Programme co-funded by the EUROPEAN UNION

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

Working document

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SH-CAPAC Project, WP1

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Glossary

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
HCF	Health coordination framework
HCM	Health coordination mechanism
HeRAMS	Health Resources Availability Mapping System
HIV	Human immunodeficiency virus
HRH	Human resources for health
IASC	Inter-Agency Standing Committee
ICCPR	International Covenant on Civil and Political Rights
ICESR	International Covenant on Economic, Social and Cultural Rights
IEC	Information education communication
IFRCRC	International Federation of Red Cross and Red Crescent Societies
IMCI	Integrated management of childhood illnesses
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
MOH	Ministry of Health
MS	Member State
MSF	Médecins sans Frontières (Doctors without Borders)
MUAC	Mid-upper arm circumference
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

1 Why do we need a Health Coordination Framework?

The European region is at the heart of an expanding range of increased migration streams. This influx generates the presence of different types of migrants which can be categorized according to the phase of the migration trajectory they are in and/or the type of residence status they have at that point. This ranges from 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. The different types of migrants not only 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.

In addition to challenges related to the migrants' profiles, the availability, accessibility, acceptability and quality of services, caregivers' attitude and understanding of the law and bureaucratic barriers also impact the potential health response. Finally, health of refugees, asylum seekers and migrants is a complex public health problem with cross cutting issues such as sexual and reproductive health, mental health and psychosocial support, injuries and sexual and gender-based violence treatment and prevention, demanding a multisectorial response to the recent influx of refugees, asylum seekers and other migrants into the European Union.

A mapping of health care response to the recent influx of refugees, asylum seekers and other migrants in 19 European Union (EU) Member States (MS) (see template of the mapping exercise in Annex 1) has demonstrated that so far:

- The health response has mainly consisted of an ad hoc humanitarian health response with regard to new arrivals and mobile populations.
- The health response is fragmented: the involvement of many different partners, not all acting in harmony, results in overlapping, duplication and unmet health needs because of the lack of adequate coordination, both within a member state, at member state and at European level.
- Undocumented migrants are regularly only covered for emergency care by the public sector but are often receiving assistance from NGOs.
- In addition to traditional governmental and non-governmental organisations, there is now also an important involvement of spontaneous, self-organized volunteers that should be taken into consideration.
- There is no coordinated approach to integrating migrants (particularly third country nationals into national health and welfare systems.

All of these above-mentioned elements necessitate a **coordinated response** anchoring migrants' health in a human rights framework and harnessing all partners, stakeholders and good will at national, local and municipal level. It is important that the Ministry of Health or equivalent health authority at national or local level is in the driver's seat, playing a leading role. The absence of a coordination process may weaken the health system and its governance in the long run because of fragmentation of the health responses.

Responding to the health needs of refugees, asylum seekers and other migrants requires thus also an enormous coordinated effort of EU Governments, Red Cross societies, NGOs, the European Union, the UN agencies (especially UNHCR, WHO and UNICEF) and the International Organization for Migration (IOM).

2 The aim of this Health Coordination Framework

The present document is aimed at supporting individual EU Member States in defining the fundamental elements that ought to be present in the **development of a coordination mechanism for the multiple national and international stakeholders** 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.

It is addressed primarily to the national or subnational health authorities responsible for defining an operational strategy for harnessing the contributions of different actors to the provision of health care for and the implementation of public health interventions addressed to these populations. It is also intended for

the different governmental and non-governmental actors as well as international organizations who participate in the national and local efforts directed at responding to the health needs of these vulnerable populations.

3 Rights, obligations and entitlements to health

WHO defines health as *a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity* (WHO, 1948). With the Universal Declaration of Human Rights (UDHR, 1948), the *enjoyment of the highest attainable standard of health* was put forward as a fundamental right of every human being. The human right to health applies universally and was codified into binding law by the International Covenant on Economic, Social and Cultural Rights (ICESCR) and the International Covenant on Civil and Political Rights (ICCPR) in 1966. In 2000, the UN Committee on Economic, Social and Cultural Rights (CESCR) issued "General Comment 14", an authoritative explanation of the Article 12.1 on the right to health of the ICESCR. It states in paragraph 12 (b) that governments have legal obligations to ensure that *"health facilities, goods and services are accessible to all, especially the most vulnerable of marginalized sections of the population, in law and in fact, without discrimination on any of the prohibited grounds"* [32], defined as *"race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth, physical or mental disability, health status (including HIV/AIDS), sexual orientation, civil, political, social or other status"* (§18). In addition, the CESCR specified that States have an obligation to respect the right to health *"by refraining from denying or limiting equal access (…) for all persons, including (…) asylum seekers and illegal immigrants, to preventive, curative and rehabilitative health services*" [31]. **All 27 EU Member States ratified this "International Bill of Human Rights"** (=UDHR, ICESCR and ICCPR).

In the EU, the right to healthcare is also included in the Charter of Fundamental Rights of the European Union (Art 35): "the right to healthcare includes the right of every person to access preventive health care and the right to benefit from medical treatment under the conditions established by national laws".

Furthermore, 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 and more specifically emergency care and essential treatment of illnesses and of serious mental disorders (Art 19.1), necessary medical and other assistants to applicants with special needs, including mental health care (Art 19.2), assessment of vulnerable persons such as minors who have been victim of torture, rape or other serious forms of psychological, physical or sexual violence, such as victims of female genital mutilation (Art. 21) and applicants with special needs (Art 22), treatment for victims of sexual and gender-based violence and torture (Art 25.1), minors who have been victim (Art. 23.4) and prevention of SGBV in the reception facilities (Art 18.4). Besides, Member States need to guarantee applicants' subsistence and protection of their physical and mental health (Art. 17.2), ensure adequately trained staff, bound by confidentiality rules (Art 18.7), necessary basic training of staff with respect to both male and female applicants (Art 29.1), free legal assistance (Art. 26.2).

4 Setting the scene for a health response

The current context requires that prompt action is taken to guarantee the above entitlements to health care to all refugees, asylum seekers and other migrants present in the European Union Member States. Contextual elements to take into account are:

- The health needs of a vulnerable population of at least 1,000,000 people who have recently entered the EU in 2015 are an issue of public health importance. This population may amount to two million refugees, asylum seekers and other migrants at the end of 2016.
- The health needs we are observing are a compounded effect of acute critical health needs that warrant humanitarian interventions as well as health needs that require access to regular comprehensive health care and public health interventions provided by the countries' health systems.
- The deteriorated purchasing power of these population groups, among others things, lead to rising malnutrition rates. Their access to care other than emergency care is limited in most EU Member States.
- Gaps exist in the national health information and disease surveillance systems. These, in turn, increase the risk of vaccine preventable diseases and epidemic outbreaks. Hundreds of thousands of children should keep on track with their vaccination schedule.

- The profile of the displaced population has become very gender- and age diverse indicating an increased need for sexual, reproductive and child health services, as well as geriatric care.
- Many of these migrants are survivors of different types of violence. Some are amputees needing prostheses, there are victims of psychological and physical trauma needing specialized treatment and there are others in need of specific clinical, psychosocial and forensic actions in response to sexual violence experiences. Sexual violence is also a specific reason for claiming asylum and a priority health concern, which requires both prevention and response interventions at all stages of migration and in all types of reception facilities.
- A number of migrants have serious chronic conditions (e.g. cancer, diabetes…) the treatment of which should be continued.
- The Member States' legal and policy frameworks do not always alleviate barriers ensuring access to health care; a gap exists between the recognition of the universal right of all to health care and its adherence in several EU member states.
- Migrants' health goes beyond the traditional management of communicable diseases and is closely linked with the social determinants of health.
- Migration in itself is not a health risk but the migration process can often bring circumstances posing important health risks and challenges.
- Sometimes unnecessary mandatory health checks have been imposed in some member states. The right balance needs to be found between ethics and people's' rights versus security pressures.
- The crisis is dynamic, influenced by changing politics, seasons and the evolution of the major conflicts triggering it. We are dealing with a protracted crisis with increased impact on various local sectors, including health, compounded by insufficient planning of a long-term integrated multi-sectoral response.

> *"In spite of a common perception that there is an association between migration and the importation of infectious diseases, there is no systematic association. Communicable diseases are primarily associated with poverty. Refugees and migrants are exposed mainly to the infectious diseases that are common in Europe, independently of migration. The risk that exotic infectious agents such as Ebola virus and Middle Eastern Respiratory coronavirus (MERS-CoV), will be imported in Europe is extremely low, and experience has shown that, when it occurs, it affects regular travellers, tourists or health care workers rather than refugees and migrants."*
>
> Quote from Z. Jakab, WHO regional director for Europe, 2 September 2015. Source: WHO EURO. Population movement is a challenge for refugees and migrants as well as for the receiving population. Copenhagen: Denmark. WHO. 2015.

5 What is the purpose of this Health Coordination Framework?

This Health Coordination Framework seeks to provide strategic guidance for establishing or strengthening a mechanism under the leadership of the Ministry of Health (MOH) or any other national/regional/local government designated agency. It provides basic elements for developing or strengthening a health coordination mechanism for all participating national and international stakeholders involved in the health response to the recent influx of refugees, asylum seekers and other migrants to share information, adopt a coordinated approach, establish common objectives, harmonize efforts and use available (human and financial) resources efficiently to ensure access to appropriate integrated health services for these population segments.

When Member States apply this Health Coordination Framework, it will help them in:

1. Establishing a standing coordination mechanism, led by the Ministry of Health, 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 for responding to the health needs of these populations with the participation of the different stakeholders that are part of the coordination mechanism
4. Mobilizing the necessary resources to implement the actions mentioned in the above
5. Monitoring and evaluating the health response to the refugees, asylum seekers and other migrants

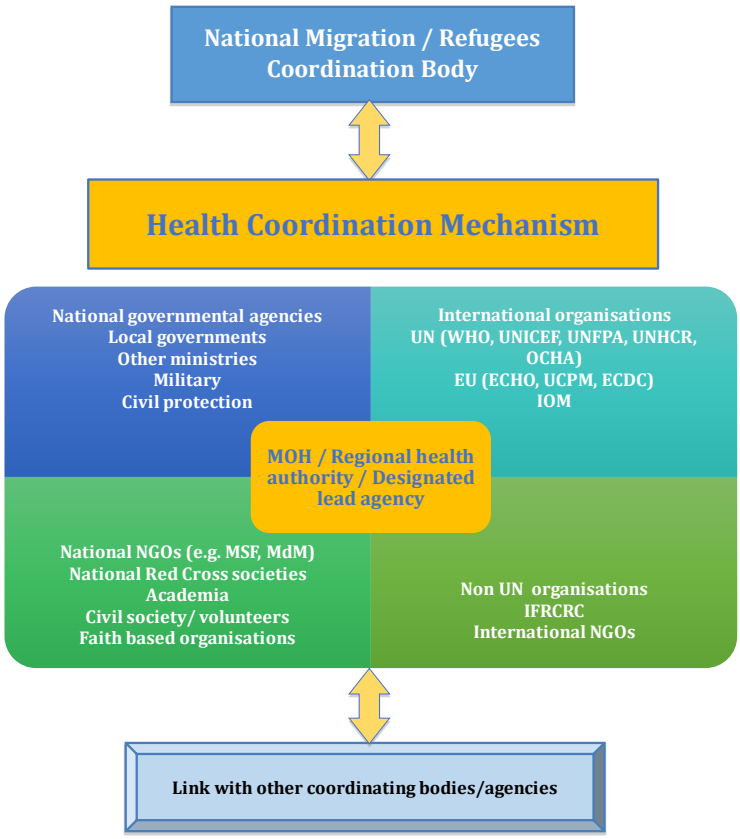
6. Leading the communication and advocacy[1] efforts in support to the health response to these populations.

The following chapters present the key actors, the functions, basic principles and process of the health coordination mechanism. All these chapters will be further elaborated after discussion during the SH-CAPAC workshop in Ghent on February 23 and 24.

6 Who should be part of the Health Coordination Mechanism at country level?

It is important to note that the Health Coordination Mechanism (HCM) can be established at various levels namely at national, regional or local level. At each level the relevant health authority should coordinate the process (e.g. Ministry of Health at national level, regional health authority at subnational level). The health authority 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. Figure 1 illustrates the role and linkages of the country's health authority with the various potential partners and is by no means exhaustive. The national partners are represented on the left hand side with public services 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 with the UN and EU related organisations in the upper section and the other international organisations in the lower portion.

Figure 1: Actors to be involved in the health coordination mechanism



[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.

The Health Coordination team should link with other coordinating bodies or agencies dealing with non-health sectors but that have an impact on health i.e. water and sanitation, food security or agencies who have common programs such as SGBV and who are not partners of the team. This is important to avoid duplication and ensure complementarity.

7 Functions of the Health Coordination team

1. Coordination mechanisms and inclusion of all health actors (mapping of actors, contact, them, regular meetings…)
2. Coordination of needs assessment & analysis including gap identification

Functions 2 to 8 will imply the participation of specific national technical staff as per topic and the partners involved in that specific function.

3. Coordination of Strategic planning with attention to cross cutting issues such as RH+ SGBV, mental health, and filling gaps
4. Development of action plans to respond to the health needs identified
5. Coordination of Contingency planning for protracted situations aiming at adopting a health systems approach
6. Application of standards; ensure use of national policies, norms and standards (support development/revision of guidelines if needed using recognised international best practices)
7. Coordination of training and capacity building: in areas identified as priorities using existing or developed protocols
8. Monitoring and evaluation (with partners' contribution and involvement)
9. Resource mobilisation (financial, human resources, supplies)
10. Advocacy
11. Reporting to the national migration coordinating body (country specific), to relevant stakeholders and information to media, public.

8 Basic principles of the Health Coordination team

- Comply with values of equity, human rights, gender, cultural sensitivity.
- Ensure health provision based on health needs.
- Ensure safety, confidentiality, respect and non- discrimination.
- Be inclusive: identify all health actors (including volunteers).
- Complement and strengthen existing coordination structures (make use of what exists already) at national and sub national level (important for hotspots and involvement of regional health authorities). Avoid parallel systems.
- Focus on affected people needs, work at the field level and adopt a result-oriented approach.
- Identify major gaps, problems, barriers, etc., and learn from other similar situations (neighbouring countries…). Learn from error and mistakes.
- Set realistic objectives based on key priorities, get the buy in (understand and respect the partners' mandates) and build from there.
- Ensure transparency.
- Give feed back to the populations concerned, stakeholders involved.

9 Health Coordination Mechanism

The table below shows the different steps to be taken in order to set up a successful coordination team.

Table 1: Stepwise approach for successful coordination mechanism

Process of the functioning Health Coordination Mechanism		
Process item	**What**	**How/remarks**
1. Designation of the Health Coordination Mechanism (HCM) team/coordinator	The MOH or designated health body by the national/regional authority designates a team and coordinator for the Health Coordination Mechanism	The coordinator should if possible be supported by other technical public health professionals as per context, an epidemiologist, information management specialist and a communication specialist
2. Mapping of stakeholders	☐ Identify local 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 available financial and human resources ☐ Understand their mandates, expectations and constraints ☐ Gather information, guidelines and tools	☐ Gather info (simple form) ☐ Consider use of a tool: e.g.: o WHO assessment
3. Ensure regular successful meetings	☐ HCM chairs (co-chairing possible as decided by MOH) ☐ Choose suitable venue ☐ Set realistic agenda: "smart" objectives ☐ Hand out info ☐ Ensure recording of minutes with action sheets (who is responsible for what) ☐ Keep meetings short ☐ Set date for the next meeting ☐ Be open to new partners ☐ Former agreements follow-up	☐ Focus on problem solving/action not just info sharing ☐ Consider subgroups for specific issues (vaccination campaign, SGBV, mental health…) reporting back to the coordination meetings
4. 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 ☐ If WHO is part of the HCM, it can liaise with UNCT	☐ Invite their representative at the HCM team meetings ☐ Designate someone from the HCM team to attend the respective meetings as relevant

Process of the functioning Health Coordination Mechanism		
Process item	**What**	**How/remarks**
5. Information management	☐ Identify information management and communication specialist (from onset) ☐ Plan health assessment ☐ Regular update of the data base & info system, ☐ Internal feedback to all partners of the HCM and to national coordinating body	☐ Focus on information for action that will inform national and decentralized health planning
6. External communication	☐ Ensure feedback to national coordinating body, other relevant line ministries, stakeholders including UN and EU, media, public ☐ Respect confidentiality[2]	☐ Importance of having a communication specialist in the team: highlight advantages to the general population
7. Specific coordination functions	☐ See chapter 7 for specific functions of the Health Coordination team ☐ Ensure coordinated approach ☐ Ensure capacity building ☐ Ensure respect of norms and standards ☐ Ensure, strategic health planning for an integrated approach to provision of public health services to the migrant population	☐ This has the potential to strengthen the national health system through activities that will also benefit the local population.

The **Health Coordination team** can be organized at central, regional or local level. It is suggested to ensure a core group comprised of a coordinator, a health information person and a staff member from the health authority with public health experience. A communication specialist would be desirable especially at national level or in a prominent hotspot.

The coordinator should be designated by the health authority of the corresponding level and should be someone with proven leadership skills, knowledge of and experience with migrant crisis and with public health background. The health information person should be someone with epidemiological or basic health statistics experience, an information management person or the staff member/clerk in charge of compiling health data at the local level. The additional staff member with public health experience could be an asset.

According to the level, contextual needs and dynamics of the situation, additional persons from the health authority may be called upon to participate in the meeting. An immunization 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.

The core team should map the main (national and international) stakeholders and invite them to be part of the health coordination mechanism.

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

The health coordination team would ensure the mapping of partners involved in terms of 'Who is doing What Where and When'.

When planning health assessment or subsequent action plans, the following elements need to be taken into consideration:

1) What has already been done?
2) Access:
   - to health services
   - opening hours, especially for women and girls
   - communication (interpreters, pictograms, local facilitators)
3) Staff:
   - availability of female and male staff, local staff?
   - training in culturally sensitive communication
   - training in specific areas such as SGBV and psychosocial support
4) 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
5) Risk reduction: can be initiated immediately without assessment
   - WASH: provision of appropriate water and sanitation taking into consideration a gender perspective
   - appropriate lighting in facilities especially sanitary
   - presence of Minimal Initial Services Package (MISP) at facilities
   - application of SGBV guidelines
6) Environment:
   - community awareness/ education programs/ public information campaigns
   - use of local field workers
7) Services:
   - type of services available including referrals
   - specific attention on services for reproductive health including BEOC, SGBV
   - vaccination according to norms (emphasis on measles, mumps & rubella and polio)
   - screening for CD as per country of origin
   - surveillance especially TB
   - psycho social support
   - care for unaccompanied minors
8) 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 (should be agreed upon by the coordination team)
   - respect of confidentiality
9) Financial and human resources:
   - Funding source: where does the funding come from? (e.g. government, UN, EU, NGO, volunteers….)
   - 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; if available, pledged amount

- Human resources for health: number of staff by category/specialty

10) Provide internal feedback to all partners of the HCM and to national coordinating body.

10 Characterising the health response by population segment

To advance health coordination in the four types of countries, being: (1) countries of first arrival, (2) transit countries, (3) traditional and (4) new destination countries; it is important to look at the pattern of strengths and weaknesses shown (see annex 2 for more information on these categories):

- Entitlements for asylum seekers in traditional destination countries were no better than in other countries. Wealthier countries might be expected to give better entitlements, but there are severe restrictions on the types of care available to asylum seekers in the first 15 months of their stay.
- Entitlements for irregular migrants are slightly better in the traditional destination countries – though there are considerable variations. It is above all in the countries not used to dealing with migrants at all that serious problems are bound to arise for this group. As long as services are provided by NGOs, the legal barriers to care can be circumvented, but laws only allow regular health services to provide a limited amount of help. These issues must be urgently placed on national agendas.
- Concerning accessibility, information for asylum seekers tends to be better and pathways to care easier than for other groups of migrants. This may, however, only be true for primary care (which is generally provided in the centres). Very few countries of any type provide information for irregular migrants. This task is usually left to NGOs.
- Concerning the responsiveness of health services to the special needs of migrants, there is a very large difference between traditional destination countries and the others. There is thus an urgent need in the latter for interpreter services, training courses on the needs of migrants, and migrant participation.
- Health systems in certain traditional destination countries are currently handicapped by the restrictions they impose on the **entitlements to care** of both asylum seekers and irregular migrants. The other countries above show serious failings in their **responsiveness to the needs of migrants** (affecting all groups).

The following table presented in a matrix form segments the target population and highlights the respective salient aspects of the response that ought to be put in place to meet their health needs and that need to be taken into account for coordinating the health response.

There are different types of migrants which can be categorized according to the phase of the migration trajectory they are in and/or the type of residence status they have at that point. This ranges from 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. The different types of migrants not only 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
Recent arrivals	Hotspot/ Registration facility	Initial assessment/triage Acute care Psychological first aid SGBV prevention & response SRH	Governmental agency NGO Volunteers IOM	MOH/RHA with IOM/UNHCR
Unaccompanied minors recently arrived	Hotspot/ Registration facility	Initial assessment/triage Acute care Psychological first aid Protection SGBV prevention &	Governmental agency NGO Volunteers IOM	MOH/RHA with IOM/UNHCR

Population segment	Location of response	Type of health response	Key actors in the health response	Authority/ coordination
		response SRH		
People in transit	Reception facilities	Acute care Psychological first aid Protection Comprehensive PHC[3], 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) NGO	MOH/RHA with IOM/UNHCR/MI
Unaccompanied minors in transit	Reception facilities (protected)/special minors protection facilities	IAcute care Psychological first aid Protection Comprehensive PHC[3], 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) NGO	MOH/RHA with IOM/UNHCR/MI
Asylum seekers	Reception facilities/ health centre/hospital	Comprehensive PHC[3], mobile clinics, flexible referral to SHC SGBV prevention & response SRH	MOH/RHA/LHA/ designated lead agency NGO	MOH/RHA/MI Integration into regular health system initiated
Unaccompanied minors seeking asylum	Reception facilities/special minors protection facilities/ health centre/hospital	Comprehensive PHC[3], mobile clinics, flexible referral to SHC SGBV prevention & response SRH	MOH/RHA/LHA/ designated lead agency NGO	MOH/RHA/MI+ child protection Integration into regular health system initiated
Refugee status granted	Reception facilities/ Health centre/hospital	Comprehensive PHC[3], flexible referral to SHC SRH	MOH/RHA/LHA/ designated lead agency	MOH/RHA Integrated into national health system
Unaccompanied minors with refugee status granted	Reception facilities/ Health centre/hospital	Comprehensive PHC[3] flexible referral to SHC SRH	MOH/RHA/LHA/ designated lead agency	MOH/RHA+ child protection Integrated into national health system
Undocumented migrants	Health centre/hospital NGO facility Red Cross facility	Comprehensive PHC[3], referral to SHC	MOH/RHA/LHA NGO Red Cross	MOH/RHA
Undocumented unaccompanied minors	Health centre/hospital NGO facility Red Cross facility	Comprehensive PHC[3], referral to SHC	MOH/RHA/LHA NGO Red Cross	MOH/RHA+ child protection

[3] Comprehensive PHC: A PHC–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, emphasizes 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.

11 Concluding remarks

The guidelines provided above are part of Work Package (WP) 1 of the SH-CAPAC project and are still work in progress. This is a first draft of the Health Coordination Framework to be completed based on EU Member States' inputs in a workshop in Ghent on 23-24 February 2016.

The current Health Coordination Framework assumes a dynamic use, considering the nature of the refugee crisis, and the Member States are free 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 MOH's (or any other designated agency) responsibility and authority. Moreover, it is a first tool of a set of instruments that will help the MS in implementing the framework, consisting of an assessment tool (WP2 of the SH-CAPAC project), an action plan (WP3), a resource package tool for reducing access barriers (WP4) and training in cultural-sensitive care (WP5).

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 for establishing the health coordination mechanism and/or to strengthen the current coordination arrangements in the respective countries.

ANNEX 1: Template of mapping matrix

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

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 [country]. 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:

- xxx
- xxx

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

<table>
<tr><th colspan="2">1. COUNTRY CONTEXT</th></tr>
<tr><td>When influx started
(by year up till 2015, month since 2015)</td><td>Up till beginning of 2015:
Since beginning of 2015:
(please complete or correct)</td></tr>
<tr><td>Current number as of Feb 1 (AS/ REF/ UDM/ unaccompanied minors)</td><td>A. Most recent data per category: ?

<table>
<tr><th>Residing in [Country]</th><th>(month) 2015</th></tr>
<tr><td>Refugees</td><td></td></tr>
<tr><td>Asylum Seekers</td><td></td></tr>
<tr><td>Returned Refugees</td><td></td></tr>
<tr><td>Internally Displaced Persons (IDPs)</td><td></td></tr>
<tr><td>Returned IDPs</td><td></td></tr>
<tr><td>Stateless Persons</td><td></td></tr>
<tr><td>Various</td><td></td></tr>
<tr><td>Total Population of Concern</td><td></td></tr>
<tr><td>Originating from [Country]</td><td></td></tr>
<tr><td>Refugees</td><td></td></tr>
<tr><td>Asylum Seekers</td><td></td></tr>
<tr><td>Returned Refugees</td><td></td></tr>
<tr><td>Internally Displaced Persons (IDPs)</td><td></td></tr>
<tr><td>Returned IDPs</td><td></td></tr>
<tr><td>Various</td><td></td></tr>
<tr><td>Total Population of Concern</td><td></td></tr>
</table>

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: ?</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/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	

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			
(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				

ANNEX 2: Typology of countries according to influx

2.1 EU countries of first arrival experiencing a large influx of unauthorized migrants

The countries most affected at the moment are Greece and Italy, but changing political circumstances and seasonal variations can lead to shifts in migration routes. Greece is having to shoulder the burden of accommodating and caring for large numbers of migrants, including providing them with health care. Most migrants will travel northwards if they can, and the proposed 'hotspots' may facilitate this movement. Many will remain, however, so Greece faces a large increase in numbers of asylum seekers, as well as irregular migrants. The latter include those who do not register at all, those who register without applying for asylum, those who apply for asylum but decide to go underground, and those whose application is refused (either immediately or after legal consideration). If attempts to block the irregular migration route between Turkey and Greece are successful, this is likely only to divert the flow to other countries. They will then experience similar problems to those of Greece today.

2.2 Transit countries

These countries are characterized by a large influx, but at the same time a large outflow of migrants. (Greece therefore also belongs in this category.). Transit countries can be placed under great strain, but the strain is temporary in nature. Similarly, only immediate and stopgap forms of health care – first aid – can be administered to migrants in transit, unless they are so incapacitated that they are unable to travel further. The provision of 'health cards' containing essential information, as well as vaccinations, can also be done in transit countries.

Other transit countries currently include, Croatia, Slovenia and Austria. The Baltic States and Poland have long been transit countries for migrants arriving via Russia. France, Germany and Denmark may be transit countries for migrants trying to reach the UK and Sweden respectively. From this two things are clear:

- It is possible to be a transit country at the same time as a country of arrival and a country of destination.
- The migratory pressure on transit countries may change suddenly and unpredictably

2.3 Traditional destination countries

Countries of destination are at present chosen by the asylum seekers themselves, or by those transporting them. This may change when a compulsory system of redistribution is put in place. It seems likely that the chance of obtaining international protection, the conditions of asylum, the presence of relatives and ethnic networks, the language, and likely future prospects all play a role. Therefore, the most popular countries of destination tend to be relatively wealthy countries with a history of granting asylum.

The migratory pressure experienced by these countries can be considerable, but it is of a different kind to those described above. In several of the destination countries listed, reception and accommodation facilities (including health services) have already reached or exceeded the limit of their capacity. These countries may

be familiar with the typical health needs of asylum seekers, but unable to meet them adequately because of restrictions on entitlement, poor accessibility of services and inadequate resources for overcoming linguistic and cultural barriers.

In addition to the 'immediate' problems (those arising in countries of arrival), the other problems described above are happening now – in fact they have been getting worse for some time. Health care services for asylum seekers in some areas are said to be close to breaking down. In some cases, the first health assessment will indicate a need for long-term treatment. However, organizing such treatment is an immediate problem, which has to be solved here and now.

2.4 New destination countries

In the current situation, many countries with very little previous experience of providing asylum are experiencing an increase in asylum applications and numbers of irregular migrants. Most of these countries are in Eastern Europe, but Spain and Portugal also fall in this category. Such countries have in the past received extremely small numbers of asylum seekers. They are now faced with the problem of scaling-up provisions and acquiring new skills and resources. This problem will become even more acute if the EU's plans for relocating asylum seekers are realized.