR EUROPE. EASTERN MEDITERRANEAN AND WESTERN BALKANS ROUTE, 2016 UNHCR.
- European Commission, Managing the Refugee Crisis. State of play and future actions, January 2016
  - MdM, Médecins du Monde. 8 NGOs for migrants/refugees' health in 11 countries. Project 717307. Annex I (part B), 2016.
- FRA, European Union Agency for Fundamental Rights. Monthly data collection on the current migration situation in the EU. December 2015 monthly report. 23 November – 31 December 2015. http://fra.europa.eu/sites/default/files/fra_uploads/fra-2016-monthly-compilation-com-update-1_en.pdf

Please provide us with any other sources that you deem appropriate for your country.

Suggested more sites to consult:

1) UNHCR Greece: www.unhcr.gr includes a mapping of all stakeholders
2) IOM Greece: Greece.iom.int , http://missingmigrants.iom.int/mediterranean-update-12-february-2016
3)
4) Hellenic Police: www.astynomia.gr (statistics- in Greek)
5) Mèdecins Sans Frontiéres: www.msf.gr
6) Praksis: www.praksis.gr
7) Hellenic Centre for Disease Control and Prevention (KEELPNO): www.keelpno.gr
8) http://missingmigrants.iom.int/mediterranean-update-12-february-2016
9) http://www.asylumineurope.org/reports/country/Greece/statistics

1. COUNTRY CONTEXT	
When influx started	

(*by year up till 2015, month since 2015*)	 Eurostat, 2/02/2016.
Current number as of Feb 18th ***(AS/ REF/ UDM/ unaccompanied minors)***	A. **Most recent data per category**: **88.057** arrivals by sea in 2016 (updated 18th feb 2016) 856,723 arrivals by sea in 2015 http://data.unhcr.org/mediterranean/country.php?id=83 **385.069**migrants entered into Greece in the first three quarters of 2015 http://data.unhcr.org/mediterranean/country.php?id=83

Preview Nov 2015 - Feb 2016: the UNHCR does not anticipate that these movements will decrease: between November 2015 and February 2016, there could be an average of 5,000 arrivals per day from Turkey, resulting in up to a total of 600,000 arrivals in Croatia, Greece, Serbia, Slovenia and the former Yugoslav Republic of Macedonia (FYROM) (UNHCR Winterization Plan for the Refugee Crisis in Europe, November 2015 – February 2016, in MdM Annex 1) **(554.867 arrivals since Nov 2015 – Feb 15th 2016)**
http://data.unhcr.org/mediterranean/country.php?id=83

Since the beginning of 2015, **944.780** refugees have arrived in Greece by sea from Turkey (Jan 2015 – Feb 18th 2016). Locations such as the islands of Lesbos (549.993 arrivals – 58.21%), and Chios (145.608 arrivals – 15,41%) have been two of the main common entry points in the country since the beginning of the year
http://data.unhcr.org/mediterranean/country.php?id=83

The total number of people who arrived in Greece by sea in November 2015 was around 151,000 with an average of 4,560 arrivals per day.154 During this period, the Hellenic Coastguard had to take action in 497 cases, mostly because of ungovernable or waterlogged boats.155 In December, the number of new arrivals by sea decreased compared to previous weeks, a fact attributed to adverse weather conditions.156
The total number of people who arrived in Greece by sea in December 2015 was about 109,000. Lesvos was the main point of entry, followed by Chios, Samos, Leros, Kos, Rhodes, Symi, Lipsi, Kalymnos and Amorgos. New arrivals include mostly Syrians, followed by Afghan and Iraqi nationals.
During December 2015, 286 incidents were reported where the Hellenic Coastguard had to take action. These incidents involved missions in which 7,435 people were rescued. The majority of incidents were related either to ungovernable boats or to waterlogged boats.
(FRA Monthly Review Dec 2015)

Residing in Greece [1]	**In june 2015**
Refugees [2]	8,231
Asylum Seekers [3]	29,157
Returned Refugees [4]	0
Internally Displaced Persons (IDPs) [5]	0
Returned IDPs [6]	0

	<table><tr><td>**Stateless Persons [7]**</td><td>214</td></tr><tr><td>**Various [8]**</td><td>0</td></tr><tr><td>**Total Population of Concern**</td><td>37,602</td></tr><tr><td>**Originating from Greece [1]**</td><td></td></tr><tr><td>**Refugees [2]**</td><td>112</td></tr><tr><td>**Asylum Seekers [3]**</td><td>84</td></tr><tr><td>**Returned Refugees [4]**</td><td>0</td></tr><tr><td>**Internally Displaced Persons (IDPs) [5]**</td><td>0</td></tr><tr><td>**Returned IDPs [6]**</td><td>0</td></tr><tr><td>**Various [8]**</td><td>0</td></tr><tr><td>**Total Population of Concern**</td><td>196</td></tr></table> source: http://www.unhcr.org/cgi-bin/texis/vtx/page?page=49e48e726&submit=GO B. **Most recent data on total number**: **Updated data (feb 18th 2016):** Total arrivals in Greece (Jan 2015- Feb 18th, 2016): **944.780** Total arrivals in Greece during Jan 2016: **60.502** Average daily arrivals during Jan 2016: **1.952** Total arrivals in Greece during Feb 2016: **27.555** Average daily arrivals during Feb 2016: **1.531** Source: http://data.unhcr.org/mediterranean/country.php?id=83
Percentage of F/M/T, age groups and origin	A. **Most recent data per category:** Demographics (since Jan 1st- Feb 18th, 2016) : Children 36%, Women 21%, Men 43% Syrian Arab Republic: 45%, Afghanistan 29%, Iraq 17%, Iran 4%, Pakistan 3%, Others 3% http://data.unhcr.org/mediterranean/country.php?id=83

	The total number of children who arrived in Greece by sea in December 2015 was about 19,500. The majority was Syrian, Iraqi and Afghan nationals.157 No further data was made available regarding the gender and age profiles of the new arrivals. (FRA Monthly Review Dec 2015) The total number of asylum applications for November 2015 was 1171. The main region of registration was Attica, followed by Thessaloniki, Lesvos, South and North Evros, Rhodes, Amygdaleza and Patra. The majority of applicants were 18–34 years old. They originated from Syria, Iraq, Pakistan, Albania, Afghanistan, and other countries. The total number of asylum applications for December 2015 was 1314, including 45 unaccompanied children.160 The main region of registration was Attica, followed by Thessaloniki, Lesvos, South and North Evros, Rhodes, Amygdaleza and Patra.161 The majority of applicants were 18–34 years of age. They originated from Syria, Iraq, Pakistan, and other countries. 99.9 % of Syrians, 61.9 % of Afghans and 3 % of Pakistanis were given asylum in 2015.162 In 2015, some 82 people were relocated to Finland (24), Germany (10), Lithuania (4), Luxemburg (30) and Portugal (14). From 12 October 2015 to 3 January 2015, Greece submitted 577 requests for relocation, including many children (217 between 0–13 years of age and 28 between 14–17 years) (FRA Monthly Review Dec 2015) 91% of the migrants arriving to Greece are composed of: ● nationals of Syria (55%), ● Afghanistan (25%) ● and Iraq 11%).(2) Other countries of origin represented in the region are Eritrea, Pakistan, Nigeria, Somalia, Morocco, Bangladesh, among others.(3) (2) Source: http://data.unhcr.org/mediterranean/regional.php (3) If we consider the regional overview, 78% of the migrants come from these three nationalities (Syria 48%, Afghanistan 21%, Iraq 9%).

B. **Most recent data by gender, age group, origin**:

ASYLUM APPLICANT	2014
Total	9.430
Males	81,1%
Females	18,9%
Less than 18 years	14,3%
18 - 64 years	85,4%
65 years or over	0,2%
Unaccompanied minors (Asylum applicant)	440
Males	92,0%
Females	8,0%
IRREGULAR MIGRANT	73.670
Males	86,5%
Females	13,4%
Less than 18 years	11,3%
18 years or over	88,7%

Source: Eurostat, 2/02/2016.

2. HEALTH CARE RESPONSES

Please correct or complete the information where possible.

Health care coordination at national/regional level

A. **Existence of a national coordination mechanism of the health response**: **YES**

B. **Explanation**: By initiative of Secretariat General of Public Health (Hellenic Ministry of Health), a coordinating and supervising National Team has been established since May 2015

Participants: Delegates from the Ministry of Health and the Alternative Ministry of Migration Policy, officials from the Directorate of Public Health (MoH), the Directorate of Primary Health Care (MoH) and the Hellenic CDC, academics with scientific expertise in Health Crisis Management and representatives from UNHCR and IOM.

	Main Objective: the development of a National Strategic Plan on Migration Health response (current status: under finalization) **Other Objectives:** - Integration of the health care services for refugees, asylum seekers end migrants into the existing national health systems - Public Health Protection - Reinforcement of NHS capacity - Coordination of all Health related activities by mobilizing the regional Pubic Health authorities and the Medical Associations - Advocacy of Health promotion and health education - Facilitate partnerships, networks and multi-country frameworks **First Priorities:** - Legislative measures for universal and indiscriminate access to comprehensive health services for all the population on the move (under public consultation) - Administrative Circular issued by the SG of Public Health providing the Administrative District Officers, the Regional Public Health Authorities and the local Medical Associations with guidelines regarding the control and coordination of the plethora of NGO's, volunteers and solidarity associations acting on the field (already issued) - Development of the National Strategic Plan on Migration Health response (under finalization) - Joined Ministerial Decision (MoH, MoM) on "determination of adulthood" (already issued) Kos, Leros, Samos, Chios, Lesvos Plan to provide 50.000 reception places in Greece and 50.000 reception places along the Western Bakans route (European Commission - Press release (05/11/2015) Progress following Western Balkans Route Leaders' Meeting in MdM, Annex 1) Under the "Hotspot approach"18, the Greek Government is establishing hotspots on five islands (Chios, Kos, Leros, Lesvos and Samos) and three Relocation Centers in the mainland (one in Attica and two in Thessaloniki).The Ministry of Defense has an active role in the construction of the Hotspots and Relocation Centers whilst the Public Order Ministry will make sure that all of the five hotspots will have been staffed and capable of registering refugees and migrants by the end of February. UNHCR provides technical support in their design. (REGIONAL REFUGEE AND MIGRANT RESPONSE PLAN FOR EUROPE, UNHCR) **<u>Hotspots</u>**

	Lesvos – operational **Leros** and **Chios** – operational **Samos** - to be operational by the end of February or beg of March **Kos** – to be operational by the end of February or beg of March *In the Hotspots of Lesvos and Chios: MDM conducts First Health Screenings and Triage (FHST) in order to timely meet the needs of vulnerable individuals with acute or chronic health conditions or disabilities **Relocation Centers** **Schisto** (Attica): operational **Diavata** (Thessaloniki): to be operational by the end of February or beg of March **OLTH** (Port of Thessaloniki): to be operational by the end of February or beg of March **Pre-repatriation Centers** Two centers in Attica (Amygdaleza and P.Ralli) *medical and mental support on a daily basis by Hellenic CDC One center in Korinthos *medical support on a daily basis by HCDC, MSF, Health Center of Loutraki **Open Reception Centers** Eleonas: 24/7 medical support (HCDC, MSF, WAHA) Elliniko: 12/7 medical support (HCDC, MDM) – on call for 24/7 Since 2012, Giatroi tou Kosmou – Médecins du monde (MdM EL) has been present on these islands with medical teams providing medical services (…) Police, Coast Guards and municipal, regional and national authorities as well as civil society actors have allocated additional staff and resources. However, insufficient public infrastructure, staffing shortages and lack of resources within the Greek territory make it impossible to meet all the needs of this vulnerable population (MdM, Annex 1)

	Health reform program in Greece: total health expenditures dropped by 31.9%, source: Barriers and facilitating factors in access to health services in Greece, WHO 2015, in: MdM, Annex 1) MdM Greece is also operating a mobile unit in the transit area of Idomeni, close to the border with FYROM. (MdM, Annex 1)
First entry assistance services	The reception, registration and asylum system in Greece fall under the responsibility of the Greek State. In 2011, the "First Reception Service" (FRS) was established by Law 3907/2011, with the objective to register and refer asylum-seekers and migrants to competent authorities. The onset of the emergency and increasing numbers of refugees and migrants strained the already limited resources of the Greek authorities, affecting their capacity to ensure immediate and sufficient presence, ownership and a centralized response to the situation. The lack of first-line reception capacity led to thousands of new arrivals sleeping rough on the islands and in Athens in the first months of the emergency. The identification of suitable reception sites was challenging and lengthy. Eventually, the Greek authorities made sites available on Lesvos, Chios, Kos, Leros and Samos to accommodate refugees and migrants pending their registration. The existing first reception sites still lack sufficient capacity, they do not meet basic assistance and protection standards,and availability of services such as WASH and health care is limited. (REGIONAL REFUGEE AND MIGRANT RESPONSE PLAN FOR EUROPE (. EASTERN MEDITERRANEAN AND WESTERN BALKANS ROUTE, 2016 UNHCR) Basic health care services have been provided to migrants by the Spanish RC Emergency Response Units (ERUs) in Samos and Chios since October, and the Norwegian/French/Canadian Red Cross Societies` ERU in Idomeni as of October 2015. (¿?) To date, all ERUs have been or are in the process of handing-over their operations to the HRC, which will continue to ensure basic health care to migrants in these locations both through existing and newly recruited local staff. **NGOs at the entry points of refugees provide:** - First aid - Triage/ screening for serious health problems - Curative clinical care (mobile or stationary) - Provision of basic NCD medication - Health card/booklet provided - Clinical management of SGBV - Link to pre-defined referral hospital, including for comprehensive emergency obstetric care - Encourage continuation of breastfeeding - Hygiene kits, health kits etc. - Ambulance services available/ accessible

Response to 'An Agenda for Action' as agreed during the High Level Meeting on Refugee and Migrant Health in Rome in November 2015:
Cross the appropriate 'Yes', 'No' or 'There is no information available' option in the blue boxes. Additional information or sources can be mentioned underneath the box.

Integration of the health care services for refugees, asylum seekers end migrants into the existing national health systems	x Yes	 No	 There is no information available
Limit initial screening upon arrival to relevant risk assessment	x Y es	 No	 There is no information available
Non Communicable Diseases included in the provision of services	x Yes	 No	 There is no information available
Active participation and empowerment of the refugees and migrants throughout all stages of health service provision, including design and planning	 Yes	x No	 There is no information available
Training of health professionals involved in the provision of health care	x Yes	 No	 There is no information available

3. WHERE-WHAT-WHO			
Please correct or complete the information where possible.			
Migrant group	**WHERE are they receiving the health care?**	**WHAT type of health care provision are they receiving?**	**WHO is the actor/agency providing the health care?**
(1) Recent arrivals	During the reporting period there was a notable number of people in poor health conditions due to exhaustion from the journey and the living conditions after arrival.194 There are medical groups in all sea locations run by NGOs who provide consultations and medication, while difficult cases are referred to the hospital.195 (FRA Monthly Review Dec 2015). UNHCR and IOM are monitoring first-line reception procedures in border locations on the islands and the mainland. • UNHCR, IOM, NGOs, volunteer organizations and the local population are present on the coasts of the islands to receive the refugees and migrants and provide basic assistance and services, including medical care. UNHCR and NGOs support the Hellenic Coast Guard and the local authorities in cases of shipwreck, including psychosocial support, facilitation of family reunification and communication between family members who were separated during the rescue operation, and medical referrals. Hellenic Red Cross (HRC) is increasing its support in Athens, specifically at the transit centres which are opened and managed by the Greek government.	IFRC has extended the timeframe of the Greece emergency operation until September 2016 to provide on-going assistance to migrants and strengthen the efforts of the HRC in this regard. IOM, in coordination with the First Reception Service is operating the open reception centre in Athens to accommodate vulnerable migrants (single parent families, pregnant women, unaccompanied children, the elderly, and those withmedical needs) wishing to return to their country of origin. The reception centre accommodates up to 110 migrants. Currently, the centre is hosting approximately 80 migrants, mainly from Morocco, who have been registered and are booked to return next week. In addition relocation services to a total of 157 refugees who were relocated to other EU Member States as part of the EU relocation program (Table 1). IOM implements this service in cooperation with the Asylum Service who is responsible for the selection procedure. IOM delivers pre-departure assistance and cultural orientation sessions. IOM also provides pre-departure medical examinations and escorts to final destinations, as necessary. (IOM - situation report 28 January) **<u>Reception Centre of Elaionas</u>**	Partner National Societies German Red Cross's support of relief goods Danish Red Cross supporting health services in the northern area of Lesvos with hygiene promotion, PSS activities and RFL services British Red Cross has been supporting HRC in water and sanitation and distribution of food, water and hygiene kits, and is now looking into supporting the start-up of cash transfer programming. ICRC continues to collaborate with HRC and IFRC on RFL support, forensic advisory services as well as monitoring visits to immigration detention centres throughout Greece. Swiss Red Cross is currently supporting the salary of a HRC migration officer based in Lesvos and supported with a logistics delegate. Additional human resources support as staff on loan to the IFRC has been provided by the Australian Red Cross Belgian Red Cross and Luxemburg Red Cross with field coordinators Norwegian Red Cross with a Head of Country Office. An RDRT from the Palestine Red Crescent was deployed in coordination with the Middle East and Norther Africa Region to support PSS activities. source: Information bulletin IFRC Regional Office for Europe Migration response. IFRC. http://www.ifrc.org/docs/Appeals/16/IB6_Migration%20response_Europe_010216.pdf

	source: Information bulletin IFRC Regional Office for Europe Migration response. IFRC. http://www.ifrc.org/docs/Appeals/16/IB6_Migration%20response_Europe_010216.pdf In the **Hotspots** of Lesvos and Chios: MDM conducts First Health Screenings and Triage (FHST) in order to timely meet the needs of vulnerable individuals with acute or chronic health conditions or disabilities **Registration - Reception Centers** MDM, Medin (Samos), Praksis conducts First Health Screenings and Triage (FHST) in order to timely meet the needs of vulnerable individuals with acute or chronic health conditions or disabilities **<u>Open Reception Centers in Athens</u>** Eleonas: 24/7 medical support (HCDC, MSF, WAHA) Elliniko: 12/7 medical support (HCDC, MDM) – on call for 24/7 **Various governmental and nongovernmental stakeholders are providing health care services to newly arriving migrants in Greece.** • **Mobile Units** (HCDC, MSF, MDM, PRAKSIS, WAHA) in the main entry points of refugee influx (islands of Eastern Aegean and in the south of the country) • **Emergency Medicine Unit:** in Lesvos (Rural Health Center, WAHA) • **Emergency medicine boats:** supporting the rescuing operations of the coast guard (local fishermen and medical teams from NGOs)	**Hellenic CDC/MSF/WAHA**: operate morning and afternoon shifts respectively in the ambulatory clinic of the open reception Centre of Elaionas in the Centre of Athens. **Primary health care services** are provided for free, **emergencies are referred to on-call hospitals in Athens**. Provision of **dental care** is available 2 days per week. **PFA:** one a week by the **Hellenic Association of Psychologists** **<u>Reception Centre of Ellinko</u>** **Hellenic CDC/MdM**: operate morning and afternoon shifts respectively in the ambulatory clinic of the open reception Centre of Elliniko in the South suburbs of Athens. **Primary health care services** are provided for free, **emergencies are referred to on-call hospitals in Athens.** **PFA**: twice a week by the **Hellenic Association of Psychologists** **<u>Pre-repatriation centre of Korinthos</u>** **Hellenic CDC/MSF/Health Center of Loutraki**: operate alternate days the ambulatory clinic providing **Primary health care services**, **emergencies are referred to on-call hospitals** **<u>Pre-repatriation centre of Amygladeza in Attiki</u>** **Hellenic CDC:** operates ambulatory clinics in the pre-repatriation Centre of Amygladeza in Attiki and in the Immigration department of the Hellenic Police, providing **Primary health care services**, **emergencies are referred to on-call hospitals** **NGOs at the entry points of refugees provide:** - First aid - Triage/ screening for serious health problems	-In order to ensure protection-centred humanitarian assistance and access to basic services to new arrivals, UNHCR,IOM and NGOs will continue to provide food, NFIs, WASH facilities, health care, including reproductive health care for women and girls, and psycho social services at the assembly sites, the first reception sites and the temporary accommodation sites in Athens. Services will focus on and be tailored to serve those with specific needs, including specific medical aid services for SGBV survivors, such as provision of PEP kits and clinical management of rape (REGIONAL REFUGEE AND MIGRANT RESPONSE PLAN FOR EUROPE, 2016 UNHCR) **On call Hospitals of National Health System** **Rural Health Centers** **Hellenic CDC** **Hellenic Association of Psychologists** **MDM, MSF, WAHA, BOAT REFUGEE FUNDATION, SAVE THE CHILDRE, HUMAN APPEAL INTERNATIONAL, MEDIN, ADVENTISHELP, PRAKSIS, IMC, ITERNATIONAL RESQUE COMMITTEE**

	• **Stationary medical units:** in temporary reception centers, on the Greek Islands and at Eidomeni borders (MSF, MDM, WAHA) • **Medical teams on board**, supporting populations transferred by Ferries to Athens (MSF) • **Provisional health consultation office**, near Victoria Square in Athens (MSF)	- Curative clinical care (mobile or stationary) - Provision of basic NCD medication - Health card/booklet provided - Clinical management of SGBV - Link to pre-defined referral hospital, including for comprehensive emergency obstetric care - Encourage continuation of breastfeeding - Hygiene kits, health kits etc. - Ambulance services available/ accessible	
(2) People in transit	**<u>Relocation Centers</u>** Schisto (Attica): operational Diavata (Thessaloniki): to be operational by the end of February or beg. of March OLTH (Port of Thessaloniki): to be operational by the end of February or beg. of March **<u>Open Reception Centers in Athens</u>** Eleonas: 24/7 medical support (HCDC, MSF, WAHA) Elliniko: 12/7 medical support (HCDC, MDM) – on call for 24/7	Hellenic Red Cross HRC's support on both levels includes the provision of relief items which are constantly being adapted to make them more relevant, light weight and portable; health services; RFL and community engagement. source: Information bulletin IFRC Regional Office for Europe Migration response. IFRC. http://www.ifrc.org/docs/Appeals/16/IB6_Migration%20response_Europe_010216.pdf Services provided: - First aid - Triage/ screening for serious health problems - Curative and preventive clinical care - Provision of basic NCD care - Provision of basic NCD medication - Encourage continuation of breastfeeding - Hygiene kits, health kits etc. - Ambulance services available/ accessible	**Hellenic CDC:** Medical, Nursing and Mental health professionals hired by the Hellenic CDC in the framework of an Internal Security Fund (ISF) are placed in the Aegean islands to support health care needs in view of the increased migration flows. MSF, MDM, WAHA

(3) Asylum seekers	**Access to NHS as per the national population** (for as long as their application for asylum is under review)	**Access to NHS as per the national population** (for as long as their application for asylum is under review) The reception, registration and asylum system in Greece fall under the responsibility of the Greek State. In 2011, the "First Reception Service" (FRS) was established by Law 3907/2011, with the objective to register and refer asylum-seekers and migrants to competent authorities. Those seeking asylum had to express their wish to the Greek Asylum Service. Prior to the emergency, UNHCR and IOM were present on the islands and throughout the mainland in support of the authorities. UNHCR provided material assistance and legal information on asylum and other procedures to the new arrivals arrested and screened by the authorities and who were to be registered by the FRS. Since August 2015, UNHCR and IOM provided information to newly arrived refugees and migrants in the First Reception Centre in Lesvos and the Mobile Unit of the FRS in Samos on their rights and obligations as well as on AVRR. Insufficient resources made the effective functioning of the FRS challenging however, even prior to the emergency.	**Access to NHS as per the national population** (for as long as their application for asylum is under review)
(4) Refugee status granted	**Access to NHS as per the national population**	**Access to NHS as per the national population**	**Access to NHS as per the national population**
(5) Undocumented migrants	**<u>Pre-repatriation Centers</u>** Attica (Amygdaleza and P.Ralli) *medical and mental support on a daily basis by Hellenic CDC Korinthos *medical support on a daily basis by HCDC, MSF, Health Center of Loutraki	Officially, unregistered/undocumented migrants in Greece cannot access public health services (Legal report on access to healthcare in 12 countries, Macherey A-L, Vanbiervliet F., Simonnot N. Doctors of the World 3rd June 2015 – www.mdmeuroblog.wordpress.com , in MdM, Annex 1) **Referrals to NHS only for emergences**	**MSF**, **HCDC, National Health Units**

		Health Services Provided - First aid - Curative and preventive clinical care - Provision of basic NCD care - Provision of basic NCD medication - Ambulance services available/ accessible	
(6) Unaccompanied minors	**Access to NHS as per the national population**	**Access to NHS as per the national population**	**Access to NHS as per the national population**

4. FUNDING OF THE HEALTH CARE RESPONSES

Please provide us with any relevant information of funding made available by your country or other partners for health care responses:

- *FUNDING SOURCES: where does the funding come from? e.g. Government, UN agency (UNHCR, IOM, WHO Euro,…), EU, NGO, civil society organisation, faith-based organisation, private organisation, international donor, (public/private) health insurance, other (please specify)*
- *FUNDING MECHANISM: how is the health care delivery being funded? e.g. envelope (for whole year/project), lump sum amount per asylum. seeker/refugee, out-of-pocket expenses, third payer mechanism, emergency/contingency budget.*
- *FUNDING AMOUNT: Give the amount spent on health care responses, in Euros, per year/month; if available also provide the pledged amount.*
- *COMMENTS.*

Migrant group	Funding source	Funding mechanism	Funding amount	Comments
(1) Recent arrivals	**EU-ISF**	**EMERGENCY /CONTIGENCY BUDGET**	**3.270.529,90€/ for a period of 8 months**	**« Immediate reinforcement of NHS regarding Migration crisis faced by the Estearned Aegean Islands":** Medical, Nursing and Mental health professionals (141 HPs) are hired by the Hellenic CDC and placed in the NHS of Eastern Aegean islands in order to support health care needs in view of the increased migration flows.
	EU- CHAFEA- DG SANTE	**Health Program for 2016**	**1,694,352€/ for 12 months**	**"Care, Common Approach for Refugees and other migrants**

				health" Project: The Hellenic CDC is a collaborating partner in the EU project CARE with the task to organize syndromic surveillance activities from the hotspots, which will allow for hiring a small number of HPs for 12 months. **Status: Grant Agreement pending** **16 partners from Greece, Italy, Slovenia, Malta, Hungary**
	EU- CHAFEA- DG SANTE	**Third Program for the Union's action in the field of health (2014-2020)**	**1,320,113 €/ for 12 months**	**"EU-HUMAN" ("EUropean Refugees - HUman Movement and Advisory Network")** **Participating countries: Austria, Croatia, Greece, Italy, Hungary, the Netherlands, Slovenia, UK**
(2) People in transit				
(3) Asylum seekers				
(4) Refugee status granted				
(5) Undocumented migrants				

Programme co-funded by the EUROPEAN UNION

National coordination of the health care response to refugees, asylum seekers and other migrants: *Working document*

HUNGARY

READER'S GUIDE:

The SH-CAPAC consortium is conducting a mapping of the European Union Member States' health response to the refugees, asylum seekers and other migrants entering, transiting or staying in their territories.

This working document summarizes the latest information on the influx of the different categories (see box 1 on Country Context) and on the coordination of the health care responses (see box 2) in Hungary. It also maps the available information on the WHERE-WHAT-WHO of these health care responses (see box 3). This is done for different categories: (1) recent arrivals, (2) people in transit, (3) asylum seekers, (4) refugee status granted persons, (5) undocumented migrants, and where relevant, also for (6) unaccompanied minors. Lastly we would like to map the funding sources for which the Member State's input is appreciated (see box 4 on Funding of health care responses).

The information already completed below is based on different sources which were consulted online between January 20 and February 8 2016 and which is meant to give a first snapshot. ***We would like to ask you to verify the information, to correct and amend where necessary and to complete where possible.*** *This mapping exercise will help the SH-CAPAC consortium to define a framework for effective health sector coordination for addressing the needs of the refugees, asylum seekers and other migrants in the European Union.* ***Please reply before February 16 2016 to ainhoa.ruiz.easp@juntadeandalucia.es with copy to birgit.kerstens@gmail.com and daniel.lopez.acuna.ext@juntadeandalucia.es.*** *More information on the SH-CAPAC project can be found in the leaflet in attachment and on www.easp.es/sh-capac.*

Sources consulted:
Eurostat 2/02/2016.

http://data.unhcr.org/mediterranean/documents.php?page=1&view=grid&Country[]=95&Type[]

MdM, Médecins du Monde. 8 NGOs for migrants/refugees' health in 11 countries. Project 717307. Annex I (part B), 2016.
FRA, European Union Agency for Fundamental Rights. Monthly data collection on the current migration situation in the EU. December 2015 monthly report. 23 November – 31 December 2015. http://fra.europa.eu/sites/default/files/fra_uploads/fra-2016-monthly-compilation-com-update-1_en.pdf

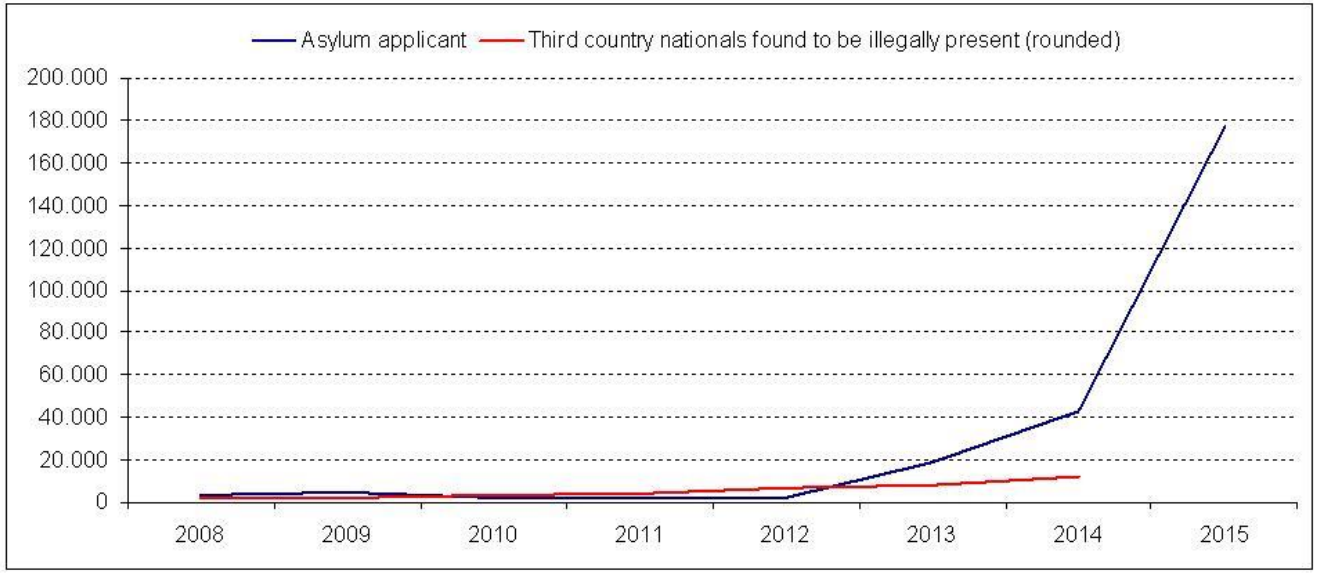
http://www.unhcr.org/pages/4a02d9346.html

UNHCR. Refugees/Migrants Emergency Response – Mediterranean

(FRA Monthly Review Dic 2015)

Please provide us with any other sources that you deem appropriate for your country.

1. COUNTRY CONTEXT

When influx started **(*by year up till 2015, month since 2015*)**	 *Eurostat 2/02/2016.* *(please complete or correct)*
Current number as of Feb 1 ***(AS/ REF/ UDM/ unaccompanied minors)***	A. **Most recent data per category:** According to UNHCR From 01 January 2015 to 20 January 2016, a total of 391,632 migrants and asylum seekers were registered arriving in Hungary. Due to the barbed-wire fence in place along the Serbian and Croatian border,

	there have been reduced numbers of arrivals since 17 October 2015. From 14 to 20 January 2016, 142 new arrivals were registered by the authorities, bringing the total for this year to 248 registered arrivals Source: http://data.unhcr.org/mediterranean/documents.php?page=1&view=grid&Country[]=95&Type[]=3) There were hopes that the relocation scheme would result in a more even distribution of asylum seekers across the 28 EU member states. Since the agreements by the European Council in September 2015 to relocate a total of 160,000 asylum seekers from the "front-line" states of Greece and Italy to other EU states over two years, only 414 asylum seekers have been relocated in the past four months.* Hungary is challenging in court the quotas they are supposed to receive. source: Information bulletin IFRC Regional Office for Europe Migration response. IFRC. http://www.ifrc.org/docs/Appeals/16/IB6_Migration%20response_Europe_010216.pdf *As of 25 January 2016: 14 to Belgium, 140 to Finland, 62 to France, 21 to Germany, 10 to Ireland, 4 to Lithuania, 30 to Luxembourg, 50 to Netherlands, 26 to Portugal, 18 to Spain and 39 to Sweden) From 01 January 2015 to 27 January 2016, a total of 391,762 migrants and asylum seekers were registered arriving in Hungary. Due to the barbed-wire fence in place along the Serbian and Croatian borders, there have been reduced numbers of arrivals since 17 October 2015. From 21 to 27 January 2016, 130 new arrivals were registered by the authorities, bringing the total for this year to 378 registered arrivals. B. **Most recent data on total number**: 204.000 entered into Hungary the first three quarters of 2015 (Frontex http://frontex.europa.eu/news/710-000-migrants-entered-eu-in-first-nine-months-of-2015-NUiBkk in MdM, Annex 1) Hungary closed its borders with Serbia and with Croatia on 17/10/2015 (MdM, Annex 1) Between 23 November and 31 December 2015, 561 people crossed the border into Hungary, mostly through the borders with Serbia. No one entered the country through the borders with Croatia. (FRA Monthly Review Dic 2015)
Percentage of F/M/T, age groups and origin	A. **Most recent data per category:**

Between 23 November and 31 December 2015, 561 people crossed the border into Hungary, mostly through the borders with Serbia. No one entered the country through the borders with Croatia. Of the 561 new arrivals 442 were men, 119 women. There were 43 persons under 18 years old, six of them were unaccompanied children.209
Between 1 January and 31 December 2015, the Police registered 391,384 new arrivals. Most of them came from Syria, Afghanistan, Pakistan and Iraq. In 2015, the Police also apprehended a large number of nationals from Kosovo and Albania. The vast majority of the new arrivals in 2015 came from the Serbian and the Croatian borders.210

In relation to asylum applications, 287 people applied for asylum during the reporting period.211 Asylum seekers were from Afghanistan (103), Pakistan (31), Syria (23), Somalia (21), and other countries.21 (…)
Between 23 November and 31 December 2015, the Office of Immigration and Nationality made 63 positive asylum decisions and 226 negative decisions (rejecting asylum claims). In 15,070 cases the Office terminated the process, as the applicants had left the country.214
The total number of asylum applications filed in 2015 (between 1 January and 31 December) was 177,134. In 542 cases (0,3 %) the Office made a positive decision granting asylum status to the claimants. In 2,910 cases (1,6 %) the Office rejected the claims. The Office terminated the procedures in 145,117 cases (82 %), as the applicants had left the country. All other procedures are ongoing, however, it is likely that the majority of them will be terminated soon as the applicants had already left the country.215
(FRA Monthly Review Dic 2015)
The most common countries of origin in descending order are: Syria, Afghanistan Pakistan, and Iraq. Source: http://data.unhcr.org/mediterranean/documents.php?page=1&view=grid&Country[]=95&Type[]=3

ASYLUM APPLICANT	2014	2015
Total	42.775	177.135
Males	76,4%	79,4%
Females	23,6%	20,6%
Less than 18 years	27,7%	25,9%
18 - 64 years	72,1%	73,9%
65 years or over	0,2%	0,2%
Unaccompanied minors (Asylum applicant)	605	
Males	98,3%	
Females	2,5%	
IRREGULAR MIGRANT	12.160	
Males	82,8%	
Females	17,2%	

Less than 18 years	10,9%	
18 years or over	89,1%	

Source: Eurostat, 2/02/2016.

Residing in Hungary [1]	At june 2015
Refugees [2]	4,192
Asylum Seekers [3]	24,431
Returned Refugees [4]	0
Internally Displaced Persons (IDPs) [5]	0
Returned IDPs [6]	0
Stateless Persons [7]	128
Various [8]	0
Total Population of Concern	28,751
Originating from Hungary [1]	
Refugees [2]	1,303
Asylum Seekers [3]	1,645
Returned Refugees [4]	0
Internally Displaced Persons (IDPs) [5]	0
Returned IDPs [6]	0
Various [8]	3
Total Population of Concern	2,951

source: http://www.unhcr.org/cgi-bin/texis/vtx/page?page=49e48dd76&submit=GO

B. **Most recent data by gender, age group, origin**:

2. HEALTH CARE RESPONSES			
Please correct or complete the information where possible.			
Health care coordination at national/regional level	A. **Existence of a national coordination mechanism of the health response**: YES/NO *(Please complete)* B. **Explanation**: *(if yes, please describe how the mechanism works and who participates; if no, please describe why there is no coordination)* Before the closing of the Croatian-Hungarian border, the NGO Menedék – partner in the European network to reduce vulnerabilities in health (cf. supra) – assisted about 6,000 persons. Menedék maintains its monitoring activities at the borders with Croatia and Serbia with mobile teams, and is ready to intervene again (giving information on asylum procedures in Hungary, mediation between the police and migrants, identifying the most vulnerable groups and referring them to relevant services such as child protection or legal aid). However, at the time the current proposal was drafted, the large majority of migrants had all been transferred to Austria (MdM, Annex 1)		
First entry assistance services			
Response to 'An Agenda for Action' as agreed during the High Level Meeting on Refugee and Migrant Health in Rome in November 2015: *Cross the appropriate 'Yes', 'No' or 'There is no information available' option in the blue boxes. Additional information or sources can be mentioned underneath the box.*			
Integration of the health care services for refugees, asylum seekers end migrants into the existing national health systems	Yes	No	There is no information available
Limit initial screening upon arrival to relevant risk assessment	Yes	No	There is no information available
Non Communicable Diseases included in the provision of services	Yes	No	There is no information available

Active participation and empowerment of the refugees and migrants throughout all stages of health service provision, including design and planning	Yes	No	There is no information available
Training of health professionals involved in the provision of health care	Yes	No	There is no information available

3. WHERE-WHAT-WHO			
Please correct or complete the information where possible.			
Migrant group	**WHERE are they receiving the health care?**	**WHAT type of health care provision are they receiving?**	**WHO is the actor/agency providing the health care?**
(1) Recent arrivals	In the open reception centres and closed detention facilities of the Office of Immigration and Nationality, the healthcare provided to people is satisfactory. People in alien police detention, however, get only basic medical care(FRA Monthly Review Dic 2015)	There were no complaints about the availability of healthcare services and medication. Even more serious medical conditions are treated properly, either on site or in hospitals of the city nearby(FRA Monthly Review Dic 2015)	civil society organisations experienced that detention clinics could not provide professional medical assistance to those with more serious medical conditions. (FRA Monthly Review Dic 2015)
(2) People in transit			
(3) Asylum seekers			
(4) Refugee status granted			
(5) Undocumented migrants			
(6) Unaccompanied minors			

4. FUNDING OF THE HEALTH CARE RESPONSES
Please provide us with any relevant information of funding made available by your country or other partners for health care responses:

- *FUNDING SOURCES: where does the funding come from? e.g. Government, UN agency (UNHCR, IOM, WHO Euro,…), EU, NGO, civil society organisation, faith-based organisation, private organisation, international donor, (public/private) health insurance, other (please specify)*
- *FUNDING MECHANISM: how is the health care delivery being funded? e.g. envelope (for whole year/project), lump sum amount per asylum. seeker/refugee, out-of-pocket expenses, third payer mechanism, emergency/contingency budget.*
- *FUNDING AMOUNT: Give the amount spent on health care responses, in Euros, per year/month; if available also provide the pledged amount.*
- *COMMENTS.*

Migrant group	Funding source	Funding mechanism	Funding amount	Comments
(1) Recent arrivals				
(2) People in transit				
(3) Asylum seekers				
(4) Refugee status granted				
(5) Undocumented migrants				

Programme co-funded by the EUROPEAN UNION

National coordination of the health care response to refugees, asylum seekers and other migrants: *Working document*

ITALY

READER'S GUIDE:

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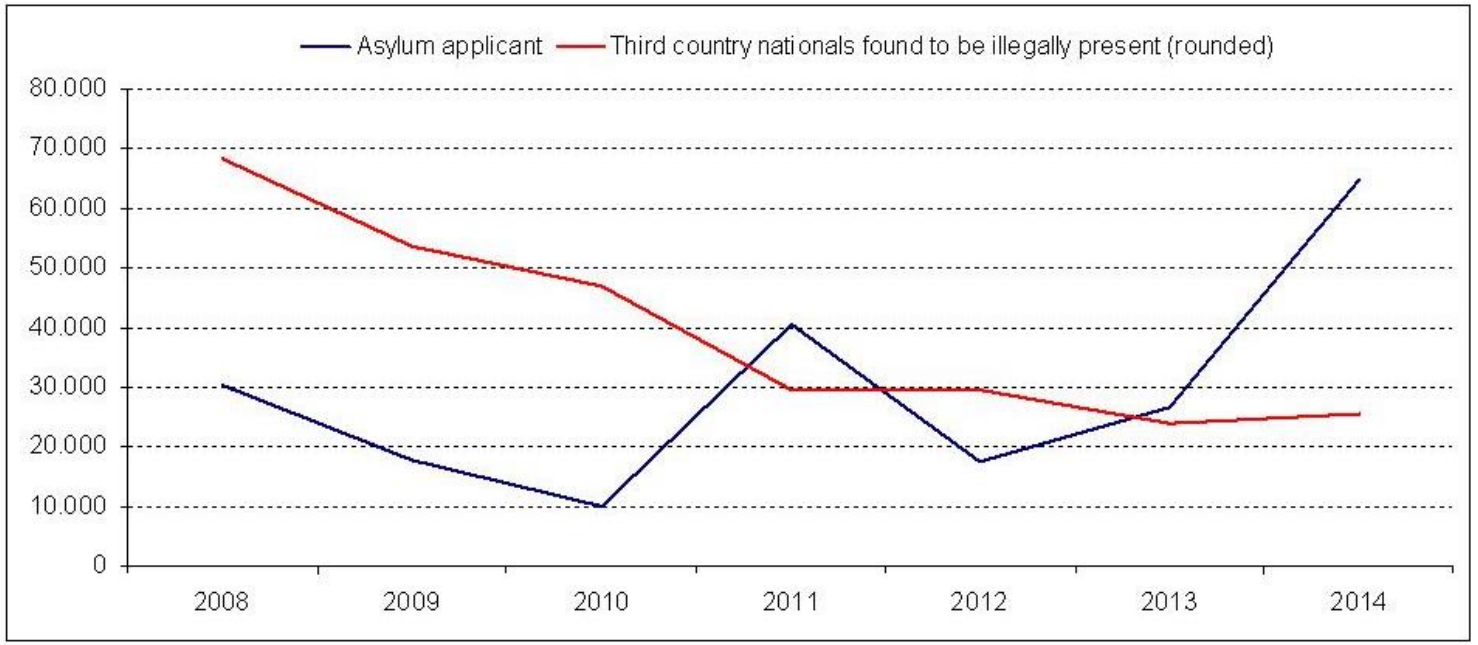
Sources consulted:

- European Commission (2016a). Managing the Refugee Crisis. State of play and future actions, January 2016. http://ec.europa.eu/dgs/home-affairs/what-we-do/policies/european-agenda-migration/background-information/docs/eam_state_of_play_and_future_actions_20160113_en.pdf
- European Commission (2016b). Member states' Support to Emergency Relocation Mechanism. http://ec.europa.eu/dgs/home-affairs/what-we-do/policies/european-agenda-migration/press-material/docs/state_of_play_-_relocation_en.pdf
- EUROSTAT (2016). Statistics 02/02/2016. http://ec.europa.eu/eurostat
- FRA, European Union Agency for Fundamental Rights (2015). Monthly data collection on the current migration situation in the EU. December 2015 monthly report. 23 November – 31 December 2015. http://fra.europa.eu/sites/default/files/fra_uploads/fra-2016-monthly-compilation-com-update-1_en.pdf
- Frontex (2015). 710 000 Migrants entered EU in first nin months of 2015. http://frontex.europa.eu/news/710-000-migrants-entered-eu-in-first-nine-months-of-2015-NUiBkk

- IFRC, International Federation of Red Cross and Red Crescent Societies (2016). Information Bulletin IFRC Regional Office for Europe Migration response, 2016. http://www.ifrc.org/docs/Appeals/16/IB6_Migration%20response_Europe_010216.pdf
- IOM, International Organization for Migration (2015). Mediterranean Update. Missing Migrants Project: 13 November 2015. http://missingmigrants.iom.int/sites/default/files/Mediterranean_Update_13_November.pdf
- IOM, International Organization for Migration (2016). Flow Monitoring Compilation, 28 January 2016.
- MdM, Médecins du Monde (2016). 8 NGOs for migrants/refugees' health in 11 countries. Project 717307. Annex I (part B).
- UNHCR, The UN Refugee Agency (2015a). 2015 UNHCR subregional operations profile: Northern, Western, Central and Southern Europe – Italy. http://www.unhcr.org/cgi-bin/texis/vtx/page?page=49e48e996&submit=GO
- UNHCR, The UN Refugee Agency (2015b). 2015 UNHCR regional operations profile – Europe. http://www.unhcr.org/cgi-bin/texis/vtx/page?page=49e48e996&submit=GOUNHCR, The UN Refugee Agency. 2015 UNHCR subregional operations profile: Northern, Western, Central and Southern Europe – Italy, 2015a. http://www.unhcr.org/cgi-bin/texis/vtx/page?page=49e48e996&submit=GO
- UNHCR, The UN Refugee Agency (2016). Refugees / Migrants Emergency Response – Mediterranean. http://data.unhcr.org/mediterranean/country.php?id=105
- WHO-Europe, World Health Organization – Europe (2011). Increased influx of migrants in Lampedusa, Italy. Joint report from the Ministry of Health, Italy and the WHO Regional Office for Europe mission of 28–29 March 2011. http://www.euro.who.int/__data/assets/pdf_file/0004/182137/e96761.pdf?ua=1

Please provide us with any other sources that you deem appropriate for your country.

1. COUNTRY CONTEXT	
When influx started (***by year up till 2015, month since 2015***)	*(please complete or correct)* In the first seven months of 2014, more than 87,000 people arrived in Italy by sea, mainly from Eritrea and the Syrian Arab Republic (Syria). From 01 January 2015 to 20 January 2016, an estimated 154,449 migrants and asylum seekers were registered arriving in Italy. These figures are reached by adding numbers circulated by the Ministry of Interior, which go up to 31 December 2015, to numbers of arrivals from 1 January 2016 onwards, which are estimated by IOM staff in the landing areas. From 14-20 January 2016, IOM staff in the landing areas estimated that 235 migrants and asylum seekers had arrived in Italy, bringing the cumulative total for this year to 607 estimated arrivals. (UNHCR 2015a)



(Eurostat 2016)

129.000 migrants entered into Italy the first three quarters of 2015.
(Frontex 2015 in MdM 2016)

Current number as of Feb 1 ***(AS/ REF/ UDM/ unaccompanied minors)***	A. **Most recent data per category**: 5,326 arrivals by sea in 2016 153,842 arrivals in 2015 8% or arrivals are unaccompanied minors (UNHCR 2016) 129.000 migrants entered into Italy the first three quarters of 2015 (Frontex 2015 in MdM 2016)

	According to the latest report of the International Organization for Migration (IOM)17, 141,777 migrants had arrived in Italy by 13th of November 2015 through the Mediterranean Sea. Eritrea, Nigeria and Somalia are among the most highly represented countries of origin among the migrants arriving by sea – only 7,232 Syrians arrived. (IOM 2015 in MdM 2016) According to the latest report of the International Organization for Migration (IOM)17, 141,777 migrants had arrived in Italy by 13th of November 2015 through the Mediterranean Sea. Eritrea, Nigeria and Somalia are among the most highly represented countries of origin among the migrants arriving by sea – only 7,232 Syrians arrived (http://missingmigrants.iom.int/sites/default/files/Mediterranean_Update_13_November.pdf , in MdM, Annex 1) Throughout 2015, more than 27,900 migrants have directly arrived in the ports of Calabria or have been relocated there immediately after their arrival on the Sicilian coast. Up to today, over 5,000 migrants are in first reception centres and many hundreds of “transit migrants” are not registered, waiting to go to other European countries. (MdM 2016) The overall number of arrivals in the considered period is 10,137 persons.270 Several rescue at sea operations took place in the Central Mediterranean. On 24 November, Italian Navy ship “Duilio” rescued 116 people.271 On 5 December, MSF declared to have rescued about 4600 people in 31 rescue operations at sea in the previous three days.272 On the same day, the Italian Navy ship “Cigala Fulgosi” rescued 301 immigrants and brought them to the port of Catania (Sicily).273 The MSF ship “Argos” disembarked 526 rescued persons in Pozzallo on 4 December.274 On the same day, the ship “Corsi” rescued 127 people.275 On 6 December the Norwegian ship “Siem Pilot” disembarked 906 people in Calabria.276 On the same day, 233 people have been rescued by ship “Diciotti”.277 In the Ionian Sea on 7 December 2015, 603 migrants were rescued in Taranto (Apulia) by the Italian Navy ship “Aviere 603”. Among them, there were 480 men, 105 women, and 18 children, some of them unaccompanied. According to data provided by the local Prefecture Office, 200 of them were hosted in local reception centres, while all the others were sent to reception centres located in other Italian regions (Emilia-Romagna, Tuscany, Lombardy, Veneto, Piedmont, Lazio, and Campania).278 (FRA 2015) Residing in Italy [1]Refugees [2] 93,715 Figure refers to the end of 2014 in the absence of updated information available.Asylum Seekers [3] 48,307Returned Refugees [4] 0Internally Displaced Persons (IDPs) [5] 0Returned IDPs [6] 0Stateless Persons [7] 606Various [8] 0Total Population of Concern 142,628Originating from Italy [1]Refugees [2] 68Asylum Seekers [3] 137Returned Refugees [4] 0Internally Displaced Persons (IDPs) [5] 0Returned IDPs [6] 0Various [8] 0Total Population of Concern 205. (UNHCR 2015a)

	From 01 January 2015 to 20 January 2016, an estimated 157,083 migrants and asylum seekers were registered arriving in Italy. These figures are reached by adding numbers circulated by the Ministry of Interior, which go up to 31 December 2015, to numbers of arrivals from 1 January 2016 onwards, which are estimated by IOM staff in the landing areas. From 21-27 January 2016, IOM staff in the landing areas estimated that 2,634 migrants and asylum seekers had arrived in Italy, up from 235 in the previous week. This brings the cumulative total for this year to 3,241 estimated arrivals. (IOM 2016) B. **Most recent data on total number**:
Percentage of F/M/T, age groups and origin	A. **Most recent data per category:** B. **Most recent data by gender, age group, origin**: 11% children, 14% women, 75% men Eritrea 25% Nigeria 14% Somalia 8% Sudan 6% Gambia 5% Syria 5% Senegal 4% Mali 4% Bangladesh 3% Morocco 3% (UNHCR 2016) Additional rescue operations took place around Christmas. On 24 December 2015, 661 migrants were rescued by the MSF ship “Bourbon Argos”, the Italian Navy ship “Cigala Fulgosi”, and the Italian Coast Guard (*Guardia Costiera*) ship “Dattilo”, and disembarked in Augusta (Sicily). Among them, there were 546 men, 103 women, and 12 children. One young man, who has not been identified yet, had died before reaching the Italian shores. Migrants came mostly from Pakistan, Afghanistan, and Sub-Saharan Africa.279 On 28 December 2015, 931 migrants were disembarked in Palermo by the Norwegian ship “Siem Pilot”. Among them, there were 841 men, 64 women (two of whom were pregnant), and 26 unaccompanied children. They were received at the docks by local police authorities, IRC, and Caritas. Healthcare was provided by the local hospital.280 On the same day, 114

migrants coming from New Guinea, Senegal, and Nigeria disembarked in Catania (Sicily) after being rescued by the Italian Navy ship “Dattilo”. They were immediately transferred to reception centres located in northern Italy.281
Relocation procedures continued to be carried out during the reporting period, leading to a total of some 190 asylum seekers departing from Italy to other EU Member States.
(FRA 2015)

ASYLUM APPLICANT	2014
Total	64.625
Males	92,4%
Females	7,6%
Less than 18 years	6,8%
18 - 64 years	93,1%
65 years or over	0,1%
Unaccompanied minors (Asylum applicant)	2.505
Males	98,0%
Females	2,0%
IRREGULAR MIGRANT	25.300
Males	94,1%
Females	5,9%
Less than 18 years	0,8%
18 years or over	99,2%

(Eurostat 2016)

2. HEALTH CARE RESPONSES	
Please correct or complete the information where possible.	
Health care coordination at national/regional level	A. **Existence of a national coordination mechanism of the health response**: YES/NO *(Please complete)* B. **Explanation**: *(if yes, please describe how the mechanism works and who participates; if no, please describe why there is no coordination)* The Calabria region is among the most fragile in terms of supply and management of health services offered to the population. Due to a management that has been considered lacking transparency and ineffective by the Government, the regional health system has been entrusted to the direct supervision of Prefects appointed ad hoc from 2013 onwards. To date the Government has stated that the restructuring process will take time, so that the "Commissariamento" is not expected until 2018. According to data provided by the MoH in August 2015, the number of employees of the Regional Health Service is not sufficient. In October 2015 the Governor of the Region sent a letter to the MoH to emphasize that, despite the work of the Prefects, the basic levels of care are still not always guaranteed, with strong budgetary imbalances. (MdM 2016) In Italy, the Emergency Appeal was revised in November 2015, allowing the IFRC to support the Italian Red Cross to assist up to 105,000 people (increased from 85,000 in the original version) by adding contingency stock provision for 20,000 (including mainly shelter and hygiene items) as a preparedness measure during the ongoing migration crisis that could partially be used for to meet the urgent needs in other affected countries around the region. Currently, the Italian RC is in the process of procuring these stocks in coordination with the Global logistics services of the IFRC. The Italian Red Cross has been focusing its support on the provision of basic food and non-food items; health care; including First Aid and Psychosocial Support; hygiene promotion; Restoring Family Links (RFL) services, as well as building the response capacities of the National Society. (IFRC 2016) In Italy, all key elements of the governance and stewardship building blocks in relation to the preparedness to cope with the consequences of a massive influx of displaced populations are addressed through the Italian Ministry of Interior, with coordination leadership from the local authority for the area of Lampedusa represented by the special commissioner for the immigration emergency, the Prefect of Palermo. Legal frameworks and institutional arrangements are in place, showing a good basis of readiness by the Italian health system to address public health challenges triggered by a potential mass influx of migrants. There is an effective legal framework for multisectoral crisis management arrangements and the public health law and regulations allow for any extraordinary measures necessary to effectively manage a public health emergency. In addition, while the Italian Government has implemented European laws with regard to

	immigration, the Sicilian Regional Government(Italy is divided into administrative regions which hold the responsibility of providing and managing health care. Sicily, constituting one of these regions, holds additional administrative autonomy in the areas of taxation and legislative capacity), after responding to past crises with massive debarking of migrants, issued several law directives aiming to provide "essential and continuative treatment" to the immigrant population. The institutional framework foresees a multisectoral emergency management structure under the "Special Commissioner for the Immigration Emergency". This was activated to coordinate the logistical challenges of managing the emergency immigration in Lampedusa, the transfer of migrants to hospitality centres on the mainland, and repatriations. Preparedness and management efforts of the current situation in Lampedusa are coordinated and led by the Ministry of Interior, the Civil Protection, which falls under the Prime Minister's office, the police, the Armed Forces, the Ministry for Health, and the Regional Health Authorities. In Lampedusa, the Ministry of Interior is also supported through a legal agreement with the United Nations High Commission for Refugees (UNHCR), International Organization for Migration (IOM), Italian Red Cross, and the nongovernmental organizations Médecins Sans Frontières (MSF) and Save the Children. (WHO-Europe 2011)
First entry assistance services	MSF announced its decision to withdraw from the first reception centre (*centro di primo soccorso e accoglienza*, CPSA) in Pozzallo (Sicily) due to the critical reception conditions at the facility, which had already been reported in November 2015.289 MSF criticises the Ministry of Interior for not improving the conditions at the centre, which are detention-like and do not take into account the needs of vulnerable people arriving in Italy.290 The position of MSF was endorsed by a question to the government tabled in the senate on 10 December 2015. The document describes the detention-like conditions at the reception centre, where persons are not allowed to leave the facility even for a few hours and the police carries out thorough and systematic checks at the entrance; international protection procedures are not guaranteed since basic information is not provided and "economic migrants" are hastily distinguished from asylum seekers with no attention paid to their individual history and experience, thus infringing upon the right to international protection. 291 This question was submitted to Parliament by Luigi Manconi, president of the Senate Human Rights Commission, in cooperation with ASGI, Oxfam, MSF, and the association A buon diritto.292 The Lampedusa-based organisation Askavusa has launched a public call for the closure of the Lampedusa reception centre, following the demonstration against forced identification organised by Eritrean asylum seekers living in the centre.293 Along with the closure of this facility, the organisation points to the bad living conditions experienced in the centre, and asks for the possibility for every human being to travel across European borders without being forced to identification. The organisation also advocates for the demilitarisation of the island of Lampedusa, for the suspension of Italy's participation in wars, and for a halt to the production and sale of weapons.294

	(FRA 2015) Main known entry points: In the Channel of Sicily migrants are usually rescued in international waters and brought to the ports of Lampedusa, Sicily (Catania, Augusta, Pozzallo, Porto Empedocle, Trapani, Messina, Palermo) Calabria (Crotone, Reggio Calabria, Vibo, and others) or Apulia (mainly Taranto). Sometimes migrants are also brought to Sardinia (Cagliari), or Campania (Salerno). Main known exit points: Exit points are irregular and therefore little is known about them. IOM Italy estimates that most Syrians and Eritreans and many Sudanese tend to move on to other European countries within 24-48 hours after reaching Italy, while most Sub-Saharan Africans remain in Italy. Lampedusa, Trapani – operational Pozzallo and Porto Empedocle – facilities are ready and the hotspots could be opened quickly pending political decision by Italy Taranto and Augusta – still under preparation and could be operation end of March (European Commission 2016a)

Response to 'An Agenda for Action' as agreed during the High Level Meeting on Refugee and Migrant Health in Rome in November 2015: *Cross the appropriate 'Yes', 'No' or 'There is no information available' option in the blue boxes. Additional information or sources can be mentioned underneath the box.*			
Integration of the health care services for refugees, asylum seekers end migrants into the existing national health systems	Yes	No	There is no information available
Limit initial screening upon arrival to relevant risk assessment	Yes	No	There is no information available
Non Communicable Diseases included in the provision of services	Yes	No	There is no information available
Active participation and empowerment of the refugees and migrants throughout all stages of health service provision, including design and planning	Yes	No	There is no information available
Training of health professionals involved in the provision of health care			There is no

	Yes	No	information available

3. WHERE-WHAT-WHO			
Please correct or complete the information where possible.			
Migrant group	**WHERE are they receiving the health care?**	**WHAT type of health care provision are they receiving?**	**WHO is the actor/agency providing the health care?**
(1) Recent arrivals	First basic medical screening at the dock (MdM 2016)	Most centres are not able to directly offer healthcare to the migrants hosted, so migrants who need care are referred to the National Health system at local level. However, there are strong barriers to access the system. Three barriers: administrative, cross-cultural, lack of specialized services (MdM 2016)	
(2) People in transit		Several associations, including ASGI, MSF, Italian Refugees Council (CIR), UNHCR, and Caritas, sent a letter to the Ministry of Health concerning the exemption from healthcare fees for asylum seekers. Considering that since 1 October 2015 asylum seekers in Italy are not allowed to work during the first two months after the application for international protection and that, after this period of time, they are considered able to pay healthcare fees, unless they demonstrate they are unemployed, the abovementioned associations have asked the Ministry of Health to clarify how this set of rules is consistent with	

Migrant group	WHERE are they receiving the health care?	WHAT type of health care provision are they receiving?	WHO is the actor/agency providing the health care?
		the EU legislation concerning healthcare assistance for asylum seekers. (FRA 2015)	
(3) Asylum seekers			
(4) Refugee status granted			
(5) Undocumented migrants			
(6) Unaccompanied minors			

4. FUNDING OF THE HEALTH CARE RESPONSES

Please provide us with any relevant information of funding made available by your country or other partners for health care responses:

- *FUNDING SOURCES: where does the funding come from? e.g. Government, UN agency (UNHCR, IOM, WHO Euro,…), EU, NGO, civil society organisation, faith-based organisation, private organisation, international donor, (public/private) health insurance, other (please specify)*
- *FUNDING MECHANISM: how is the health care delivery being funded? e.g. envelope (for whole year/project), lump sum amount per asylum. seeker/refugee, out-of-pocket expenses, third payer mechanism, emergency/contingency budget.*
- *FUNDING AMOUNT: Give the amount spent on health care responses, in Euros, per year/month; if available also provide the pledged amount.*
- *COMMENTS.*

Migrant group	Funding source	Funding mechanism	Funding amount	Comments
(1) Recent arrivals				
(2) People in transit				
(3) Asylum seekers				
(4) Refugee status granted				
(5) Undocumented migrants				

Programme co-funded by the EUROPEAN UNION

National coordination of the health care response to refugees, asylum seekers and other migrants: *Working document*

MALTA

READER'S GUIDE:

The SH-CAPAC consortium is conducting a mapping of the European Union Member States' health response to the refugees, asylum seekers and other migrants entering, transiting or staying in their territories.

This working document summarizes the latest information on the influx of the different categories (see box 1 on Country Context) and on the coordination of the health care responses (see box 2) in Malta. It also maps the available information on the WHERE-WHAT-WHO of these health care responses (see box 3). This is done for different categories: (1) recent arrivals, (2) people in transit, (3) asylum seekers, (4) refugee status granted persons, (5) undocumented migrants, and where relevant, also for (6) unaccompanied minors. Lastly we would like to map the funding sources for which the Member State's input is appreciated (see box 4 on Funding of health care responses).

The information already completed below is based on different sources which were consulted online between January 20 and February 8 2016 and which is meant to give a first snapshot. ***We would like to ask you to verify the information, to correct and amend where necessary and to complete where possible.*** *This mapping exercise will help the SH-CAPAC consortium to define a framework for effective health sector coordination for addressing the needs of the refugees, asylum seekers and other migrants in the European Union.* ***Please reply before February 16 2016 to ainhoa.ruiz.easp@juntadeandalucia.es with copy to birgit.kerstens@gmail.com and daniel.lopez.acuna.ext@juntadeandalucia.es.*** *More information on the SH-CAPAC project can be found in the leaflet in attachment and on www.easp.es/sh-capac.*

Sources consulted:

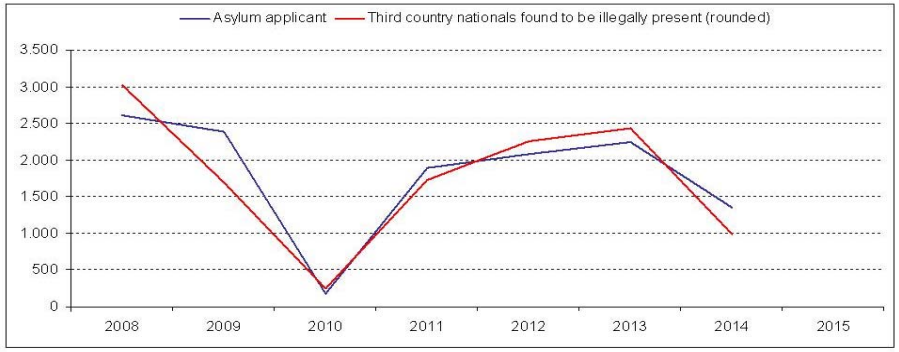
- http://www.unhcr.org/pages/4a02d9346.html
- UNHCR. Refugees/Migrants Emergency Response

Please provide us with any other sources that you deem appropriate for your country.

1. COUNTRY CONTEXT

When influx started
(*by year up till 2015, month since 2015*)

Up till beginning of 2015:



Source: 2/2/2016.

Since beginning of 2015: ?
(please complete or correct)

Current number as of Feb 1 ***(AS/ REF/ UDM/ unaccompanied minors)***

A. **Most recent data per category**:

Residing in Malta	***June 2015***
Refugees	6,095
Asylum Seekers	425
Returned Refugees	0
Internally Displaced Persons (IDPs)	0
Returned IDPs	0
Stateless Persons	0
Various	0
Total Population of Concern	*6,520*
Originating from Malta	
Refugees	5
Asylum Seekers	0
Returned Refugees	0
Internally Displaced Persons (IDPs)	0
Returned IDPs	0
Various	0

	Total Population of Concern | *5* Source: http://www.unhcr.org/cgi-bin/texis/vtx/page?page=49e48eba6&submit=GO# B. **Most recent data on total number**: ?
Percentage of F/M/T, age groups and origin	A. **Most recent data per category:** Source: Eurostat, 2/2/2016. B. **Most recent data by gender, age group, origin**: ? Not Available for now.
Additional information	**Another report can be found on the url below. It lists a number of interesting graphical data comparing the past few years. Click on Statistics after the home page opens up.** **http://www.unhcr.org.mt/**

ASYLUM APPLICANT	2014	2015
Total	1.350	
Males	80,1%	
Females	19,9%	
Less than 18 years	23,3%	
18 - 64 years	76,3%	
65 years or over	0,7%	
Unaccompanied minors (Asylum applicant)	55	
Males	90,9%	
Females	9,1%	
IRREGULAR MIGRANT	990	
Males	81,8%	
Females	18,2%	
Less than 18 years	19,2%	
18 years or over	80,8%	

2. HEALTH CARE RESPONSES			
Please correct or complete the information where possible.			
Health care coordination at national/regional level	A. **Existence of a national coordination mechanism of the health response**: YES B. **Explanation**: *(if yes, please describe how the mechanism works and who participates; if no, please describe why there is no coordination)* **The coordination is between the different health services, Public health, Primary Health Care, Acute Medical care facilities and Police, Ministry of Foreign Affairs, Civil Protection, Ministry of Social Dialogue as well as Migrant Health Liaison Unit of the Health Department, In addition there is an inter-ministerial Committee on Integration of migrants.**		
First entry assistance services	The first entry response is coordinated by Ministry of Foreign Affairs, Police, and Health and Civil protection. All migrants are registered and screened for their health condition and infectious diseases. Treatment is given according to needs. Migrants are provided with food and water, accommodation (detention centre and open centres or other accommodation centres depending on their status, age and gender), clothing and medicine. They are also supported with personal funds to be able to make contact with their families and for their personal needs.		
Response to 'An Agenda for Action' as agreed during the High Level Meeting on Refugee and Migrant Health in Rome in November 2015: *Cross the appropriate 'Yes', 'No' or 'There is no information available' option in the blue boxes. Additional information or sources can be mentioned underneath the box.*			
Integration of the health care services for refugees, asylum seekers end migrants into the existing national health systems	**yes**		
Limit initial screening upon arrival to relevant risk assessment	**yes**		
Non Communicable Diseases included in the provision of services	**yes**		
Active participation and empowerment of the refugees and migrants throughout all stages of health service provision, including design and planning			**There is no information available**
Training of health professionals involved in the provision of health care	**Yes**		

3. WHERE-WHAT-WHO			
Please correct or complete the information where possible.			
Migrant group	**WHERE are they receiving the health care?**	**WHAT type of health care provision are they receiving?**	**WHO is the actor/agency providing the health care?**
(1) Recent arrivals	At open or detention centres. Health Clinics and Acute hospital care. If Migrants are living in the community they would have free access to Health Centres and acute hospital care, (as well as private health care should they wish to make use of this). Also they are entitled for free medicines e.g. for TB, Parturition and Chronic diseases etc. These services include outpatients care, specialist care, nursing care and mobile nursing community services. Vaccinations are also free of charge.	"The Maltese Red Cross has provided Restoring Family Links services (phone calls and tracing) and psychosocial support by staff and approximately 10 volunteers. With the support of the ICRC, the Red Cross of Malta has finalized its RFL contingency plan and purchased equipment." (Source: Information bulletin IFRC Regional Office for Europe Migration response. IFRC. http://www.ifrc.org/docs/Appeals/16/IB6_Migration%20response_Europe_010216.pdf)	Maltese Red Cross ICRC MEH through HPDPD, Primary care and Acute health services (Hospital). Free healthcare is provided by the National Health Services. Detention services also engaged private health companies to provided free healthcare to migrants in closed and open centres so as to make health reach them at source.
(2) People in transit	Same as above		
(3) Asylum seekers	Same as above		
(4) Refugee status granted	Same as above		
(5) Undocumented migrants	Same as above		
(6) Unaccompanied minors	Same as above		

4. FUNDING OF THE HEALTH CARE RESPONSES

Please provide us with any relevant information of funding made available by your country or other partners for health care responses:

- *FUNDING SOURCES: where does the funding come from? e.g. Government, UN agency (UNHCR, IOM, WHO Euro,…), EU, NGO, civil society organisation, faith-based organisation, private organisation, international donor, (public/private) health insurance, other (please specify)*
- *FUNDING MECHANISM: how is the health care delivery being funded? e.g. envelope (for whole year/project), lump sum amount per asylum seeker/refugee, out-of-pocket expenses, third payer mechanism, emergency/contingency budget.*
- *FUNDING AMOUNT: Give the amount spent on health care responses, in Euros, per year/month; if available also provide the pledged amount.*
- *COMMENTS.*

Migrant group	Funding source	Funding mechanism	Funding amount	Comments
(1) Recent arrivals	Government	Through the provision of health care services by means of yearly national health budget	NA	
(2) People in transit	Government	Through the provision of health care services by means of yearly national health budget	NA	
(3) Asylum seekers	Government	Through the provision of health care services by means of yearly national health budget	NA	
(4) Refugee status granted	Government	Through the provision of health care services by means of yearly national health budget	NA	
(5) Undocumented migrants	Government	Through the provision of health care services by means of yearly national health budget	NA	

National coordination of the health care response to refugees, asylum seekers and other migrants: *Working document*
THE NETHERLANDS

Programme co-funded by the EUROPEAN UNION

READER'S GUIDE:

The SH-CAPAC consortium is conducting a mapping of the European Union Member States' health response to the refugees, asylum seekers and other migrants entering, transiting or staying in their territories.

This working document summarizes the latest information on the influx of the different categories (see box 1 on Country Context) and on the coordination of the health care responses (see box 2) in The Netherlands. It also maps the available information on the WHERE-WHAT-WHO of these health care responses (see box 3). This is done for different categories: (1) recent arrivals, (2) people in transit, (3) asylum seekers, (4) refugee status granted persons, (5) undocumented migrants, and where relevant, also for (6) unaccompanied minors. Lastly we would like to map the funding sources for which the Member State's input is appreciated (see box 4 on Funding of health care responses).

The information already completed below is based on different sources which were consulted online between January 20 and February 8 2016 and which is meant to give a first snapshot. ***We would like to ask you to verify the information, to correct and amend where necessary and to complete where possible.*** *This mapping exercise will help the SH-CAPAC consortium to define a framework for effective health sector coordination for addressing the needs of the refugees, asylum seekers and other migrants in the European Union.* ***Please reply before February 16 2016 to ainhoa.ruiz.easp@juntadeandalucia.es with copy to birgit.kerstens@gmail.com and daniel.lopez.acuna.ext@juntadeandalucia.es.*** *More information on the SH-CAPAC project can be found in the leaflet in attachment and on www.easp.es/sh-capac.*

Sources consulted:

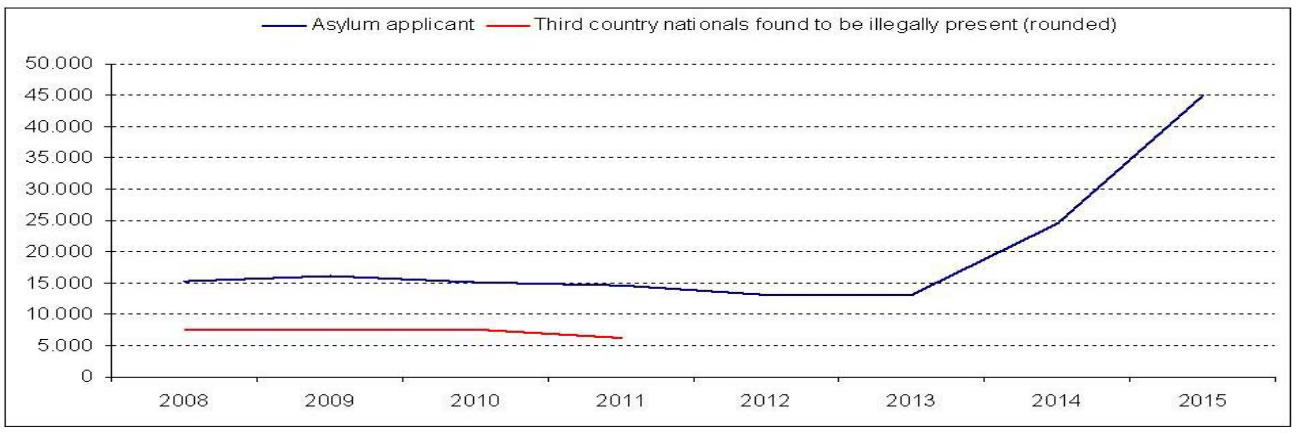
- UNHCR. 2015 UNHCR subregional operations profile - Northern, Western, Central and Southern Europe. The Netherlands

http://www.unhcr.org/cgi-bin/texis/vtx/page?page=49e48eca6&submit=GO

- Eurostat, 2/02/2016

- Information bulletin IFRC Regional Office for Europe Migration response. IFRC. http://www.ifrc.org/docs/Appeals/16/IB6_Migration%20response_Europe_010216.pdf
- https://www.coa.nl/en

Please provide us with any oth*er sources that you deem appropriate for your country.*

1. COUNTRY CONTEXT	
When influx started **(*by year up till 2015, month since 2015*)**	**Up till beginning of 2015**: **Since beginning of 2015**: 
Current number as of Feb 1 ***(AS/ REF/ UDM/ unaccompanied minors)***	A. **Most recent data per category**: ?

Residing in Country	***June 2015***
Refugees	**82,494**
Asylum Seekers	**8,097**
Returned Refugees	**0**
Internally Displaced Persons (IDPs)	**0**
Returned IDPs	**0**
Stateless Persons	**1,951**
Various	
Total Population of Concern	**92,542**
Originating from Country	
Refugees	**64**
Asylum Seekers	**48**
Returned Refugees	**0**
Internally Displaced Persons (IDPs)	**0**
Returned IDPs	**0**
Various	**1**
Total Population of Concern	**113**

At june 2015:

Most recent data on total number: ?

Percentage of F/M/T, age groups and origin	A. **Most recent data per category:** ? B. **Most recent data by gender, age group, origin**: ?

ASYLUM APPLICANT	2014	2015
Total	24.495	44.970
Males	72,8%	72,7%
Females	27,2%	27,1%
Less than 18 years	20,9%	23,5%
18 - 64 years	77,9%	75,7%
65 years or over	1,1%	0,8%
Unaccompanied minors (Asylum applicant)	960	
Males	82,8%	
Females	17,7%	
IRREGULAR MIGRANT		
Males		
Females		
Less than 18 years		
18 years or over		

	Asylum seekers at COA-facilities from 1995 due to 8 februari 2016

	People in COA-facilities, categoriesed by age

	Top-5 nationalities/persons in COA-facilities _____ **unaccompanied minors in COA-facilities (custodial care)** 8 februari 2016 2.666 **Top-5 nationalities unaccompanied minors in COA-facilities (custodial care)** _____

	Refugee status granted at COA-facilities

2. HEALTH CARE RESPONSES	
Please correct or complete the information where possible.	
Health care coordination at national/regional level	A. **Existence of a national coordination mechanism of the health response**: YES *(Please complete)* B. **Explanation**: The Central Organization for the Reception of Asylum seekers (COA) is responsible for the reception and daily care of all people living within their facilities. This includes the organization of health care. For this COA has contracted one of the major healthcare insurance companies in the Netherlands Menzis. Menzis has created a special health care center for asylum seekers (GCA) with locations on all reception facilities of COA. In these GCA locations a general practitioner holds practice. This general practitioner is assisted by doctor's assistant and a consultant for mental health care. If a specialist or hospital care is needed Menzis has contracted regular health care institutions and practitioners. All medical information is collected and managed in a central information system of GCA. Because of this central information system all medical information is available in the case that a resident of COA has to be moved to another location. All health care that is being given in the Netherlands is overseen by the Health Inspector. Due to the sudden increase of asylum seekers and refugees coming to the Netherlands this system was under presure. In a very short time span a lot of new locations had to be opened. For a certain period of time the Netherlands had to take emergency measures. Asylum seekers and refugees were place in sports centers and other forms of location so the people did not need to stay on the streets. They could stay there for a period of 72 hours. In these emergency locations the municipalities were responsible for providing health care. They made amongst others use of the service the Netherlands Red Cross could provide. The Netherlands Red Cross has been responding in 117 different locations providing clothes, beds, blankets, hygiene kits and first aid. More than 5,000 medical cases have been treated. Approximately 135 staff members have been mobilized and 12,000 volunteer shifts (one volunteer can be involved in several) during the response. Momentarily emergency locations are no longer needed and the refugees and asylum seekers are housed in reception

	facilities of COA. When a refugee or asylum seeker receives a residence permit they are housed in the municipalities. They have the same rights and obligations as Dutch citizens. This means that they are obliged to taking out a health insurance for basic health care. The refugees who were granted a status can make use of the regular healthcare in The Netherlands. It is for municipalities possible to support refugees with a status granted in social services related to prevention, participation and assimilation requirements. Other migrants also have to have a health insurance. If they have no insurance they have to pay for health care themselves. Emergency health care is accessible for undocumentend migrants. They need to pay for the health care they received by themselves. If this is not possible, the care provider can invoice the care provided with Zorginstituut Nederland. They receive 80% of their invoice.
First entry assistance services	

Response to 'An Agenda for Action' as agreed during the High Level Meeting on Refugee and Migrant Health in Rome in November 2015:
Cross the appropriate 'Yes', 'No' or 'There is no information available' option in the blue boxes. Additional information or sources can be mentioned underneath the box.

Integration of the health care services for refugees, asylum seekers end migrants into the existing national health systems	**See above** Yes		
Limit initial screening upon arrival to relevant risk assessment	**Yes for tuberculoses** Yes		
Non Communicable Diseases included in the provision of services			

		No	
Active participation and empowerment of the refugees and migrants throughout all stages of health service provision, including design and planning		No	
Training of health professionals involved in the provision of health care	Yes		

3. WHERE-WHAT-WHO			
Please correct or complete the information where possible.			
Migrant group	**WHERE are they receiving the health care?**	**WHAT type of health care provision are they receiving?**	**WHO is the actor/agency providing the health care?**
(1) Recent arrivals	Reception locations/regular health care institutions	Basic Health Care	Reception locations/regular health care institutions
(2) People in transit	N/A		
(3) Asylum seekers	Reception locations/regular health care institutions	Basic Health Care	Reception locations/regular health care institutions
(4) Refugee status granted	Regular health care institutions	Basic Health Care	Regular health care institutions
(5) Undocumented migrants	Regular health care institutions	Emergency Health Care	Regular health care institutions
(6) Unaccompanied minors	Reception locations/regular health care institutions	Basic Health Care	Reception locations/regular health care institutions

4. FUNDING OF THE HEALTH CARE RESPONSES				
Please provide us with any relevant information of funding made available by your country or other partners for health care responses: ▪ *FUNDING SOURCES: where does the funding come from? e.g. Government, UN agency (UNHCR, IOM, WHO Euro,…), EU, NGO, civil society organisation, faith-based organisation, private organisation, international donor, (public/private) health insurance, other (please specify)* ▪ *FUNDING MECHANISM: how is the health care delivery being funded? e.g. envelope (for whole year/project), lump sum amount per asylum seeker/refugee, out-of-pocket expenses, third payer mechanism, emergency/contingency budget.* ▪ *FUNDING AMOUNT: Give the amount spent on health care responses, in Euros, per year/month; if available also provide the pledged amount.* ▪ *COMMENTS.*				
Migrant group	**Funding source**	**Funding mechanism**	**Funding amount**	**Comments**
(1) Recent arrivals	National Government	Envelope	Around € 5.000 per person per year	
(2) People in transit	N/A	N/A	N/A	
(3) Asylum seekers	National Government	Envelope	Around € 5.000 per person per year	
(4) Refugee status granted	Refugees through health insurances and National Government	Third payer	€ 74,6 billion	Total health care cost in the Netherlands. No information available related to only refugees status granted.
(5) Undocumented migrants	National Government or Own payments by undocumented migrants	Third payer Out-of-pocket expenses	€ 30.833.000	**Over the year 2014**

Programme co-funded by the EUROPEAN UNION

National coordination of the health care response to refugees, asylum seekers and other migrants: *Working document*

POLAND

READER'S GUIDE:

The SH-CAPAC consortium is conducting a mapping of the European Union Member States' health response to the refugees, asylum seekers and other migrants entering, transiting or staying in their territories.

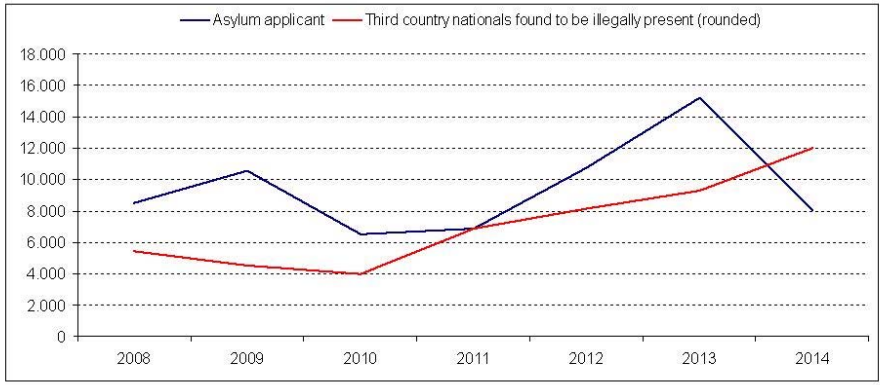
This working document summarizes the latest information on the influx of the different categories (see box 1 on Country Context) and on the coordination of the health care responses (see box 2) in Poland. It also maps the available information on the WHERE-WHAT-WHO of these health care responses (see box 3). This is done for different categories: (1) recent arrivals, (2) people in transit, (3) asylum seekers, (4) refugee status granted persons, (5) undocumented migrants, and where relevant, also for (6) unaccompanied minors. Lastly we would like to map the funding sources for which the Member State's input is appreciated (see box 4 on Funding of health care responses).

The information already completed below is based on different sources which were consulted online between January 20 and February 8 2016 and which is meant to give a first snapshot. ***We would like to ask you to verify the information, to correct and amend where necessary and to complete where possible.*** *This mapping exercise will help the SH-CAPAC consortium to define a framework for effective health sector coordination for addressing the needs of the refugees, asylum seekers and other migrants in the European Union.* ***Please reply before February 16 2016 to ainhoa.ruiz.easp@juntadeandalucia.es with copy to birgit.kerstens@gmail.com and daniel.lopez.acuna.ext@juntadeandalucia.es.*** *More information on the SH-CAPAC project can be found in the leaflet in attachment and on www.easp.es/sh-capac.*

Sources consulted:

- Eurostat, 2/02/2016
- OIM (GMDAC) http://iomgmdac.org/total-asylum-applications-in-europe-by-sex-and-age-2015/
- UNHCR. Refugees/Migrants Emergency Response – Mediterranean (http://www.unhcr.org/pages/4a02d9346.html)
  http://www.unhcr.org/cgi-bin/texis/vtx/page?page=49e48df06&submit=GO

Please provide us with any other sources that you deem appropriate for your country.

1. COUNTRY CONTEXT	
When influx started (***by year up till 2015, month since 2015***)	 Eurostat, 2/02/2016. *(please complete or correct)*
Current number as of Feb 1 ***(AS/ REF/ UDM/ unaccompanied minors)***	A. **Most recent data per category** Residing in Poland: Refugees: 15,741 Asylum Seekers: 2,470 Returned Refugees: 0 Internally Displaced Persons (IDPs): 0 Returned IDPs: 0 Stateless Persons: 10,825 Various: 0 Total Population of Concern: 29,036

	Originating from Poland: Refugees: 1,401 Asylum Seekers: 340 Returned Refugees: 0 Internally Displaced Persons (IDPs): 0 Returned IDPs: 0 Various: 0 Total Population of Concern: 1,741 Source: http://www.unhcr.org/cgi-bin/texis/vtx/page?page=49e48df06&submit=GO B. **Most recent data on total number**: Total asylum applications in 2015: 10615 (in 2015 10615 people applied for asylum in Poland) Source: OIM (GMDAC) http://iomgmdac.org/total-asylum-applications-in-europe-by-sex-and-age-2015/
Percentage of F/M/T, age groups and origin	A. **Most recent data per category:** B. **Most recent data by gender, age group, origin**:

2. HEALTH CARE RESPONSES			
Please correct or complete the information where possible.			
Health care coordination at national/regional level	A. **Existence of a national coordination mechanism of the health response**: YES/NO *(Please complete)* B. **Explanation**: *(if yes, please describe how the mechanism works and who participates; if no, please describe why there is no coordination)* Generally, migration policy is a task of ministry of interior and administration. minister of interior and administration is a chief of Migration committee. Ministry of interior group includes, among others, The National Border Guard Headquarters and Office fo Roreigners (OFF). Intersectoral Committee for refugees relocation and resettlement (leaded by ministry of interior) started its work in October 2015. It includes 3 working goups: 1) safety (leaded by Border Guard vice-commendant), 2) financing (leaded by OFF chief), 3) integration (leaded by a person from ministry of labour and social policy). Among the members are representatives of different ministries, including ministry of health; there are also NGOs represented, ex. Red Cross and other humanitarian ones. However, another intersectoral committee for safety issues in the relocation and resettlement process is planned – it would probably replace the one mentioned above. Also here the participation of MoH is planned. Office for Foreigners (OFF) is coordinating operational plan of refugees relocation and resettlement. It is cooperating with NGOs and international organizations, including IOM and UN High Commissioner for Refugees.		
First entry assistance services			
Response to 'An Agenda for Action' as agreed during the High Level Meeting on Refugee and Migrant Health in Rome in November 2015: *Cross the appropriate 'Yes', 'No' or 'There is no information available' option in the blue boxes. Additional information or sources can be mentioned underneath the box.*			
Integration of the health care services for refugees, asylum seekers end migrants into the existing national health systems		x	
	Yes	No	There is no information available
Limit initial screening upon arrival to relevant risk assessment			
	Yes	No	There is no information available
Non Communicable Diseases included in the provision of services			

	Yes	No	There is no information available
Active participation and empowerment of the refugees and migrants throughout all stages of health service provision, including design and planning	Yes	No	There is no information available
Training of health professionals involved in the provision of health care	Yes	No	There is no information available

3. WHERE-WHAT-WHO			
Please correct or complete the information where possible.			
Migrant group	**WHERE are they receiving the health care?**	**WHAT type of health care provision are they receiving?**	**WHO is the actor/agency providing the health care?**
(1) Recent arrivals			
(2) People in transit			
(3) Asylum seekers			
(4) Refugee status granted			
(5) Undocumented migrants			
(6) Unaccompanied minors			

4. FUNDING OF THE HEALTH CARE RESPONSES				
Please provide us with any relevant information of funding made available by your country or other partners for health care responses: ▪ *FUNDING SOURCES: where does the funding come from? e.g. Government, UN agency (UNHCR, IOM, WHO Euro,…), EU, NGO, civil society organisation, faith-based organisation, private organisation, international donor, (public/private) health insurance, other (please specify)* ▪ *FUNDING MECHANISM: how is the health care delivery being funded? e.g. envelope (for whole year/project), lump sum amount per asylum. seeker/refugee, out-of-pocket expenses, third payer mechanism, emergency/contingency budget.* ▪ *FUNDING AMOUNT: Give the amount spent on health care responses, in Euros, per year/month; if available also provide the pledged amount.* ▪ *COMMENTS.*				
Migrant group	**Funding source**	**Funding mechanism**	**Funding amount**	**Comments**
(1) Recent arrivals				
(2) People in transit				
(3) Asylum seekers				

(4) Refugee status granted				
(5) Undocumented migrants				

Programme co-funded by the EUROPEAN UNION

National coordination of the health care response to refugees, asylum seekers and other migrants: *Working document*
PORTUGAL

READER'S GUIDE:

The SH-CAPAC consortium is conducting a mapping of the European Union Member States' health response to the refugees, asylum seekers and other migrants entering, transiting or staying in their territories.

This working document summarizes the latest information on the influx of the different categories (see box 1 on Country Context) and on the coordination of the health care responses (see box 2) in Portugal. It also maps the available information on the WHERE-WHAT-WHO of these health care responses (see box 3). This is done for different categories: (1) recent arrivals, (2) people in transit, (3) asylum seekers, (4) refugee status granted persons, (5) undocumented migrants, and where relevant, also for (6) unaccompanied minors. Lastly we would like to map the funding sources for which the Member State's input is appreciated (see box 4 on Funding of health care responses).

The information already completed below is based on different sources which were consulted online between January 20 and February 8 2016 and which is meant to give a first snapshot. ***We would like to ask you to verify the information, to correct and amend where necessary and to complete where possible.*** *This mapping exercise will help the SH-CAPAC consortium to define a framework for effective health sector coordination for addressing the needs of the refugees, asylum seekers and other migrants in the European Union.* ***Please reply before February 16 2016 to ainhoa.ruiz.easp@juntadeandalucia.es with copy to birgit.kerstens@gmail.com and daniel.lopez.acuna.ext@juntadeandalucia.es.*** *More information on the SH-CAPAC project can be found in the leaflet in attachment and on www.easp.es/sh-capac.*

Sources consulted:

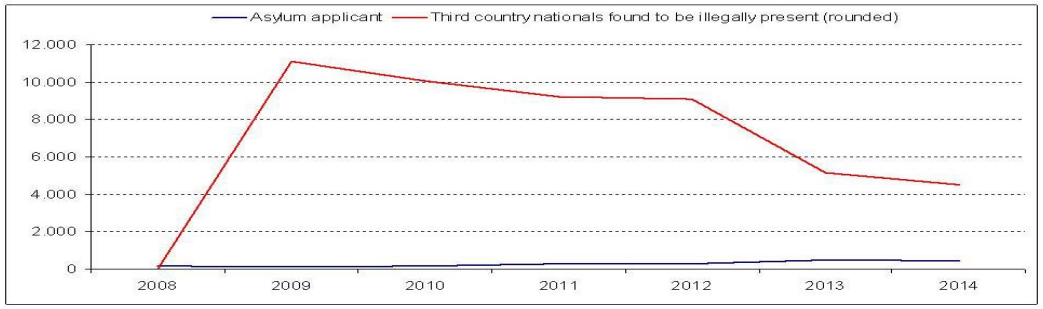
- http://www.unhcr.org/pages/4a02d9346.html
- UNHCR. Refugees/Migrants Emergency Response – Mediterranean

Please provide us with any other sources that you deem appropriate for your country.

1. COUNTRY CONTEXT

When influx started
(*by year up till 2015, month since 2015*)

Up till beginning of 2015: no influx
Since beginning of 2015: ? *(please complete or correct)*



Source: Eurostat, 2/02/2016.

Current number as of Feb 1 ***(AS/ REF/ UDM/ unaccompanied minors)***

A. **Most recent data per category**:

Residing in Portugal	***June 2015***
Refugees	699
Asylum Seekers	641
Returned Refugees	0
Internally Displaced Persons (IDPs)	0
Returned IDPs	0
Stateless Persons	14
Various	0
Total Population of Concern	*1,354*
Originating from Portugal	
Refugees	31
Asylum Seekers	49
Returned Refugees	0
Internally Displaced Persons (IDPs)	0
Returned IDPs	0
Various	0
Total Population of Concern	*80*

Source: http://www.unhcr.org/cgi-bin/texis/vtx/page?page=49e48edc6&submit=GO

<table>
<tr><td></td><td>B. Most recent data on total number: ?</td></tr>
<tr><td>Percentage of F/M/T, age groups and origin</td><td>A. Most recent data per category:

<table>
<tr><th>ASYLUM APPLICANT</th><th>2014</th></tr>
<tr><td>Total</td><td>440</td></tr>
<tr><td>Males</td><td>61,4%</td></tr>
<tr><td>Females</td><td>38,6%</td></tr>
<tr><td>Less than 18 years</td><td>18,2%</td></tr>
<tr><td>18 - 64 years</td><td>80,7%</td></tr>
<tr><td>65 years or over</td><td>2,3%</td></tr>
<tr><td>Unaccompanied minors (Asylum applicant)</td><td>15</td></tr>
<tr><td>Males</td><td>33,3%</td></tr>
<tr><td>Females</td><td>66,7%</td></tr>
<tr><td></td><td></td></tr>
<tr><td>IRREGULAR MIGRANT</td><td>4.530</td></tr>
<tr><td>Males</td><td>63,4%</td></tr>
<tr><td>Females</td><td>36,6%</td></tr>
<tr><td>Less than 18 years</td><td>3,1%</td></tr>
<tr><td>18 years or over</td><td>95,9%</td></tr>
</table>

Source : Eurostat, 2/02/2016.

B. Most recent data by gender, age group, origin: ?</td></tr>
</table>

2. HEALTH CARE RESPONSES	
Please correct or complete the information where possible.	
Health care coordination at national/regional level	A. **Existence of a national coordination mechanism of the health response**: YES B. **Explanation**: the Directorate-General of Health integrates the working party on the European Agenda for Migration. DGS coordinates health response, which is provided regionally or locally. The ACM (http://www.acm.gov.pt) provides the necessary global approach to migration needs.
First entry assistance services	Yes, at ports or airports, depending on the conditions (health authorities). It has been defined that migrants coming relocation processes should be observed by the health team at local health units within a week from arrival.

Response to 'An Agenda for Action' as agreed during the High Level Meeting on Refugee and Migrant Health in Rome in November 2015:
Cross the appropriate 'Yes', 'No' or 'There is no information available' option in the blue boxes. Additional information or sources can be mentioned underneath the box.

	Yes	No	There is no information available
Integration of the health care services for refugees, asylum seekers end migrants into the existing national health systems	X		
Limit initial screening upon arrival to relevant risk assessment			X
Non Communicable Diseases included in the provision of services	X		
Active participation and empowerment of the refugees and migrants throughout all stages of health service provision, including design and planning			X
Training of health professionals involved in the provision of health care	X		

3. WHERE-WHAT-WHO

Please correct or complete the information where possible.

Migrant group	WHERE are they receiving the health care?	WHAT type of health care provision are they receiving?	WHO is the actor/agency providing the health care?
(1) Recent arrivals	Point of entry and sometimes ACM facilities	According to needs	DGS and sometimes hospitals or health centres
(2) People in transit	Point of entry	According to needs	Health centres, hospitals
(3) Asylum seekers		All care needed, included mental health	Health centres, hospitals
(4) Refugee status granted		All care needed, included mental health	Health centres, hospitals
(5) Undocumented migrants		Urgent care, communicable diseases that pose a danger to PH, maternal, reproductive and child care, immunization	Health centres, hospitals
(6) Unaccompanied minors		All care needed, included mental health	Health centres, hospitals

4. FUNDING OF THE HEALTH CARE RESPONSES

Please provide us with any relevant information of funding made available by your country or other partners for health care responses:

- *FUNDING SOURCES: where does the funding come from? e.g. Government, UN agency (UNHCR, IOM, WHO Euro,…), EU, NGO, civil society organisation, faith-based organisation, private organisation, international donor, (public/private) health insurance, other (please specify)*
- *FUNDING MECHANISM: how is the health care delivery being funded? e.g. envelope (for whole year/project), lump sum amount per asylum seeker/refugee, out-of-pocket expenses, third payer mechanism, emergency/contingency budget.*
- *FUNDING AMOUNT: Give the amount spent on health care responses, in Euros, per year/month; if available also provide the pledged amount.*
- *COMMENTS.*

Migrant group	Funding source	Funding mechanism	Funding amount	Comments
(1) Recent arrivals	Government			Situations vary
(2) People in transit	Government			Situations vary
(3) Asylum seekers	Government, European and NGO, civil society, private organisation			Situations vary
(4) Refugee status granted	Government, European and NGO, civil society, private organisation			Situations vary
(5) Undocumented migrants	Government			

Funding needs additional information and responses.

Programme co-funded by the EUROPEAN UNION

National coordination of the health care response to refugees, asylum seekers and other migrants: *Working document*
ROMANIA

READER'S GUIDE:

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This working document summarizes the latest information on the influx of the different categories (see box 1 on Country Context) and on the coordination of the health care responses (see box 2) in Romania. It also maps the available information on the WHERE-WHAT-WHO of these health care responses (see box 3). This is done for different categories: (1) recent arrivals, (2) people in transit, (3) asylum seekers, (4) refugee status granted persons, (5) undocumented migrants, and where relevant, also for (6) unaccompanied minors. Lastly we would like to map the funding sources for which the Member State's input is appreciated (see box 4 on Funding of health care responses).

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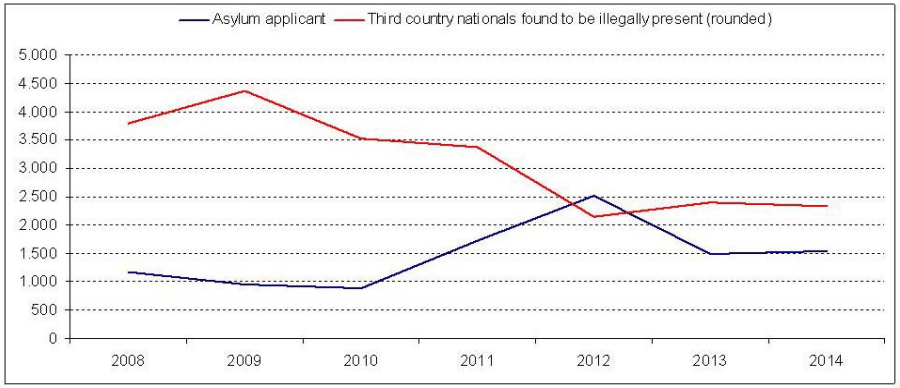
Sources consulted:

- http://www.iom.int/
- http://www.unhcr.org/pages/4a02d9346.html
- UNHCR. Refugees/Migrants Emergency Response http://www.unhcr.org/cgi-bin/texis/vtx/page?page=49e48df96&submit=GO
- http://gov.ro/en/news/decisions-on-the-nationwide-management-of-the-refugee-flow

Please provide us with any other sources that you deem appropriate for your country.

1. COUNTRY CONTEXT	
When influx started (***by year up till 2015, month since 2015***)	**Up till beginning of 2015**: 2011-2012  Source: Eurostat, 2/02/2016. **Since beginning of 2015**: ? *(please complete or correct)*
Current number as of Feb 1 ***(AS/ REF/ UDM/ unaccompanied minors)***	A. **Most recent data per category**: Asylum Seekers: 98 Refugees: 2600 UDM: 31 UAM: 1 B. **Most recent data on total number**:
Percentage of F/M/T, age groups and origin	A. **Most recent data per category:** B. **Most recent data by gender, age group, origin**:

ASYLUM APPLICANT	2014
Total	1.545
Males	77,0%
Females	23,0%
Less than 18 years	24,3%
18 - 64 years	74,8%
65 years or over	1,0%
Unaccompanied minors (Asylum applicant)	95
Males	94,7%
Females	5,3%
IRREGULAR MIGRANT	2.335
Males	77,5%
Females	22,5%
Less than 18 years	12,0%
18 years or over	88,2%

Source: Eurostat, 2/02/2016.

2. HEALTH CARE RESPONSES	
Please correct or complete the information where possible.	
Health care coordination at national/regional level	A. **Existence of a national coordination mechanism of the health response**: YES/NO *(Please complete)* B. **Explanation**: *(if yes, please describe how the mechanism works and who participates; if no, please describe why there is no coordination)* **Emergency health care is provided to all migrants regardless of the form of protection they receive from the Romanian Government. The basic health care package is provided only to those migrants that have received a form of protection in Romania (refugee, subsidiary protection etc.)** Source: IOM National coordination, not specifically for health care: "Coalition for refugee integration": "Prime Minister Victor Ponta, accompanied by several ministers, representatives of state institutions and local authorities, had a meeting with representatives of civil society on one of the topics of interest for public opinion in Romania: nationwide management of the refugee flow that Europe is confronted with. The meeting aimed at establishing a framework of cooperation between state authorities and non-governmental organizations working in the area of reception, support and integration of refugees. Prime Minister outlined that the Romanian society and the state are facing for the first time a challenge of this kind and, as they lack institutional experience in this regard, it is natural to initiate a dialogue of the central and local authorities with the NGOs. Civil society representatives with experience in the field have reported the main shortcomings of the refugees' integration process, and have advanced concrete proposals to overcome them. One of the conclusions of the meeting is that we do not deal with a crisis, but with an opportunity to create a functional system for the integration of refugees, both on short term and for the future. At the proposal of Prime Minister Victor Ponta, there were adopted several decisions with practical effect. It was decided to institutionalize dialogue on refugees under the form of a series of monthly meetings as part of a "National Coalition for the integration of refugees", which aims at improving the institutional and legislative framework in the field. The coalition will put together state authorities and NGOs interested and willing to participate in efforts to integrate refugees. It was decided to create a secretariat of the Coalition and there were appointed officials in charge of the major directions of activity: primary logistics, healthcare, education, legislative adjustment, medium and long term integration, public information. The first meeting of the "Coalition for refugee integration" with a well-defined agenda, will be held in the last week of October [2015]." Source: http://gov.ro/en/news/decisions-on-the-nationwide-management-of-the-refugee-flow
First entry assistance services	Refugees resettled to Romania as part of the internationally established quota are screened and provided a fit to travel health check before arrival. IOM in Romania provides subsequent non-emergency medical assistance until their protection status is confirmed by the Immigration Authorities.

	Response to 'An Agenda for Action' as agreed during the High Level Meeting on Refugee and Migrant Health in Rome in November 2015: *Cross the appropriate 'Yes', 'No' or 'There is no information available' option in the blue boxes. Additional information or sources can be mentioned underneath the box.*		
Integration of the health care services for refugees, asylum seekers end migrants into the existing national health systems	**X** Yes	No	There is no information available
Limit initial screening upon arrival to relevant risk assessment	**X** Yes	No	There is no information available
Non Communicable Diseases included in the provision of services	**X** Yes	No	There is no information available
Active participation and empowerment of the refugees and migrants throughout all stages of health service provision, including design and planning	**X** Yes	No	There is no information available
Training of health professionals involved in the provision of health care	**YES (Note 1)** Yes	No	There is no information available

Note 1: The ICRC conducted a two-day training on RFL for staff and volunteers of the Romanian Red Cross, in Bucharest on 5-6 December 2015 (Source: Information bulletin IFRC Regional Office for Europe Migration response. IFRC. http://www.ifrc.org/docs/Appeals/16/IB6_Migration%20response_Europe_010216.pdf)

3. WHERE-WHAT-WHO

Please correct or complete the information where possible.

Migrant group	WHERE are they receiving the health care?	WHAT type of health care provision are they receiving?	WHO is the actor/agency providing the health care?
(1) Recent arrivals	Emergency rooms	Emergency	Government
(2) People in transit	IOM provides health care services at the Emergency Transit Canter in Timisoara	Ambulatory	IOM
(3) Asylum seekers	Emergency rooms	Emergency	Government
(4) Refugee status granted	National health care system	Basic health package	Government
(5) Undocumented migrants	Emergency rooms	Emergency	Government
(6) Unaccompanied minors	National health care system	Basic health package	Government

4. FUNDING OF THE HEALTH CARE RESPONSES

Please provide us with any relevant information of funding made available by your country or other partners for health care responses:

- *FUNDING SOURCES: where does the funding come from? e.g. Government, UN agency (UNHCR, IOM, WHO Euro,…), EU, NGO, civil society organisation, faith-based organisation, private organisation, international donor, (public/private) health insurance, other (please specify)*
- *FUNDING MECHANISM: how is the health care delivery being funded? e.g. envelope (for whole year/project), lump sum amount per asylum seeker/refugee, out-of-pocket expenses, third payer mechanism, emergency/contingency budget.*
- *FUNDING AMOUNT: Give the amount spent on health care responses, in Euros, per year/month; if available also provide the pledged amount.*
- *COMMENTS.*

Migrant group	Funding source	Funding mechanism	Funding amount	Comments
(1) Recent arrivals	Government	State budget	Unavailable	Only for emergency services
(2) People in transit	IOM	IOM	Undisclosed	IOM is providing medical health care and pre-departure health checks to all migrants transiting the Emergency Transit Centre in Timisoara
(3) Asylum seekers	Government	State budget	Unavailable	Only for emergency services
(4) Refugee status granted	Government	State budget	Unavailable	Basic care package
(5) Undocumented migrants	Government	State budget	Unavailable	Only for emergency services

Programme co-funded by the EUROPEAN UNION

National coordination of the health care response to refugees, asylum seekers and other migrants: *Working document*

SLOVAKIA

READER'S GUIDE:

The SH-CAPAC consortium is conducting a mapping of the European Union Member States' health response to the refugees, asylum seekers and other migrants entering, transiting or staying in their territories.

This working document summarizes the latest information on the influx of the different categories (see box 1 on Country Context) and on the coordination of the health care responses (see box 2) in Slovakia. It also maps the available information on the WHERE-WHAT-WHO of these health care responses (see box 3). This is done for different categories: (1) recent arrivals, (2) people in transit, (3) asylum seekers, (4) refugee status granted persons, (5) undocumented migrants, and where relevant, also for (6) unaccompanied minors. Lastly we would like to map the funding sources for which the Member State's input is appreciated (see box 4 on Funding of health care responses).

The information already completed below is based on different sources which were consulted online between January 20 and February 8 2016 and which is meant to give a first snapshot. ***We would like to ask you to verify the information, to correct and amend where necessary and to complete where possible.*** *This mapping exercise will help the SH-CAPAC consortium to define a framework for effective health sector coordination for addressing the needs of the refugees, asylum seekers and other migrants in the European Union.* ***Please reply before February 16 2016 to ainhoa.ruiz.easp@juntadeandalucia.es with copy to birgit.kerstens@gmail.com and daniel.lopez.acuna.ext@juntadeandalucia.es.*** *More information on the SH-CAPAC project can be found in the leaflet in attachment and on www.easp.es/sh-capac.*

Sources consulted:

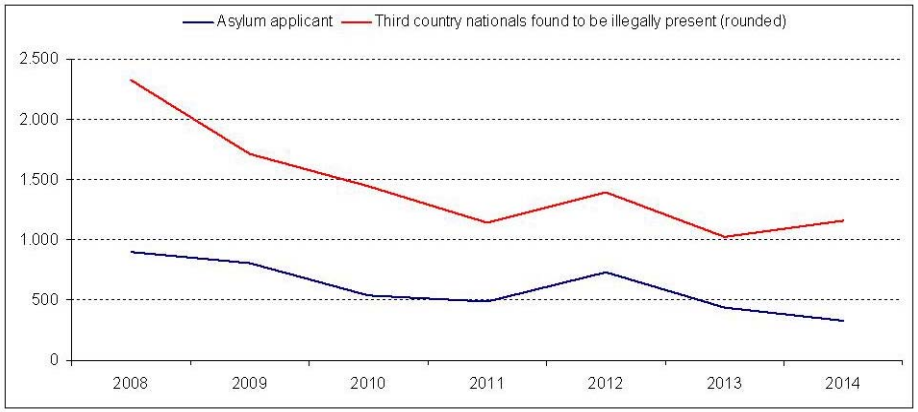
- http://www.unhcr.org/pages/4a02d9346.html
- UNHCR. Refugees/Migrants Emergency Response http://www.unhcr.org/cgi-bin/texis/vtx/page?page=49e48e016&submit=GO

Please provide us with any other sources that you deem appropriate for your country.

1. COUNTRY CONTEXT

When influx started
(***by year up till 2015, month since 2015***)

Up till beginning of 2015: 2012



Source: Eurostat: 2/2/2016.

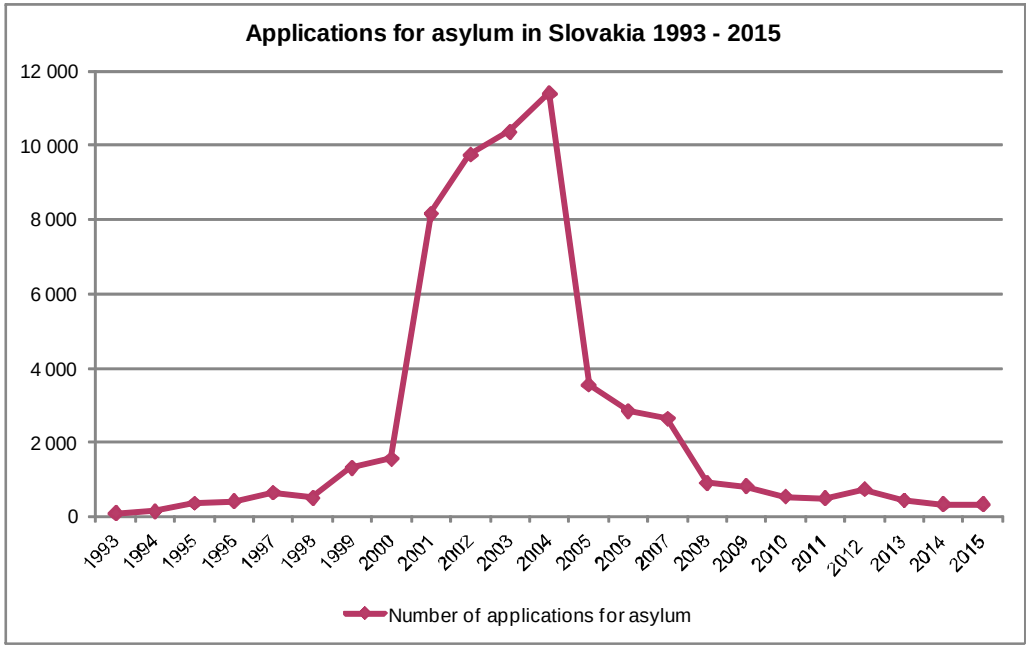
Since beginning of 2015: In the year 2015 there were 330 asylum seekers in Slovakia. An asylum has been granted to 8 people. The biggest number of migrants in Slovakia was recorded among years 2001 – 2005 with the highest peak in 2004, when total amount of the migrants were 11 395. The next years were: 2003 – 10 358 migrants, 2002 – 9 743 migrants, 2001 – 8 151 migrants and 2005 – 3 549 migrants. Statistic information about migrant flow is shown in the table and the picture below. This information describes migrants' trends in Slovakia from 1993 when the Slovak Republic was established as a sovereign country.1)

Year	Applications for asylum*	Asylum granted	Asylum denied	Citizenship granted
1993	96	41	20	0
1994	140	58	32	0
1995	359	80	57	0
1996	415	72	62	4
1997	645	69	84	14
1998	506	53	36	22
1999	1320	26	176	2
2000	1556	11	123	0
2001	8151	18	130	11
2002	9743	20	309	59
2003	10358	11	531	42

2004	11395	15	1592	20
2005	3549	25	827	2
2006	2849	8	861	5
2007	2642	14	1177	18
2008	909	22	416	4
2009	822	14	330	1
2010	541	15	180	3
2011	491	12	186	7
2012	732	32	334	0
2013	441	15	124	7
2014	331	14	197	12
2015	330	8	124	5
Total	**58 321**	**653**	**7 908**	**238**

*Total number

1) Source: The Migrants Office of the Ministry of Interior of the Slovak Republic



Current number as of Feb 1 ***(AS/ REF/ UDM/***	A. **Most recent data per category**:

unaccompanied minors)

Residing in Slovakia	***June 2015***
Refugees	799 (2014)
Asylum Seekers	61
Returned Refugees	0
Internally Displaced Persons (IDPs)	0
Returned IDPs	0
Stateless Persons	1,523
Various	48
Total Population of Concern	*2,531*
Originating from Slovakia	
Refugees	305
Asylum Seekers	498
Returned Refugees	0
Internally Displaced Persons (IDPs)	0
Returned IDPs	0
Various	0
Total Population of Concern	*803*

Source: http://www.unhcr.org/cgi-bin/texis/vtx/page?page=49e48e016&submit=GO

B. **Most recent data on total number**: Migrants flow in Slovakia in the year 2015

Month	**Applications for asylum**	**Asylum granted**	**Asylum denied**	**Citizenship granted**
February	12	1	9	0
March	36	3	20	0
April	10	1	15	0
May	23	0	5	0
Jun	12	1	19	0
July	13	0	6	0
August	8	0	12	0
September	10	1	7	2
October	14	1	8	0
November	15	0	6	0
December	161	0	5	3
Total	**330**	**8**	**125**	**5**

Percentage of F/M/T, age groups and origin

A. **Most recent data per category:** ?

ASYLUM APPLICANT	2014
Total	330
Males	78,8%
Females	21,2%
Less than 18 years	19,7%
18 - 64 years	80,3%
65 years or over	0,0%
Unaccompanied minors (Asylum applicant)	10
Males	100,0%
Females	0,0%
IRREGULAR MIGRANT	1.155
Males	74,0%
Females	26,0%
Less than 18 years	8,2%
18 years or over	91,8%

Source: Eurostat: 2/2/2016.

B. **Most recent data by gender, age group, origin**: Total number of migrants in Slovakia in December 2015 (origin, age, gender)

State of origin	0-14		15-17		18-25		26-39		40-49		50+		Total	
	M	F	M	F	M	F	M	F	M	F	M	F	M	F
Georgia											1		1	0
India					3								3	0
Iraqi	16	29	10	5	8	13	14	12	12	13	10	8	70	80
Pakistan			1				2						3	0
Turkey							1						1	0
Ukraine											1		1	0
Vietnam				2									0	2
Total	**16**	**29**	**11**	**7**	**11**	**13**	**17**	**12**	**12**	**13**	**12**	**8**	**79**	**82**

2. HEALTH CARE RESPONSES	
Please correct or complete the information where possible.	
Health care coordination at national/regional level	A. **Existence of a national coordination mechanism of the health response**: YES/~~NO~~ B. **Explanation**: Although, there is no official state regulation in the field of health care that has been laid by act only for the case of migrants' crisis or massive influx of migrants, the ministry of health initiated meeting with emergency health care providers and public health officers in the last September. The migrant crisis is understood as the one from public health threats. The aim of the meeting was to set up measures for emergency health care in the case of huge migrants' wave that might have come from Hungary. The measures for emergency care and transport of sick migrants have been set. In the field of public health has been prepared list of countries with high risk of contagious diseases, three local hospitals with isolation ward have been selected and vaccinations scheme has been supplemented on special vaccination routine in the migrants who don't have any vaccination certificate from mother country or international organisation (especially for children in with specific age clusters). The public health measures will be executed by GPs and public health authorities.
First entry assistance services	The primary health care is provided in the migrants facilities that are governed by the Ministry of Interior. These facilities have contracts with GPs who provide health care for local residents too. If there are serious life threatening conditions emergency care is provided under national regulations and standards in the same quality as for citizens. Expenditures for health care are refund from the state budget and the health insurance company does audit of the expenditures. All these measures are executed under the state regulation (act no. 480/2002).

Response to 'An Agenda for Action' as agreed during the High Level Meeting on Refugee and Migrant Health in Rome in November 2015:
Cross the appropriate 'Yes', 'No' or 'There is no information available' option in the blue boxes. Additional information or sources can be mentioned underneath the box.

Integration of the health care services for refugees, asylum seekers end migrants into the existing national health systems	**Yes** Yes	No	There is no information available
Limit initial screening upon arrival to relevant risk assessment	**Yes (TBC, hepatitis B, HIV...)** Yes	No	There is no information available
Non Communicable Diseases included in the provision of services	**Yes** Yes	No	There is no information available
Active participation and empowerment of the refugees and migrants throughout all stages of health service provision, including design and planning	Yes	No	**No, official information available** There is no information available
Training of health professionals involved in the provision of health care	**Yes, but very limited now** Yes	No	There is no information available

3. WHERE-WHAT-WHO

Please correct or complete the information where possible.

Migrant group	WHERE are they receiving the health care?	WHAT type of health care provision are they receiving?	WHO is the actor/agency providing the health care?
(1) Recent arrivals	In the facility or in a hospital	GPs, emergency care if needed	GP, physician in the hospital
(2) People in transit	In the facility or in a hospital	GPs, emergency care if needed	GP, physician in the hospital
(3) Asylum seekers	In the facility or in a hospital	GPs, emergency care if needed	GP, physician in the hospital
(4) Refugee status granted	In the facility or in a hospital	GPs, emergency care if needed	GP, physician in the hospital
(5) Undocumented migrants	In the facility or in a hospital	GPs, emergency care if needed	GP, physician in the hospital
(6) Unaccompanied minors	In the facility or in a hospital	GPs, emergency care if needed	GP, physician in the hospital

4. FUNDING OF THE HEALTH CARE RESPONSES

Please provide us with any relevant information of funding made available by your country or other partners for health care responses:

- *FUNDING SOURCES: where does the funding come from? e.g. Government, UN agency (UNHCR, IOM, WHO Euro,…), EU, NGO, civil society organisation, faith-based organisation, private organisation, international donor, (public/private) health insurance, other (please specify)*
- *FUNDING MECHANISM: how is the health care delivery being funded? e.g. envelope (for whole year/project), lump sum amount per asylum seeker/refugee, out-of-pocket expenses, third payer mechanism, emergency/contingency budget.*
- *FUNDING AMOUNT: Give the amount spent on health care responses, in Euros, per year/month; if available also provide the pledged amount.*
- *COMMENTS.*

Migrant group	Funding source	Funding mechanism	Funding amount	Comments
(1) Recent arrivals	State Budget	State budget pays expenditures for health care providers. The health insurance control payments.	No available	
(2) People in transit	State Budget	State budget pays expenditures for health care providers. The health insurance control payments.	No available	
(3) Asylum seekers	State Budget	State budget pays expenditures for health care providers. The health insurance control payments.	No available	
(4) Refugee status granted	State Budget	State budget pays expenditures for health care providers. The health insurance control payments.	No available	
(5) Undocumented migrants	State Budget	State budget pays expenditures for health care providers. The health insurance control payments.	No available	

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SLOVENIA

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Sources consulted:

- UNHCR. Refugees/Migrants Emergency Response - Mediterranean http://data.unhcr.org/mediterranean/regional.php
  - 2015 UNHCR subregional operations profile - Northern, Western, Central and Southern Europe. Slovenia. http://www.unhcr.org/cgi-bin/texis/vtx/page?page=49e48e096&submit=GO

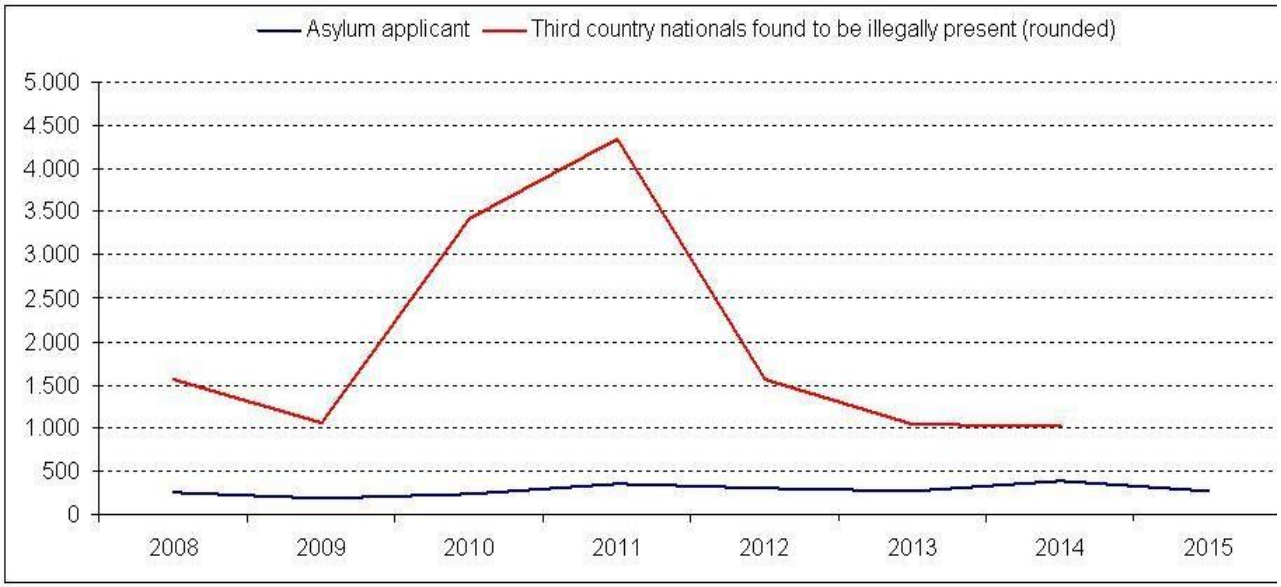
- UNHCR. Regional Refugee and Migrant Response Plan. Eastern Mediterranean and Western Balkans Route, UNHCR, 2016.
- MdM, Médecins du Monde. 8 NGOs for migrants/refugees' health in 11 countries. Project 717307. Annex I (part B), 2016.
- FRA, European Union Agency for Fundamental Rights. Monthly data collection on the current migration situation in the EU. December 2015 monthly report. 23 November – 31 December 2015. http://fra.europa.eu/sites/default/files/fra_uploads/fra-2016-monthly-compilation-com-update-1_en.pdf
- Source: UNHCR. Slovenia 3W.pdf

Please provide us with any other sources that you deem appropriate for your country.

1. COUNTRY CONTEXT

When influx started
(*by year up till 2015, month since 2015*)

Up till beginning of 2015:



Source: Eurostat, 2/02/2016.

	Since beginning of 2015: Since the start of the crisis on 16 October 2015, 421,245 migrants and asylum seekers have been registered entering Slovenia (20 January 2016). Source: http://data.unhcr.org/mediterranean/documents.php?page=1&view=grid&Country[]=207&Type[]=3http://data.unhcr.org/mediterranean/documents.php?page=1&view=grid&Country%5b%5d=207&Type%5b%5d=3 http://data.unhcr.org/mediterranean/documents.php?page=1&view=grid&Country%5b%5d=207&Type%5b%5d=3 *(please complete or correct)*
Current number as of Feb 1 ***(AS/ REF/ UDM/ unaccompanied minors)***	A. **Most recent data per category**: ?

Residing in Slovenia	***June 2015***
Refugees	283
Asylum Seekers	43
Returned Refugees	0
Internally Displaced Persons (IDPs)	0
Returned IDPs	0
Stateless Persons	4
Various	0
Total Population of Concern	*330*
Originating from Slovenia	
Refugees	24
Asylum Seekers	22
Returned Refugees	0
Internally Displaced Persons (IDPs)	0
Returned IDPs	0
Various	0
Total Population of Concern	*46*

	Source: http://www.unhcr.org/cgi-bin/texis/vtx/page?page=49e48e096&submit=GOhttp://www.unhcr.org/cgi-bin/texis/vtx/page?page=49e48e096&submit=GO http://www.unhcr.org/cgi-bin/texis/vtx/page?page=49e48e096&submit=GO B. **Most recent data on total number**: "Since the start of the crisis on 16 October 2015, 431,449 migrants and asylum seekers have been registered entering Slovenia. From 21-27 January, there were 10,204 registered arrivals, down from 13,559 the previous week. The daily average of registered arrivals over the reporting period was to this week, down from 1,937 in the previous week. This brings the cumulative total for 2016 to 52,845 registered arrivals." (Source: IOM-Situation Report | 28 January 2016)
Percentage of F/M/T, age groups and origin	A. **Most recent data per category:**

ASYLUM APPLICANT	2014	2015
Total	385	275
Males	75,3%	83,6%
Females	24,7%	16,4%
Less than 18 years	29,9%	30,9%
18 - 64 years	68,8%	70,9%
65 years or over	0,0%	0,0%
Unaccompanied minors (Asylum applicant)	65	
Males	100,0%	
Females	0,0%	
IRREGULAR MIGRANT	1.025	
Males	91,7%	
Females	8,3%	
Less than 18 years	8,8%	
18 years or over	91,2%	

Source: Eurostat, 2/02/2016

B. **Most recent data by gender, age group, origin**: "The Border Police Division provides lower numbers, indicating some 323,500 arrivals between 23 November and 31 December, originating mainly from Syria, Afghanistan and Iraq, including some 100,000 children. They entered Slovenia mainly from Croatia by train or bus.307 Only few of them applied for asylum in Slovenia." (Source: FRA Monthly Review Dec 2015)

2. HEALTH CARE RESPONSES	
Please correct or complete the information where possible.	
Health care coordination at national/regional level	A. **Existence of a national coordination mechanism of the health response**: YES/NO *(Please complete)* B. **Explanation**: *(if yes, please describe how the mechanism works and who participates; if no, please describe why there is no coordination)* Coordination done in Ljubljana. Partners (not only related to health): ADRA, Crisis Youth Centre Krško, Društvo Up, Evangeličanska humanistična organizacija, Firefighters Association, ICRC, Jesuite Refugee Service, Karitas, MdM, NiLu humanitarna organizacija, Order of Malta, PIC, Red Cross, Slovenska filantropija, UNHCR, WAHA (Source: UNHCR. Slovenia 3W.pdf)
First entry assistance services	"Based on an MdM BE assessment in Slovenia in October 2015, it was reported that when over 6,000 people entered the country daily, service provision was insufficient in particular concerning primary healthcare at border areas such as at Hamica and Sentijl (Slovenia). Reception and transit areas were quickly set up by the army and government to provide basic needs to migrants diverted through its borders. But the Sentijl transit camp – near the Austrian border – only has a hosting capacity for 4,000 people, which quickly proved insufficient as influxes peaked to 9,000 crossings a day in October" (MdM Annex 1) "The Slovenian Red Cross is also responding to the basic needs of migrants on the move mainly through a DREF allocation. In December 2015, the DREF operation`s Plan of Action was revised, to increase the number of the vulnerable people assisted from 10,000 to 15,000 people and to extend the operational timeframe until March 2016. The needs in the field have also changed due to the development of the situation, and the distributed hygiene and food kits have been adapted to those needs."

Response to 'An Agenda for Action' as agreed during the High Level Meeting on Refugee and Migrant Health in Rome in November 2015:
Cross the appropriate 'Yes', 'No' or 'There is no information available' option in the blue boxes. Additional information or sources can be mentioned underneath the box.

Integration of the health care services for refugees, asylum seekers end migrants into the existing national health systems	Yes	No	There is no information available
Limit initial screening upon arrival to relevant risk assessment			There is no information available

	Yes	No	
Non Communicable Diseases included in the provision of services	Yes	No	There is no information available
Active participation and empowerment of the refugees and migrants throughout all stages of health service provision, including design and planning	Yes	No	There is no information available
Training of health professionals involved in the provision of health care	Yes	No	There is no information available

3. WHERE-WHAT-WHO

Please correct or complete the information where possible.

Migrant group	WHERE are they receiving the health care?	WHAT type of health care provision are they receiving?	WHO is the actor/agency providing the health care?
(1) Recent arrivals	Reception facilities at Dobova and Gruskovje (Croatia-Slovenia border, entry points) Reception facility at at Brežice Reception facility at Lendava	"Medication is readily available at all times, and all costs of healthcare are covered by the state. From 1 to 31 December 2015, 56 people were hospitalised" (Source: FRA Monthly Review Dec 2015) "On 25 January, IOM deployed a psychologist to provide psychosocial services to migrants and refugees in accommodation and reception centres in Dobova and Sentilj." (Source: IOM-Situation Report | 28 January 2016). "Except for one occasion when a group of people passed through Slovenia without	"A medical team is still present at the registration and accommodation centres Brežice and Šentilj." (Source: FRA Monthly Review Dec 2015) IOM MdM Slovenian Red Cross Society Caritas UNHCR

		receiving food or beverages due to miscommunication, food and water have been systematically and regularly provided at all the reception and accommodation centres." (More detailed information, p. 61. FRA Monthly Review Dec 2015). "A makeshift reception facility was set up at Dobova, where migrants were assisted mostly by the Administration of the Republic of Slovenia for Civil Protection and Disaster Relief, the Slovenian Red Cross Society, Caritas, UNHCR and local and international volunteers." (Source: Regional Refugee and Migrant Response Plan, UNHCR, 2016).	Local and international volunteers WAHA (in Dobova) (Source: UNHCR. Slovenia 3W.pdf)
(2) People in transit	Transit camps at Šentilj, Gorna Radgona and Jesenice (cross-bordering to Austria); Source: http://data.unhcr.org/mediterranean/documents.php?page=1&view=grid&Country[]=207&Type[]=3http://data.unhcr.org/mediterranean/documents.php?page=1&view=grid&Country%5b%5d=207&Type%5b%5d=3 http://data.unhcr.org/mediterranean/documents.php?page=1&view=grid&Country%5b%5d=207&Type%5b%5d=3 http://data.unhcr.org/mediterranean/documents.php?page=1&view=grid&Country%5b%5d=207&Type%5b%5d=3	"Based on the number of arrivals and number of trains, if processing cannot be completed in Dobova, refugees and migrants are taken to either entry or exit transit facilities at Gruškovje, Gornja Radgona or Šentilj for further registration and access to services in particular medical care, and later depart to Austria. On 18 January 2016, Gornja Radgona reception facility will close due to expiration of the lease agreement. Lendava reception facility is being enlarged to take over the services offered to the refugees and migrants." (Source: Regional Refugee and Migrant Response Plan, UNHCR, 2016).	

	http://data.unhcr.org/mediterranean/documents.php?page=1&view=grid&Country%5b%5d=207&Type%5b%5d=3		
(3) Asylum seekers			
(4) Refugee status granted			
(5) Undocumented migrants			
(6) **Unaccompanied minors**			

4. FUNDING OF THE HEALTH CARE RESPONSES

Please provide us with any relevant information of funding made available by your country or other partners for health care responses:

- *FUNDING SOURCES: where does the funding come from? e.g. Government, UN agency (UNHCR, IOM, WHO Euro,…), EU, NGO, civil society organisation, faith-based organisation, private organisation, international donor, (public/private) health insurance, other (please specify)*
- *FUNDING MECHANISM: how is the health care delivery being funded? e.g. envelope (for whole year/project), lump sum amount per asylum seeker/refugee, out-of-pocket expenses, third payer mechanism, emergency/contingency budget.*
- *FUNDING AMOUNT: Give the amount spent on health care responses, in Euros, per year/month; if available also provide the pledged amount.*
- *COMMENTS.*

Migrant group	Funding source	Funding mechanism	Funding amount	Comments
(1) Recent arrivals	Government			
(2) People in transit				
(3) Asylum seekers				
(4) Refugee status granted				
(5) Undocumented migrants				

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National coordination of the health care response to refugees, asylum seekers and other migrants: *Working document*

SPAIN

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This working document summarizes the latest information on the influx of the different categories (see box 1 on Country Context) and on the coordination of the health care responses (see box 2) in Spain. It also maps the available information on the WHERE-WHAT-WHO of these health care responses (see box 3). This is done for different categories: (1) recent arrivals, (2) people in transit, (3) asylum seekers, (4) refugee status granted persons, (5) undocumented migrants, and where relevant, also for (6) unaccompanied minors. Lastly we would like to map the funding sources for which the Member State's input is appreciated (see box 4 on Funding of health care responses).

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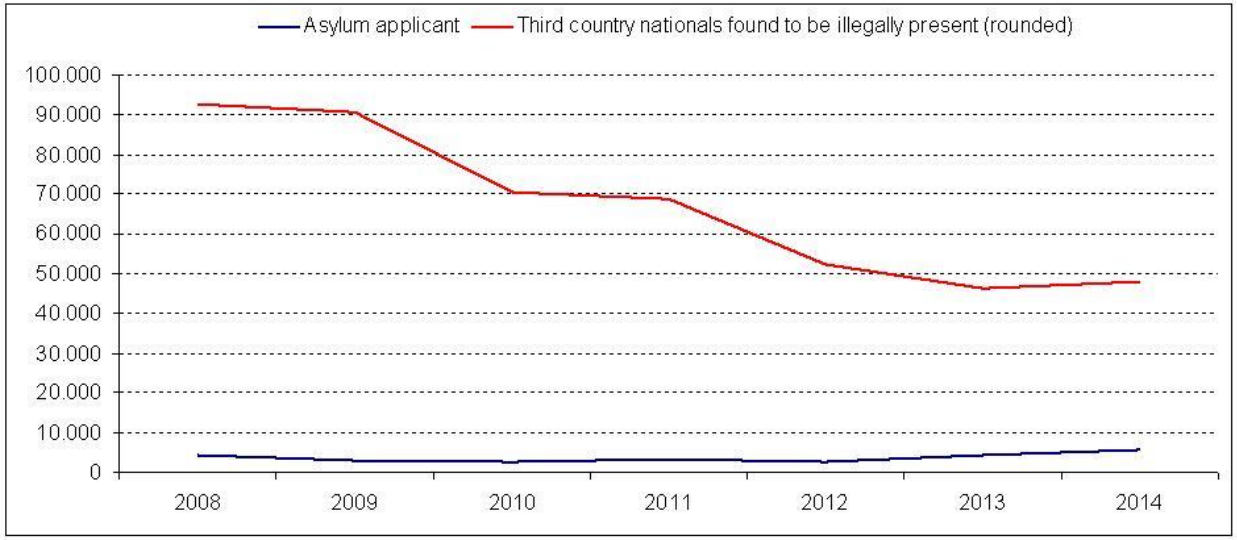
Sources consulted:

Eurostat, 2/02/2016.

MdM, Médecins du Monde. 8 NGOs for migrants/refugees' health in 11 countries. Project 717307. Annex I (part B), 2016.

UNHCR. Refugees/Migrants Emergency Response - Mediterranean
http://data.unhcr.org/mediterranean/regional.php / http://www.unhcr.org/pages/4a02d9346.html
http://www.unhcr.org/cgi-bin/texis/vtx/page?page=49e48eed6&submit=GO

Please provide us with any other sources that you deem appropriate for your country.

1. COUNTRY CONTEXT	
When influx started **(*by year up till 2015, month since 2015*)**	

	Eurostat, 2/02/2016. *(please complete or correct)*
Current number as of Feb 1 ***(AS/ REF/ UDM/ unaccompanied minors)***	A. **Most recent data per category** June 2015 Residing in Spain: Refugees: 5,798 Asylum Seekers: 11,020 Returned Refugees: 0 Internally Displaced Persons (IDPs): 0 Returned IDPs: 0 Stateless Persons: 440 Various: 0 Total Population of Concern: 17,258 Originating from Spain R Refugees: 60 Asylum Seekers: 87 Returned Refugees: 0 Internally Displaced Persons (IDPs): 0 Returned IDPs: 0 Various: 0 Total Population of Concern: 147. (Source: http://www.unhcr.org/cgi-bin/texis/vtx/page?page=49e48eed6&submit=GO) B. **Most recent data on total number**: Arrivals in 2015: 15,422 source: http://data.unhcr.org/mediterranean/regional.php Following the Commission's relocation scheme, Spain accepted to welcome about 17,680 refugees mainly from Syria and other war and conflicts countries, thereby making it one of the countries accepting the highest number of refugees after Germany and France. Spain has already received 2,797 migrants arriving from Ceuta, Melilla and in

	the Canaries. At least the same number of arrivals are expected in 2016. (UNHCR data on 11 November 2015, http://data.unhcr.org/mediterranean/regional.php, MdM, Annex 1)
Percentage of F/M/T, age groups and origin	A. **Most recent data per category:** Data based on figures from the Spanish Ministry of the Interior and the Spanish Police. Arrivals to the Canary Islands have been excluded from this analysis, as they are not part of the Mediterranean refugee movement. Land arrivals to the enclaves of Ceuta and Melilla are included. (Source: http://data.unhcr.org/mediterranean/regional.php) A year ago, about half of the residents of the Center for Temporary Stay of Immigrants (CETI) in Melilla were Sub Saharan Africans, but now they predominantly come from Syria. Moroccan border police has been making it increasingly difficult for Sub Saharan African migrants to seek asylum, making them more vulnerable to local trafficking networks. (MdM, Annex 1) B. **Most recent data by gender, age group, origin**: Syria: 44% Guinea Conakry: 13,6% Algeria 10,6% Morocco 5,7% Cameroon 5,0% Côte d´Ivoire 4,5% Occupied palestinian Territory 3,7% Burkina Faso 2,0% Gambia 1,6% Guinea Bissau 11% Other countries of top 7 nationalities 0,7%.

Eurostat, 2/02/2016

ASYLUM APPLICANT	2014
Total	5.615
Males	68,2%
Females	31,8%
Less than 18 years	20,4%
18 - 64 years	78,3%
65 years or over	1,3%
Unaccompanied minors (Asylum applicant)	15
Males	100,0%
Females	0,0%
IRREGULAR MIGRANT	47.885
Males	81,1%
Females	18,9%
Less than 18 years	2,5%
18 years or over	97,5%

2. HEALTH CARE RESPONSES			
Please correct or complete the information where possible.			
Health care coordination at national/regional level	A. **Existence of a national coordination mechanism of the health response**: YES/NO *(Please complete)* B. **Explanation**: *(if yes, please describe how the mechanism works and who participates; if no, please describe why there is no coordination)* In Spain there are 18 Administrative Regional Governments, each one of them autonomous in terms of a number of social competencies (Social Services, Education, Health, etc.). MdM Spain develops its work through programmes carried out in 12 out of the existing 18 Autonomous Communities. Some of those programmes through our own offices, and others implemented without a physical office. The local delegations of MdM Spain have been preparing with different local and regional public administrations, as well as with recipient organizations of refugees (Comisión Española de Ayuda al Refugiado or CEAR, Spanish Red Cross and ACCEM), strategies to host, support and assist these groups, expected to arrive in the coming weeks. (MdM, Annex 1) **The Spanish Red Cross** is working to increase the hosting capacity in preparation of the vulnerable migrants to be resettled in the country. The Red Cross is also actively supporting main arrival and transit countries (12 interventions in six countries) including shipments of medicines, raincoats, hygiene kits, mobile units, and kits for psychosocial support.		
First entry assistance services			

Response to 'An Agenda for Action' as agreed during the High Level Meeting on Refugee and Migrant Health in Rome in November 2015: *Cross the appropriate 'Yes', 'No' or 'There is no information available' option in the blue boxes. Additional information or sources can be mentioned underneath the box.*			
Integration of the health care services for refugees, asylum seekers end migrants into the existing national health systems	Yes	**x** No	There is no information available
Limit initial screening upon arrival to relevant risk assessment	Yes	No	There is no information available
Non Communicable Diseases included in the provision of services	Yes	No	There is no

			information available
Active participation and empowerment of the refugees and migrants throughout all stages of health service provision, including design and planning	Yes	No	There is no information available
Training of health professionals involved in the provision of health care	Yes	No	There is no information available

3. WHERE-WHAT-WHO			
Please correct or complete the information where possible.			
Migrant group	**WHERE are they receiving the health care?**	**WHAT type of health care provision are they receiving?**	**WHO is the actor/agency providing the health care?**
(1) Recent arrivals	The Red Cross is also actively supporting main arrival and transit countries (12 interventions in six countries) including shipments of medicines, raincoats, hygiene kits, mobile units, and kits for psychosocial support.	shipments of medicines, raincoats, hygiene kits, mobile units, and kits for psychosocial support.	Spanish Red Cross
(2) People in transit			
(3) Asylum seekers			
(4) Refugee status granted			
(5) Undocumented migrants			
(6) Unaccompanied minors			

4. FUNDING OF THE HEALTH CARE RESPONSES
Please provide us with any relevant information of funding made available by your country or other partners for health care responses: ▪ *FUNDING SOURCES: where does the funding come from? e.g. Government, UN agency (UNHCR, IOM, WHO Euro,…), EU, NGO, civil society organisation, faith-based organisation, private organisation, international donor, (public/private) health insurance, other (please specify)*

- *FUNDING MECHANISM: how is the health care delivery being funded? e.g. envelope (for whole year/project), lump sum amount per asylum. seeker/refugee, out-of-pocket expenses, third payer mechanism, emergency/contingency budget.*
- *FUNDING AMOUNT: Give the amount spent on health care responses, in Euros, per year/month; if available also provide the pledged amount.*
- *COMMENTS.*

Migrant group	Funding source	Funding mechanism	Funding amount	Comments
(1) Recent arrivals				
(2) People in transit				
(3) Asylum seekers				
(4) Refugee status granted				
(5) Undocumented migrants				

Programme co-funded by the EUROPEAN UNION

National coordination of the health care response to refugees, asylum seekers and other migrants: *Working document*
SWEDEN

READER'S GUIDE:

The SH-CAPAC consortium is conducting a mapping of the European Union Member States' health response to the refugees, asylum seekers and other migrants entering, transiting or staying in their territories.

This working document summarizes the latest information on the influx of the different categories (see box 1 on Country Context) and on the coordination of the health care responses (see box 2) in Sweden. It also maps the available information on the WHERE-WHAT-WHO of these health care responses (see box 3). This is done for different categories: (1) recent arrivals, (2) people in transit, (3) asylum seekers, (4) refugee status granted persons, (5) undocumented migrants, and where relevant, also for (6) unaccompanied minors. Lastly we would like to map the funding sources for which the Member State's input is appreciated (see box 4 on Funding of health care responses).

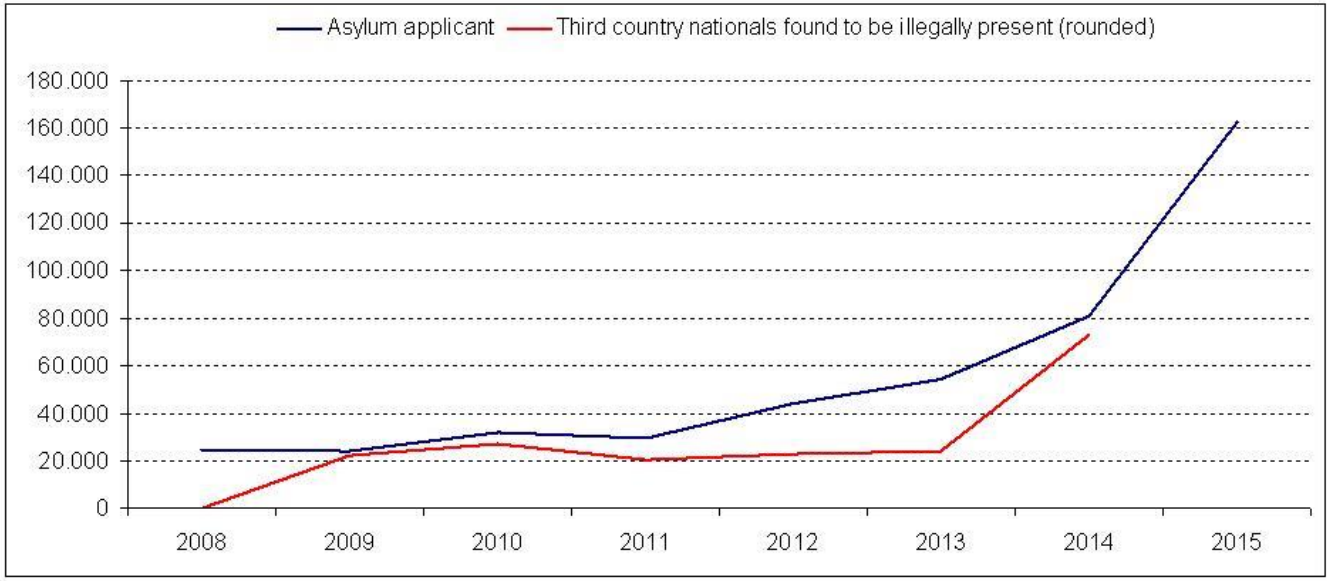
The information already completed below is based on different sources which were consulted online between January 20 and February 8 2016 and which is meant to give a first snapshot. ***We would like to ask you to verify the information, to correct and amend where necessary and to complete where possible.*** *This mapping exercise will help the SH-CAPAC consortium to define a framework for effective health sector coordination for addressing the needs of the refugees, asylum seekers and other migrants in the European Union.* ***Please reply before February 16 2016 to ainhoa.ruiz.easp@juntadeandalucia.es with copy to birgit.kerstens@gmail.com and daniel.lopez.acuna.ext@juntadeandalucia.es.*** *More information on the SH-CAPAC project can be found in the leaflet in attachment and on www.easp.es/sh-capac.*

Sources consulted:

- http://www.migrationsverket.se/download/18.7c00d8e6143101d166d1aab/1451894593595/Inkomna+ans%C3%B6kningar+om+asyl+2015+-+Applications+for+asylum+received+2015.pdf (MdM, Annex 1)
- Eurostat, 2/02/2016.
- FRA, European Union Agency for Fundamental Rights. Monthly data collection on the current migration situation in the EU. December 2015 monthly report. 23 November – 31 December 2015. http://fra.europa.eu/sites/default/files/fra_uploads/fra-2016-monthly-compilation-com-update-1_en.pdf

- Information bulletin IFRC Regional Office for Europe Migration response. IFRC. http://www.ifrc.org/docs/Appeals/16/IB6_Migration%20response_Europe_010216.pdf
- http://www.government.se/contentassets/f8effa03946941c5987f7ae76b356a02/agreement-measures-to-tackle-the-refugee-crisis.pdf
- MdM, Médecins du Monde. 8 NGOs for migrants/refugees' health in 11 countries. Project 717307. Annex I (part B), 2016.
- UNHCR. 2015 UNHCR subregional operations profile - Northern, Western, Central and Southern Europe. Sweden. http://www.unhcr.org/cgi-bin/texis/vtx/page?page=49e48f056&submit=GO
- *Please provide us with any other sources that you deem appropriate for your country.*

1. COUNTRY CONTEXT	
When influx started **(*by year up till 2015, month since 2015*)**	**Up till beginning of 2015**: (For further reference, see information on countries of origin for all asylum seekers and all asylum seeking unaccompanied children to Sweden since 2000: http://www.migrationsverket.se/download/18.23e76fe91505855cf762c8a/1447767909977/Asyls%C3%B6kande+2000-2014+samtliga+medborgarskap.pdf a compilation of all asylum seekers to Sweden 1984-2014 per country of origin: http://www.migrationsverket.se/download/18.39a9cd9514a346077211281/1421152055095/Asyls%C3%B6kande+till+Sverige+1984-2014.pdf) **Since beginning of 2015**:



Eurostat, 2/02/2016.

(please complete or correct)

Current number as of Feb 1 ***(AS/ REF/ UDM/ unaccompanied minors)***	A. **Most recent data per category**: ? Most recent data on **asylum seekers**: So far during 2016, 4 172 people have applied for asylum in Sweden, (Source: http://www.migrationsverket.se/download/18.2d998ffc151ac3871592560/1454329052951/Inkomna+ans%C3%B6kningar+om+asyl+2016+-+Applications+for+asylum+received+2016.pdf) The decrease in applications is believed to be related to the introduction of obligatory ID-controls on public transports (Ordinance on certain identity controls in case of serious threats to public order or internal security of the country, http://www.riksdagen.se/sv/Dokument-Lagar/Lagar/Svenskforfattningssamling/Svensk-forfattningssamling-201_sfs-2015-1074/), in force from 4 January 2016. (For more information: http://fra.europa.eu/sites/default/files/fra_uploads/fra-2016-monthly-compilation-com-update-2_en_0.pdf) Applications for asylum received, 2015 (on 01/11/2015), see: However, there is also a steady flow of migrants that transit through Sweden on their onward journey, to Finland or Norway from the south or towards continental Europe from Russia and Finland. (MdM, Annex 1) As of November 12, border controls on the bridge towards Denmark and ferry towards Germany have been set up. There are reports about migrants having turned to taking small boats across instead. (MdM, Annex 1) During the period of 1 to 31 December 2015, Sweden received a total number of 13,872 applications for asylum, meaning a decrease in the number of registered asylum seekers compared to the peak period of September (24,309), October (39,201) and November (36,704). (FRA Monthly Review Dic 2015) http://fra.europa.eu/sites/default/files/fra_uploads/fra-2016-monthly-compilation-com-update-2_en_0.pdf ***Residing in Country*** | ***June 2015*** Refugees | 142,207 Asylum Seekers | 56,135 Returned Refugees | 0 Internally Displaced Persons (IDPs) | 0 Returned IDPs | 0

Stateless Persons	27,167
Various	0
Total Population of Concern	225,509
Originating from Country	
Refugees	18
Asylum Seekers	10
Returned Refugees	0
Internally Displaced Persons (IDPs)	0
Returned IDPs	0
Various	0
Total Population of Concern	28

Figure refers to the end of 2014 in the absence of updated information available.
source: http://www.unhcr.org/cgi-bin/texis/vtx/page?page=49e48f056&submit=GO

B. **Most recent data on total number**: ?

From January 1, 2016 until February 1, 2016, 4 172 people have applied for asylum in Sweden.

During the period of 1 to 31 December 2015, Sweden received a total number of 13,872 applications for asylum, meaning a decrease in the number of registered asylum seekers compared to the peak period of September (24,309), October (39,201) and November (36,704). Out of the asylum applicants in December, 9,258 were men/boys and 4,614 women/girls, and 6,881 of them were children. Almost half of this group (3,217) were unaccompanied children, which is also a decrease in comparison with the previous months of September (4,712), October (9,339) and November (8,808).410 The unaccompanied children are predominately boys.411 Approximately 43 % of the unaccompanied children are 13–15 years old and 50 % are 16–17 years old. 1,507 of the asylum seekers were over 64 years old. In January, the total amount of asylum seekers were 2 546 men and 1 626 women. Included in this group is a total of 637 unaccompanied minors (of which 568 boys, 69 girls). Regarding asylum seeking unaccompanied children arriving in Sweden and residing in accommodation provided by the Migration Agency, the vast majority come from Afghanistan (see p. 55-56 http://www.migrationsverket.se/download/18.7c00d8e6143101d166d7da/1454329101976/Inskrivna+personer+i+Migrationsverkets+mottagningssystem.pdf)

Statistics on those having transited Sweden are not collected. Municipalities are not aware of an irregular migrant

	population. The main three third countries of origin of asylum applicants remain Syria , Afghanistan and Iraq as it has been throughout 2015 and previously (http://www.migrationsverket.se/Om-Migrationsverket/Statistik/Asylsokande---de-storsta-landerna.html).
Percentage of F/M/T, age groups and origin	A. **Most recent data per category:** ? B. **Most recent data by gender, age group, origin**: ?

ASYLUM APPLICANT	2014	2015
Total	81.180	162.450
Males	67,5%	70,5%
Females	32,5%	29,5%
Less than 18 years	28,7%	43,3%
18 - 64 years	69,9%	55,7%
65 years or over	1,4%	0,9%
Unaccompanied minors (Asylum applicant)	7.045	
Males	80,7%	
Females	19,3%	
IRREGULAR MIGRANT	72.835	
Males	67,7%	
Females	32,3%	
Less than 18 years	28,2%	
18 years or over	71,7%	

Hotspots	Age assessment of children has received a lot of attention in Swedish media during January. The government has

	instructed the Migration Agency to be more diligent with respect to age assessments. The medical assessment procedures in place have been criticised by medical professionals for not being precise enough. The guardianship system (god man) for unaccompanied children during the asylum process continues to be a major challenge, as emphasised by several stakeholders. The Civil Contingencies Agency continues to be concerned with the following four issues: accommodation for asylum seekers, inadequate social services, inadequate education facilities in the municipalities, and the overall situation of unaccompanied children. Many asylum seekers remain in short-term 'municipal evacuation shelters' (evakueringsboenden) for long periods of time, waiting for permanent accommodation placements for the duration of the asylum process. Current accommodations are often overcrowded and understaffed, which has led to an increase in reports on conflicts and violence at the accommodation centres. The Migration Agency has planned to keep 70 % of the evacuation shelters until April and 30 % until July 2016. Tents are no longer used as a shelter option. The Migration Agency estimates that 20,000 new accommodation places (platser på asylboenden) are needed during 2016. The reception capacity concerning unaccompanied children in municipalities has been identified as one of four areas of greatest concern in Swedish asylum management. Problems are reported from all regions (*län*) and the reception is assessed to not meet the best interests of the child as per the Convention on the Rights of Child. Overall, there is a lack of social workers and teachers at all levels of the education system at the municipal level. As a result, both social services and schools struggle to meet the needs of newly arrived children, unaccompanied or not. The main concerns with respect to unaccompanied children are finding accommodation options, to identify and investigate potential family placements, and the overcrowded temporary accommodations.The number of irregularities reported by municipalities to the Health and Social Care Inspectorate (*Inspektionen för vård och omsorg*), a government agency responsible for supervising health care, social services etc., has continued to increase and was an estimated 64 in January. Source: http://fra.europa.eu/sites/default/files/fra_uploads/fra-2016-monthly-compilation-com-update-2_en_0.pdf In the beginning of the reporting period (26 November 2015), the Swedish Migration Agency declared that it could not guarantee accommodation to all persons arriving in Sweden and was forced to prioritise families with children.442 This situation has changed for the better, although great challenges remain in terms of

	accommodation, both in quality and quantity.443 There is still a shortage of short-term municipal emergency shelters (*evakueringsboende*) to which asylum seekers can be directed upon arrival. During the reporting period, asylum seekers have had to wait for days before their asylum applications were registered and were during the time forced to stay in so-called assembly halls (*samlingslokaler*) primarily located in the city of Malmö.444 These assembly halls (for example conference locations) are not intended for living. Some of them have very poor sanitary conditions and which leads to a very limited access to healthcare.445 (More detailed description, p. 73-74; FRA Monthly Review Dic 2015)

2. HEALTH CARE RESPONSES	
Please correct or complete the information where possible.	
Health care coordination at national/regional level	**Existence of a national coordination mechanism of the health response**: YES/NO (Please complete) no A. **Explanation**: *(if yes, please describe how the mechanism works and who participates; if no, please describe why there is no coordination)* The situation regarding availability and accessibility of healthcare is sometimes challenging, mainly with respect to the primary health care system (*primärvård*), psychiatric and dental care. However, the health care system, which is the responsibility of the region and the county councils, is assessed to be less strained than the areas mentioned above (e.g. social services etc.).The availability of health care differs between different parts of the country. In smaller municipalities where large accommodation centres for asylum applicants are located, but where the regional healthcare system cannot respond to the increasing needs, the challenges are greater.[475] Civil society organisations are expressing their concern particularly regarding the risk that groups and individuals in need of specific care during the asylum and reception processes are not identified. Source: http://fra.europa.eu/sites/default/files/fra_uploads/fra-2016-monthly-compilation-com-update-2_en_0.pdf All asylum seekers shall be offered a health examination upon arrival to Sweden. According to regulation SOSFS 2011:11 issued by the National Board of Health and Welfare (https://www.socialstyrelsen.se/sosfs/2011-11) the

	examination shall be offered to all asylum seekers (children and adults) as well as to undocumented migrants. The health examination is voluntary and includes talking about the patient's general health, mental and physical (*hälsosamtal*), taking tests and asking about vaccination levels to determine whether the patient requires additional vaccinations (*vaccinationsplan*). The National Board of Welfare has since 2013 operated a special website with guidelines regarding health examinations to asylum seekers (http://www.socialstyrelsen.se/vardochomsorgforasylsokandemedflera/halsoundersokning). The Public Health Agency has also published guidelines regarding health examinations and how to respond to the needs of the migrant patient (http://www.folkhalsomyndigheten.se/pagefiles/18233/Moten-om-halsa-vagledning.pdf). A further challenge for the health care in Sweden is the difficulties in targeting all the asylum seekers in order to undergo health examinations, in general the health care system tend to target those staying at accommodations for asylum seekers and tend to leave out those staying at friends or families house. One of the main explanations for this might be the lack of updated information regarding contact details to the asylum seekers, e.g. residential address. As for now the group who accommodate outside the accommodation regulated by the Migration Agency is a hard to reach group. In some regions the primary health care performs health examinations at the accommodations for asylum seekers and accommodations for unaccompanied children, and in some regions the health examinations are performed at the primary health care centers. The number of performed health examinations varies between regions. The main challenges with performing the health examinations might be due to geographical distances, lack of enough resources due to the increasing number of immigrants in a short period of time and furthermore also the lack of knowledge regarding migration health. Another great challenge is the lack of interpreters, there is a great variation within the country regarding access to registered interpretations which in some cases is essential in order to perform health examinations *(the health examination includes a part where the health history and history during migrations is discussed).* There is a lack of regional coordination of interpreters why there is great differences within the country regarding access. This has put a demand on health personnel speaking other languages except from Swedish to act as interpreters (e.g. primary care, acute care and dental care). Due to the many migrants seeking asylum in Sweden the processing time for asylum applications has prolonged from todays 9 months to more than 15 months. Furthermore the living space to be guaranteed at the accommodations for asylum seekers has decreased in order to provide accommodation to as many applicants as possible. These two factors may have an impact on psychological stress and will put an increasing demand on health care in Sweden, especially concerning psychiatric care *(there will be a variation within the country)*.

	During our initial assessment, we met many migrants, including many unaccompanied minors, who do not wish to be registered, and therefore sometimes avoid seeking care from official instances. The situation varies greatly between the different regions in Sweden. As the provision of care is decentralised it also means that the issues that migrants face vary. Many migrants travel to or through smaller cities where the resources in this exceptional situation might be even less adapted. As winter is approaching we fear that overcrowded shelters will increase risks for transmitting communicable infections. Most municipalities focus their health interventions on families travelling with children and unaccompanied minors, meaning that most of the health needs of single male travellers remain unmet. As of early September 2015, when the amount of transit and asylum seeking refugees increased drastically, MdM Sweden has been part of a network of NGOs in Stockholm, managing reception and organizing housing and medical care to those that are not protected by the Swedish migration system. Since mid-September, MdM has had a mobile unit in Stockholm assessing needs, distributing information and mediating between migrants and healthcare providers, responding to the urgent needs without substituting public health systems. (MdM, Annex 1) The situation regarding availability and accessibility of healthcare is challenging.468 Especially in smaller municipalities where large accommodation centres are located, the regional healthcare system cannot meet the increasing need, particularly when it comes to special needs, such as psychiatric treatment and post war trauma treatment. 469 However, the situation differs greatly across the country with the consequence that the asylum seekers have very different access to healthcare depending on location.470 In some regions the healthcare for asylum applicants is located to primary healthcare centres whereas other regions have created special units only attending to asylum applicants.471 A lack of vaccinations has been observed472 together with a lack of interpreters, which further impacts the access to healthcare.473 (FRA Monthly Review Dic 2015) The Swedish Red Cross provides regular support to vulnerable migrants upon arrival with Restoring Family Links

	services, psychosocial support (also for staff and volunteers), first aid, asylum advisory services, voluntary return assistance and treatment of victims of torture. The ICRC initiated the discussion on its support to the Swedish Red Cross in light of the scale up and further development of its detention activities in favour of migrants. source: Information bulletin IFRC Regional Office for Europe Migration response. IFRC. http://www.ifrc.org/docs/Appeals/16/IB6_Migration%20response_Europe_010216.pdf http://www.government.se/contentassets/f8effa03946941c5987f7ae76b356a02/agreement-measures-to-tackle-the-refugee-crisis.pdf The aim of these measures is to create decent and orderly reception and better introduction, and to mitigate the cost increases. More countries must do more to offer people protection. Sweden will stand up for the right of asylum. In times of crisis, this is more important than ever. People fleeing war and oppression must be able to obtain protection in Sweden. The implementation of the agreed measures will be followed up jointly Measures to tackle the refugee crisis Sweden and Europe are in the midst of an enormous task in providing security to people fleeing war, persecution and oppression. The Swedish asylum system is facing major challenges, as the number of people who have sought asylum in Sweden has increased dramatically. In this serious situation, the Government, the Moderate Party, the Centre Party, the Liberal Party and the Christian Democrats have agreed on necessary measures to reinforce capacity in Sweden's reception of asylum seekers and strengthen the introduction of new arrivals. The aim of these measures is to create decent and orderly reception and better introduction, and to mitigate the cost increases. More countries must do more to offer people protection. Sweden will stand up for the right of asylum. In times of crisis, this is more important

	than ever. People fleeing war and oppression must be able to obtain protection in Sweden. The implementation of the agreed measures will be followed up jointly. MEASURES TO REINFORCE SWEDEN´S ASYLUM SYSTEM Shortening processing times for asylum applications Creating space for more asylum seekers in accommodation centres Maintenance requirement for family member immigration Temporary residence permits to be introduced as a general rule for a limited period Legal routes Review on unaccompanied minors Sweden to request relocation of migrants under the JHA Council decision of 22 September MEASURES TO STRENGTHEN THE INTRODUCTION OF NEW ARRIVALS IN SWEDEN Early action in the asylum-seeking process Municipalities to share responsibility for the reception of newly arrived immigrants Better and more rapid introduction Expansion of opportunities for vocational introduction jobs More opportunities for work experience Expansion of tax deductions for household work Clearer requirements for obtaining income support Restriction of parental benefits Further opportunities to cope with the housing situation More school places More teachers and more adults in schools STRENGTHENED RESOURCES TO HANDLE THE REFUGEE CRISIS

	Application for available EU funds One-off funding to municipalities and civil society Formulation of municipal support for housing construction
First entry assistance services	

Response to 'An Agenda for Action' as agreed during the High Level Meeting on Refugee and Migrant Health in Rome in November 2015:
Cross the appropriate 'Yes', 'No' or 'There is no information available' option in the blue boxes. Additional information or sources can be mentioned underneath the box.

Integration of the health care services for refugees, asylum seekers end migrants into the existing national health systems	**X** Yes	 No	 There is no information available
Limit initial screening upon arrival to relevant risk assessment	 Yes	**X** No	 There is no information available
Non Communicable Diseases included in the provision of services	**X** Yes	 No	 There is no information available
Active participation and empowerment of the refugees and migrants throughout all stages of health service provision, including design and planning	 Yes	 No	**X** There is no information available
Training of health professionals involved in the provision of health care			**X** There is no information available

	Yes	No	

3. WHERE-WHAT-WHO
Please correct or complete the information where possible.

Migrant group	WHERE are they receiving the health care?	WHAT type of health care provision are they receiving?	WHO is the actor/agency providing the health care?
(1) Recent arrivals	at main entry and transit points	Red Cross volunteers are present at main entry and transit points to provide guidance and assistance to arriving migrants.	The Swedish Red Cross
(2) People in transit			
(3) Asylum seekers	Regional health care facilities	All asylum seekers shall be offered a voluntary health examination (see health care responses).	Regional health care facilities
(4) Refugee status granted			
(5) Undocumented migrants	Since July 2013, undocumented migrants have the same access to healthcare as asylum seekers (i.e. subsidised healthcare "that cannot be deferred" including medical examination and medicine covered by the Pharmaceutical Benefits Act, dental care "that cannot be deferred", maternity care and termination of pregnancy, and sexual and reproductive care). (…) In practice, based on our experience in the existing MdM clinic in Stockholm, we observe that many healthcare professionals		

	are still unaware of these changes. Furthermore, the vague definition of care "that cannot be deferred" had to be clarified by the National Board of Health and Welfare (*Socialstyrelsen*) and the law is often still not correctly applied. This is why we also foresee a large increase in undocumented migrants and many unmet health needs. (MdM, Annex 1)		
(6) Unaccompanied minors	All children of undocumented parents have the same rights to medical care (including vaccination) as Swedish children. In practice, based on our experience in the existing MdM clinic in Stockholm, we observe that many healthcare professionals are still unaware of these changes. (MdM, Annex 1)		

4. FUNDING OF THE HEALTH CARE RESPONSES
Please provide us with any relevant information of funding made available by your country or other partners for health care responses:

- *FUNDING SOURCES: where does the funding come from? e.g. Government, UN agency (UNHCR, IOM, WHO Euro,…), EU, NGO, civil society organisation, faith-based organisation, private organisation, international donor, (public/private) health insurance, other (please specify)*
- *FUNDING MECHANISM: how is the health care delivery being funded? e.g. envelope (for whole year/project), lump sum amount per asylum seeker/refugee, out-of-pocket expenses, third payer mechanism, emergency/contingency budget.*
- *FUNDING AMOUNT: Give the amount spent on health care responses, in Euros, per year/month; if available also provide the pledged amount.*
- *COMMENTS.*

Migrant group	Funding source	Funding mechanism	Funding amount	Comments
(1) Recent arrivals	Government agency			(all boxes) Health care funding sources come from the government, channeled through the Migration Agency. The regions and municipalities can apply for some of the funding sources, while others are paid directly. **Regions:** Regions are entitled to reimbursement from the government for some of the costs incurred for asylum seekers. Regions are also entitled to reimbursement for some of the costs incurred for persons who have applied for, or have been granted, a residence permit. Some of the state reimbursements are paid without application, but others require application. http://www.migrationsverket.se/download/18.5e83388f14

				1c129ba6310c34/1404292417628/faktablad_statlig_er_landsting.pdf **Municipalities:** Municipalites can apply for reimbursement from the government for some of the costs incurred for asylum seekers. Municipalites are also entitled to reimbursement for some of the costs incurred for persons who have applied for, or have been granted, a residence permit. Some of the reimbursements are paid without application, but others require application. http://www.migrationsverket.se/download/18.b70e31914e4e8c297f28ae/1441283029303/faktablad_statlig_ersattning_asyl_150903.pdf, http://www.migrationsverket.se/download/18.20cfdbe014887632b911409/1414585322447/faktablad_statlig_ersattning_ut_141029.pdf, http://www.migrationsverket.se/download/18.b70e31914e4e8c297f28b0/1441283183705/faktablad_statlig_er_tills

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(2) People in transit				
(3) Asylum seekers				
(4) Refugee status granted				
(5) Undocumented migrants				