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.