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

GUIDE FOR ASSESSMENT OF HEALTH NEEDS AND HEALTH PROTECTION RESOURCES

SH-CAPAC Project, WP2

August 30th 2016

Users guide

- The present document aims at supporting individual European countries in identifying the health needs of the refugees, asylum seekers and other migrants who are part of the recent influx to European countries, and to assess the available health protection resources in the given European country. The objective of the assessment is to identify gaps between health needs and available resources to provide the basis for planning and carrying out action in terms of necessary health provision and preventive measures for refugees, asylum seekers and other migrants. Guidelines to support the process of action planning and strategy development are provided separately in the SH-CAPAC WP3 report 'Planning for Action'.

- This guide for assessment speaks to the national or subnational health authorities responsible for coordinating and developing response and contingency planning of meeting the needs of the migrant populations in question. The health assessment is an integrated part of the process of planning and strategy development (see WP3). The guide is also intended for the different governmental and non-governmental actors as well as international and civil society organization who participate in the national and local efforts at responding to the health needs of refugees, asylum seekers and other migrants.

- Flexibility in the application of this guide for assessment is highly recommended. This guide for assessment and the tools provided in the guide are not the only solutions for assessment processes.

- The guide was presented and discussed together with SH-CAPAC Framework for Action Planning at the SH-CAPAC workshop involving EU Member States representatives on May 17 and 18 2016 in Copenhagen, Denmark. It was also discussed at SH-CAPAC workshop on June 15 and 16 2016 in Reggio Emilia, Italy. Recommendations form workshops are integrated. Revisions will be made publicly available on http://www.easp.es/sh-capac/.

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List of acronyms

AT	Assessment team
BEOC	Basic emergency obstetric care
CS	Civil society
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
FGM	Female genital mutilation
GP	General practitioner
HCT	Health coordination team
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
IOM	International Organization for Migration
LGBTI	Lesbian, gay, bisexual, transgender/transsexual and intersexed
LHA	Local health authority
M/C	Maternal/child
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)
NAT	National assessment team
NCD	Non-communicable disease

NGO	Non-governmental organization
NHA	National health authority
PHC	Primary health care
PMTCT	Prevention of mother to child transmission
PTSD	Post-Traumatic Stress Disorder
RH	Reproductive health
RHA	Regional health authority
SGBV	Sexual and gender-based violence
SHC	Secondary health care
SRH	Sexual and reproductive health
STI	Sexually transmitted infection
TB	Tuberculosis
THC	Tertiary health care
UCPM	(European) Union Civil Protection Mechanism
UDHR	Universal Declaration of Human Rights
UN	United Nations
UNCT	United Nations Country Team
UNFPA	United Nations Population Fund
UNHCR	United Nations High Commissioner for Refugees
UNICEF	United Nations International Children's Emergency Fund
WASH	Water, sanitation and hygiene
WHO	World Health Organization
WP	Work package

Glossary

- **Health needs**: refer to needs related to health and wellbeing; for example, needs for medicine, needs for nutrition, needs to be safe from physical and psychological harm, needs for specific health care and health prevention implied by the presence of specific sicknesses or diseases.
- **Health protection resources**: refer to health care, disease prevention and health promotion, and include health and associated social services
- **Assessment team**: is the team appointed by the Health coordination team to do the assessment. Several national/local assessment teams can be appointed in the national context to carry out the assessment in coordination.
- **Health coordination team**: is the core/executive team designated by the leading governmental authority/agency in providing health care to migrants (from asylum seekers to undocumented migrants) to lead the coordination of the health response to the influx of migrants.
- **Country scenario:** characterises the migration situation of a country. Scenario A refers to the situation of migrants arriving/being in transit, while scenario B refers to the situation of migrants waiting to settle (asylum seekers) and/or in the process of settling (granted protected status). Various health protection resources may be of specific importance in different scenarios.
- **Migratory stage**: refers to a stage or period during the trajectory of flight/migration. The asylum seeking process is for example a specific stage of migration that is followed by the grant or rejection of protected status in a given country. Health needs and risk may shift, change and/or accumulate during different migratory stages.

INTRODUCTION

Why do we need a health needs assessment?

The recent influx of large numbers of migrants and refugees to Europe has called attention to the general and special needs of individuals, families and vulnerable groups who have fled situations of persecution, violence and war. At the same time, in many countries, it has imposed a significant strain on the capacity of health systems to respond to those needs. Complicating this issue is the tension between the varied, but usually limited, legal entitlements to health care of different groups of migrants and the requirements of international agreements on the rights to health care to which the governments have formally agreed.

Under these circumstances, a health needs assessment and the subsequent development of work plans provide an opportunity to government, stakeholders and health and social services professionals, in particular, to identify the health needs of migrants and risk factors in their living circumstances, and assess the adequacy of services in meeting those needs as the basis for developing action plans to bring in improvements.

Purpose of Guide for Assessment of Health Needs and Health Protection Resources

This Guide for Assessment of Health Needs and Health Protection Resources is one of a set of work packages developed by the SH-CAPAC Project to assist European countries in their efforts to improve migrant health (See Figure 1)

Figure 1: The SH-CAPAC Program to assist member states improve migrant health

The guide aims at providing assistance in gathering essential information from a country's reservoirs of knowledge and experience among health and social services professionals, health services managers, national and local NGOs, civil society and the migrant population. Specifically, the guide is designed to assist the government and stakeholders of migrant health to:

- Identify the locations, numbers and general characteristics of these migrant populations,
- Identify the general and, particularly, the special health needs of migrants, and the health risk factors in their current living circumstances,
- Assess the extent to which the health services provided meet those needs and address those risk factors,
- Draw conclusions on the major unmet needs or the gaps in services, deficiencies in the quality or appropriateness of care, and any barriers to accessing and making full use of the services by migrants.

Dimensions of the health situation of refugees, asylum seekers and other migrants to Europe

Meeting the extensive and diverse health needs of the massive influx of refugees and other migrants to European countries poses different challenges in different countries. This complexity must be considered not only in the health response but also in the complete process of health needs assessment. In other words, the assessment must be contextualised by taking into account various intersecting factors.

Country scenarios and migratory stages

This assessment guide operates with two country scenarios.

Scenario A: Arrival and transit

In this scenario, migrants arrive, sometimes in large numbers, at particular locations, and may stay for a rather short period of time, days or even hours. Their main concern is to continue on the journey to their destination country. Requests for health care are usually only for acute or emergency conditions. The numbers may overcome the capacity of existing health and other services to receive them, creating a humanitarian crisis situation. From the point of view of this health assessment and management, it is the short period of time that migrants are present and the rapid turnover that is important.

Scenario B: Settlement (asylum seekers, settling with protected status, undocumented migrants, and stranded migrants)

In this scenario, migrants arrive in a destination country mainly to seek asylum. The critical difference from scenario A is that migrants are present for weeks, months or longer. It is at this stage of their journey that migrants begin to attend to their health problems.

Three main stages are recognised in typical destination countries: 1) the asylum seeking process, where asylum seekers are waiting, often in specific accommodation facilities, and 2) the settling process when protected status has been granted, and 3) the undocumented status of those who have been refused protected status but have not been deported. A fourth group of "settled" migrants are the ones that have been stranded in camps for weeks or months in typical arrival or transit locations following the closure of surrounding country borders.

Entitlements and barriers to health services

It is important to be aware of the very different legal situations of migrants in Scenario A and B, as a migrant's legal situation is of crucial importance to their access to health care. Therefore, entitlements to health protection and care are important aspects to include in the assessment of available health protection resources.

Emergency humanitarian aid is usually provided by a combination of NGOs and the national health system. It is usually given free of charge: the crucial issue is usually whether it is available, not whether it is accessible. In normal situations, however, when health care is delivered by the national health system, provision is subject to rules of entitlement. Different groups (nationals, EU/EFTA migrants, third-country nationals, beneficiaries of international protection, asylum seekers and undocumented migrants) are legally entitled to different levels of coverage. Therefore, unless these rules have been explicitly suspended, it is not enough for care to be available: migrants must also be entitled to receive it.

In addition, there are several kinds of non-legal barriers that can arise between service providers and their (potential) beneficiaries. The following can be distinguished: administrative barriers (overcomplicated procedures, discretionary decisions); lack of information and/or of health literacy; barriers of language and culture; and – for undocumented migrants – the risk of being reported to the authorities. Finally, a lack of 'cultural competence' or 'sensitivity to diversity' in the actual delivery of care will also constitute a barrier.[1]

Health areas and vulnerable groups

Migrant populations start with the pattern of health and disease that is typical of people of their socio-economic status in their country of origin. They are generally similar to those of European populations. Those patterns are frequently modified by the experiences of persecution, violence or war that led to their becoming refugees and migrants. They are usually further modified by the experiences and hardships of the journey, difficulties in accessing health care along the way, and then the circumstances under which they live in their destination country. For vulnerable groups, the effects of these influences are usually greater.

Table 1 lists major areas of health and disease, all of which may be affected in different ways and to different extents by the migration experience and by the circumstances in the destination country. Health care is frequently organised according to these health areas or combinations of them. A breakdown of health areas of this sort is, therefore, recommended as the approach to identifying health needs and risk factors and to the assessment of health and social services provided to meet those needs. It should also be noted that these health areas coincide with or include most of the identified vulnerable groups.[2]

[1] The MIPEX study (www.mipex.eu) has made a comprehensive overview of access to health services in European countries for three categories of migrants: migrant workers (regular), asylum seekers and undocumented migrants. See also annex 2 for an overview of recently identified challenges in access to health services for refugees, asylum seekers and other migrants.

[2] Unaccompanied minors, children and adolescents, single parents with minor children, pregnant women, people with disabilities, elderly, victims of torture, rape or other serious violence, undocumented migrants.

Table 1: List of major categories of health needs and health care	
Sexual and Reproductive Health	• Family planning • Pregnancy and childbirth • Sexual and reproductive health of minors
Child Health	• Acute illnesses • Nutrition, growth and development • Vaccinations
Communicable Diseases	• Epidemic-prone diseases • Skin infections • Parasitic diseases • Tuberculosis • STIs and HIV/AIDS
Non-communicable and Chronic Diseases	• Diabetes, cardio-vascular and lung diseases • Arthritis • Cancers
Dental Health	• Acute • Prevention
Injuries	• Emergency care
Sexual and Gender-based Violence	• Prevention • Holistic care for victims
Mental Health	• Depression, prolonged grief disorders and suicide • Post-Traumatic Stress Disorder and reactions • Substance use disorders • Perpetration of domestic or sexual violence

A three phase assessment process: Planning, data collection and reporting

The assessment process has a stepwise approach with three phases: phase A for assessment coordination and planning, phase B for data collection through several tools and phase C for reporting. Figure 2 illustrates these phases, while table 2 below gives an overview of activities within each phase and the tools/toolkits provided in the assessment guide. Notice that the activities and tools are suggestions and not the only solutions for assessment processes.

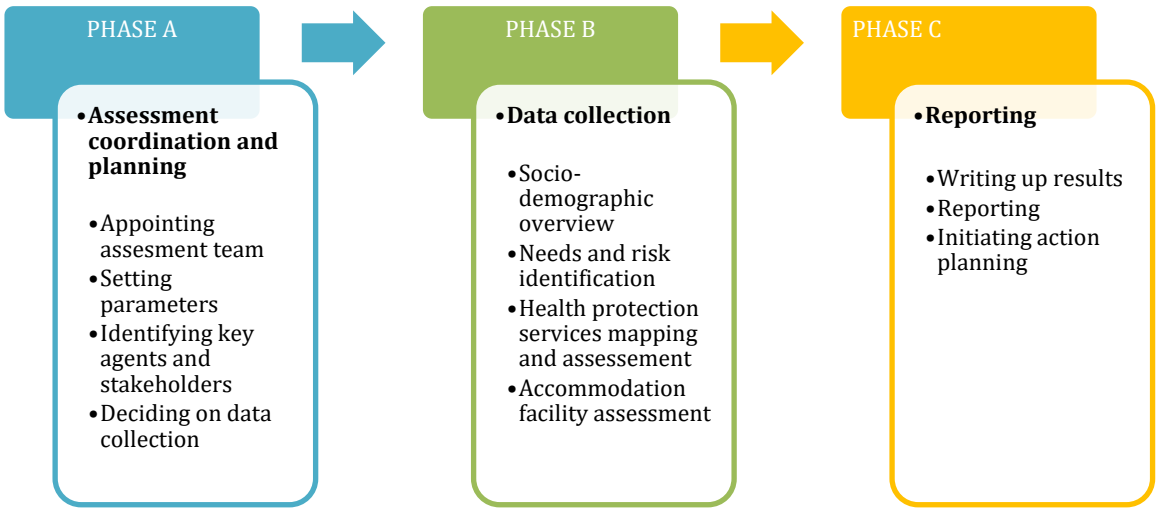

Figure 2: Assessment Phases

Table 2: Activities and list of tools within assessment phases		
Phases	**Activity**	**Tools provided**
PHASE A: Assessment coordination and planning	Appointing assessment team(s)	*See also Health Coordination Framework of SH-CAPAC WP1*
	Setting parameters and contextualising the assessment	**A1** Assessment Parameters Checklist
	Identifying and gathering key resources and stakeholders	**A2** Stakeholder Checklist
	Elaborating an assessment plan	**A3** Work plan Checklist
PHASE B: Data collection	**DIMENSION I**: Socio-demographic overview	**Tool I** Socio-demographic mapping
	DIMENSION II: Needs and risk identification	**Tool II** Key information guide to assess contextual health needs and risk factors**.**
	DIMENSION III: Health protection services mapping and assessment	**TOOLKIT III** **Tool III.1** Assessing providers' interpretations of migrant entitlements to care **Tool III.2** Mapping primary health care facilities **Tool III.3** Assessing availability of primary health care services **Tool III.4** Assessing availability of secondary health care services **Tool III.5** Identifying barriers to access to and quality of health care services
	DIMENSION IV: Accommodation facility assessment	**TOOLKIT IV** **Tool IV.1** Assessing general health protection at accommodation centres **Tool IV.2** Assessing SGBV protection at the accommodation facilities
PHASE C: Reporting	Writing up assessment notes Reporting results to Coordination Team	**C1**: Summary framework checklist
	Initiating action planning	*See guidelines/tools of SH-CAPAC WP3*

PHASE A: Assessment Planning

COORDINATION AND PLANNING

A basic precondition to carry out the assessment of health needs and available health protection resources is the establishment of a coordinating mechanism bringing together national, subnational and international stakeholders involved in the health response to the recent influx of refugees, asylum seekers and other migrants (see chapter 2 in the SH-CAPAC report 'Coordination framework for addressing the health needs of the recent influx of refugees, asylum seekers and other migrants into the EU countries'). The health coordination team within the coordinating mechanism must take the initiative to do the assessment of health needs and health protection resources.

The coordination and planning phase of the health needs assessment includes four elements: 1. appointing the assessment team(s), 2. setting parameters of a contextualised assessment, 3. identifying key agents and stakeholders and 4. deciding on data collection methods.

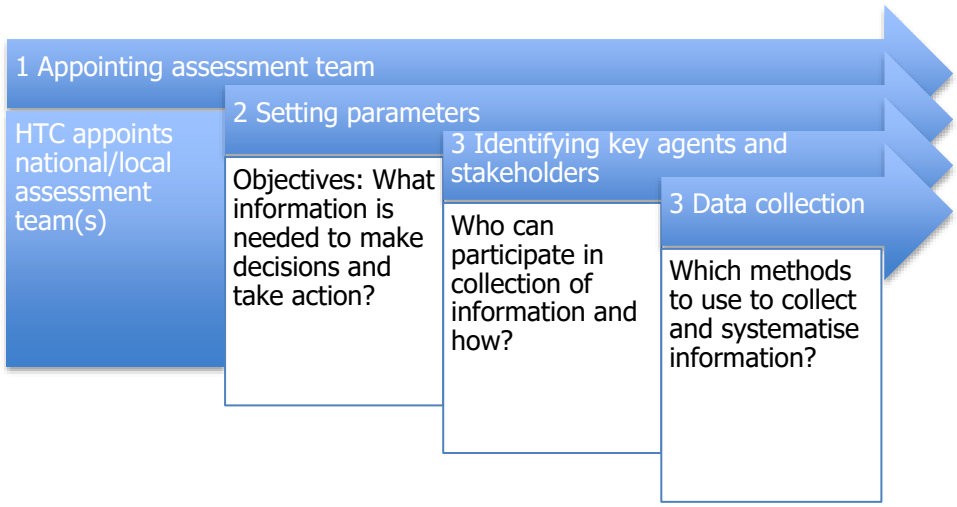

Figure 3: Coordination and planning

1 Appointing assessment team

An assessment team (AT) is appointed by the health coordination team (see WP1) to carry out the assessment and to report back to the health coordination team so that a process of planning and strategy development (see WP3) can be initiated.

Since the assessment consists of different tools and elements it can be effective to assign different tasks to different teams based on their specific skills and access to information. If more teams are appointed, the HCT ensures coordination of collaboration and shared information between these teams or one assessment team has a coordinating role.

2 Setting parameters

When initiating the assessment, careful planning and engagement with key stakeholders helps to ensure that all relevant parameters are taken into consideration; that the assessment builds on and uses all existing knowledge and available information resources; and that required resources are provided.

The assessment team is must consider and identify what information is needed to take action; including reflections on:

- At which level(s) to do the assessment (national/subnational/local)
- Which scenarios and stages of migration to emphasise in the assessment

- Which health areas and vulnerable groups to focus on.
- Which dimensions to include in the assessment (socio-demographic overview, needs and risk identification, resource assessment, accommodation facility assessment, others)

Deciding on scenarios and assessment dimensions

The actual assessment process is similar in scenario A and B. However, while there are many common challenges to be addressed in the two scenarios, there are specific issues that require different approaches. In scenario A, a specific objective of the needs assessment is to gather information that can help health authorities to manage a situation in which the numbers and health care needs of migrants may change rapidly and unexpectedly and in which the coordination of multiple organisations providing care is essential. Priorities in this situation may be the monitoring of available health resources and ensuring safe accommodation.

Under the more settled circumstances of scenario B, health authorities and health staff need to provide health care for the full spectrum of health needs and help migrants to get into the national programs for the long term care of pregnancy care, child growth and development, the management of chronic diseases and, especially the large burden of mental health problems. This process involves difficult adjustments with language, culture and lack of familiarity with the health system. The emphasis of the assessment, therefore, is much more on a qualitative approach.

Although one scenario may be predominant in a specific country setting, it is important to notice that all countries are shaped by dynamics of both scenarios A and B. In particular, countries that were earlier mainly arrival and/or transit countries are now increasingly facing challenges as destination/settling countries. It may, therefore, be appropriate to do most of the assessment at a subnational or local level, depending on whether they are scenario A or B situations. National-level assessments may be necessary for newer, more complex issues like migrant mental health or the development of appropriate and affordable systems for providing language and cultural interpretation.

Table 3: The assessment approach according to scenario A and B

	Scenario A	**Scenario B**	
Migration stage	**First arrival/transit**	**Stranded migrants and the asylum seeking process**	**Settling (transition phase)**
Level of assessment	(Subnational), local	National/subnational/local	Subnational/local
Assessment Dimension			
Socio-demographic mapping (Tool I)	Socio-demographic overview Short-term monitoring	Socio-demographic overview. Medium- to long-term monitoring	Socio-demographic overview. Medium- to long-term monitoring
Needs and risks identification (Tool II)	Health information system monitoring, and qualitative needs and risk identification inquiry	Health information system monitoring, and qualitative needs and risk identification inquiry	Qualitative needs and risk identification inquiry
Health services mapping and assessment (Toolkit III)	Quantitative mapping: availability of primary and secondary health care services and resources Qualitative assessment of entitlements, adequacy of services, and barriers to access and quality	(Quantitative mapping of primary health care services and resources.) Qualitative assessment of entitlements, adequacy of services, and barriers to access and quality	 Qualitative assessment of entitlements, adequacy of services, and barriers to access and quality
Accommodation facility assessment (Toolkit IV)	Assessment of general health, safety and security (incl. SGBV protection) in accommodation facilities	Assessment of general health, safety and security (incl. SGBV protection) in accommodation facilities	

Checklist A1 can be used when identifying the parameters of the health needs and resource assessment.

A1: Assessment Parameters Checklist				
Question	**Yes**	**No**	**Maybe**	**Explanatory note**
On which stages of migration will the assessment focus?				
Scenario A: arrival/transit				
Scenario B: asylum seeking process				
Scenario B: protected status and settling				
Scenario B: undocumented migrants				
Scenario B: stranded migrants				
Other?				
At which administrative level will the assessment be done?				
National level				
Subnational level				
Local (municipal/city) level				
Other?				
Does the assessment take into account the following assessment dimensions?				
1: Socio-demographic overview				
2: Needs and risks identification				
3: Health resource assessment				
4: Accommodation facility assessment				
Other?				
On which of the following areas of health will the assessment focus?				
Sexual and reproductive health				
Child health				
Communicable diseases				
Non-communicable and chronic diseases				
Dental Health				
Injuries				
Sexual and gender-based violence				
Mental health				
Other?				
Which of the following vulnerable groups does the assessment take into account?				
Unaccompanied minors				
Children and adolescents				
Pregnant women				
People with disabilities				
Elderly				
Undocumented minors				
LGBTI				
Victims of SGBV and torture				
Other?				

3 Identifying key agents and stakeholders

Intersectoral coordination is important for maximising access to information about health services and access to the services themselves. Checklist A2 provides a list of potential stakeholders to involve during the assessment process. Contact persons can be called on to identify sources of data (for example, sociodemographic data on migrants and the health information system) and people who can provide analyses of the data. They can also introduce managers of migrant accommodation and health service facilities and suggest appropriate people for interviews and focus group discussions.

A2: Stakeholder Checklist		
Potential stakeholders/organisations	**Identified contact person/ information** *List potential contributors, informants and participants to the assessment*	**Contributions/tasks** *List how each organisation/representative can contribute to and participate in the assessment*
Governmental/ National authorities		
Ministries of Health and Social Services Ministry of Immigration Ministry of Justice Ministry of Internal Affairs Other relevant national authorities		
Subnational authorities		
Local authorities Municipality Local hospitals and health care clinics Local police and military authorities		
International organisations		
For example: UN (WHO, UNICEF, UNFPA, UNHCR, OCHA), EU (ECHO, UCPM, ECDC), IOM		
(Inter)national NGOs		
For example: IFCRCR, national Red Cross, MSF, MdM, Associations of health care professionals		
Civil society and volunteer organisations		
Refugees support groups		
Women´s rights groups		
Children´s welfare groups		
Elderly support groups		
Faith based organisations		
LGBTI support groups		
Others		
Migrant group representatives		
Nationality based groups and associations		
Religious groups and leaders		
Other		
Academia		
(any other relevant to the country)		

4 Data collection

Data collection for the assessment of health needs and health protection resources may include gathering of both **secondary data** (existing knowledge) and collection of **primary data** (knowledge generated through interviews, surveys, field visits etc.).

Secondary data review

A secondary data review is essential to any assessment to ensure use of existing, updated information on the current crisis of meeting the extensive and diverse health needs of the massive influx of refugees and other migrants to European countries. Two important sets of secondary data are proposed for this

assessment: the socio-demographic data for mapping the composition and distribution of different groups of migrants (Tool I), and the health information system's analysis of morbidity data of migrant populations (Toolkit II). Other reports of national studies and research may be available. At international level, a number of assessment reports, guidelines and recommended actions are available from international organisations such as WHO, IOM, ECDC, UNHCR, and international NGOs like MSF.

Primary data collection

Primary data can be generated through quantitative or qualitative methods, although this guide proposes that primary data for this assessment be collected by qualitative methods only. Primary data collection should focus on the current situation, and the knowledge and experience of the people who are most familiar with migrants, their needs, and the services that are provided for them. These people are also probably the ones with some of the clearest ideas about how to solve problems that may be there.

This section summarises information and some recommendations about ways to approach collection of the data that will be used to develop the assessment of health needs and the adequacy of existing services to meet those needs. Because the situation in different countries and at the different levels of administration within countries varies so much, this information and the toolkits, described later, will need to be applied in a flexible way to meet the needs of the assessment being planned.

Data collection methods

Quantitative methods are recommended for both Tool I, Socio-demographic overview of the migrant populations in the administrative area being assessed, and for the Health Information System Analysis under Health Needs and Risk Identification (Tool II). Both use data sets that are maintained by the appropriate authorities, but may need further special analyses as part of the assessment. Normally, those additional assessments would be done by the agencies responsible for the database as special requests, which may or may not be repeated later. It is, therefore, important to be clear what information you need and match that with what the database can supply.

Most of the rest of the toolkits rely on qualitative methods – field visits, interviews and Focus Group Discussions (FGDs) to collect the information. (Tool III.2 has quantitative elements.) Individual interviews are good for collecting information about a clinic or an accommodation facility. They are also good for collecting expert knowledge and/or individuals' perspectives. FGDs are an effective way of eliciting broad (and diverse) experiences and perspectives. The objective of FGDs is not just to obtain information from a group of people, but also to encourage a discussion and evaluation of experiences and opinions among all the participants.

Preparing, managing, and analysing the results of interviews and FGDs require specific skills. It would be valuable to have someone with those skills and experience on the assessment team to help plan the assessment program and train the people who will be conducting, recording and analysing the interviews and FGDs.

Sources of information and organisation of groups

Recruitment of participants for interviews and FGDs obviously depends on the specific area and objective of the interview/FGD. The toolkits and tools provide in this guide require diverse informants. Moreover, the country scenario plays a role in whom (available) to recruit. In any case, the Stakeholder Checklist (A2) is important to use during this process to encourage the assessment team to think about all the agencies that are involved in migrant services, who are able to recommend people who have experience relevant to the information being sought with the different toolkits. Also, the assessment process can with great benefit include people from the target population.

Table 4: Overview of qualitative approaches			
Tool	**Purpose**	**Scenario A**	**Scenario B**
Tool II.1	Gain deeper understanding of health needs and risk factors	Interviews and FGDs with health professionals in reception centres/camps.	Interviews and FDGs with health professionals in accommodation centres and in primary health services. If possible interviews with health professionals in specialized care. Interviews and FDGs with migrant group representatives.
Tool III.1	Assess knowledge and interpretations of migrant entitlements to care	Interview with person in charge of the health facility; If time allows, focus group discussion	Focus group discussion with health care providers
Tool III.2	Map primary health care facilities and their capacity	Interview with persons in charge of the health facilities	Interview with persons in charge of the health facilities
Tool III.3	Assess availability of primary health care services	Short version of the tool. Data obtained from health facility manager(s) or one or two health care providers. Interviews. Possibly focus group discussions	Long version of the tool. Data obtained from health care providers (possibly include health facility managers) through focus group discussions
Tool III.4	Assess availability of secondary health care services	Interview with senior doctor(s) or the hospital manager of the hospital	
Tool III.5	Assess access to and quality of health care services for migrants	Focus group discussion with health care providers and facility managers	Focus group discussion with health care providers and facility managers
Tool IV.1	Assess standard for general health protection, safety and security in camps	Interview with health facility manager incl. field visit by senior health inspector. Interview with migrant group representatives is recommended	*(relevant for 'stranded' migrants and asylum seekers)* Interview with health facility manager incl. field visit by senior health inspector. Interview with migrant group representatives is recommended
Tool IV.2	Assess standard for prevention and management of consequences of SGBV in accommodation facilities	Interview with health facility manager incl. field visit by senior health inspector. Interview with migrant group representatives is recommended	*(relevant for 'stranded' migrants and asylum seekers)* Interview with health facility manager incl. field visit by senior health inspector. Interview with migrant group representatives is recommended

Focus groups to explore both the health needs and services within ***specific health areas*** can be organised in different ways:

In scenario A situations, it is possible that primary care services are not organised by different health areas; there is just a general health clinic. In such a situation, health care providers from those clinics could comment on all health areas together.

In scenario B situations, health care is more likely to be organised by health areas: child health, sexual and reproductive health/obstetrics and gynaecology, general adult care, mental health, etc. In that case, it may be much more effective to create FGDs of providers in one health area from several clinics in order to focus on that health area and share the experiences of different locations.

Organising FGDs by health area also allows for continuity between two or more tools that actually require the same group of informants. This applies to the following four tools:

- Tool II.1 Assessing health needs and risk factors
- Tool III.1 Knowledge and interpretation of migrants' entitlements to care
- Tool III.3 Availability of primary care services
- Tool III.5 Assessing access to and quality of care

Writing up the action plan for the assessment

The final step of the coordination and planning phase is writing the action plan that summarises and contains all decisions made during this phase A. Checklist A3 constitutes a sample checklist for the action plan including main guiding questions to prepare and initiate the next phase of the assessment: data collection. This action plan should be shared by HCT and the AT.

A3: Action plan checklist
Focus of the assessment
• Location(s): administrative level and/or institutions and health facilities. • Scenario A or B? • Will the assessment focus on particular health areas or vulnerable groups?
Purpose of the assessment
• Why is the assessment taking place? • How will the information be used? By whom?
Methodology and approach
• Which toolkits and tools will be included in the assessment? • Which data collection methods will be used? Why and how? • How will you try to ensure the validity of the data? • Who will be the informants? How will you recruit them? • Who will collect the data (Interviewers, leaders of FGDs)? How will they be selected, trained and supervised? • Who will summarise, analyse and report the data? • How will ethical considerations and potential bias be addressed?
Organisation and time schedules
• What is the overall timeframe of the assessment? • What is the schedule for the different activities of the assessment? • Who is responsible for separate components of the assessment? • Who is responsible for completing the analysis and report of the assessment? • How will the assessment results be reported to the Coordination Team?
Budget
• What are the estimated costs of the assessment? • How and by whom are these costs financed?

PHASE B: Data collection

SOCIO-DEMOGRAPHIC OVERVIEW – Tool I

The purpose of the socio-demographic overview is to monitor who is where as the basis of overseeing and anticipating future needs for the provision of appropriate health and social services to migrants.

- Who refers to the numbers of people in different categories in the process of asylum-seeking. Potentially by age and sex, country of origin, and ethnic group or language, if appropriate.
- Where refers to the government subnational and local administrative areas, whose authorities are responsible for providing services to migrants. It also identifies the particular accommodation or detention facilities that house migrant individuals and families within those administrative areas.

These data are important for managing the resources of health and social services to anticipate and meet the needs of migrants. Some migrant groups are mostly made up of young men. Others include many families with women of reproductive age, children and elderly, all requiring different services. The country of origin of migrants will indicate what translation services are required. It also indicates the probability of mental health problems resulting from the experience of war or violence. Vulnerable groups will each have their particular mix of physical, emotional and social needs.

Data collection methods

The quickest and most reliable way of obtaining the data is from the authorities in charge of migrants. (Ministry of the Interior or the government's migration agency). International statistics and information (e.g. data from the UNHCR[3]) can be helpful for anticipating a possible increase of arrivals from neighbouring countries

Scenario A: In emergency situations, the management of services to a large number of migrants passing through may require the coordination of both government and non-government health care resources. This requires a rapid initial assessment and regular monitoring of migrant numbers by location.

Because migrants at this stage are usually only seeking care for acute or emergency conditions the most important additional information required to guide the provision of services includes an age/sex breakdown, vulnerable groups, and country of origin as an indication of the possible mental health burden.

Scenario B refers to situations where migrants are present for a longer period of time and where the full range of health needs should be addressed. The process of registration provides the initial data base for the population socio-demographic statistics required, but it is also necessary to follow the changing numbers and composition of the groups of migrants in specific locations as they progress through the asylum-seeking process. The data should also include the numbers of undocumented migrants, those refused asylum or a documented status, but who have not been deported. While the health needs of these different groups do not necessarily vary, their entitlements to services and the health systems or organisations providing services are usually different.

The challenge is to obtain analyses of the data for the socio-demographic characteristics that you think are important for health planning, and for the administrative areas or accommodation facilities that you may be

[3] UNHCR Operational Data Portal: Refugees/Migrants Emergency Response - Mediterranean http://data.unhcr.org/mediterranean/regional.php.

concerned with. At peripheral administrative levels there may be a limited capacity for statistical analysis, meaning that information may be obtained infrequently or later than desired.

TOOL I.: Socio-demographic mapping

Tool I.1 below provides suggestions for socio-demographic data that are useful for the management of health resources and as the basis of this needs assessment and work planning.

The tool is meant to be flexible; adaptations might be needed to fit the context of specific administrative areas, locations or facilities. Also, not all information called for in this tool can be obtained in each situation. Much depends on the timing of assessment and access to information.

TOOL I.1: Socio-demographic mapping		
	Scenario A - Arrival/transit stage of migration (short stay)	**Scenario B – Migrants stranded in camps, or in the asylum seeking and settlement stages of migration (longer stay)**
DEMOGRAPHIC INFORMATION		
Location(s)	Administrative areas and particular points of arrival and departure.	Administrative area and specific reception centres or other accommodation facilities within those areas
Migrant populations	Daily or weekly arrivals and departures by location Numbers by sex and age[4]	Numbers of people in camps in an arrival country. Numbers of migrants by stage of asylum-seeking process by location, including those refused asylum or a documented status, but who have not been deported. Numbers by sex and age.
Vulnerable groups	Number of unaccompanied minors	Numbers in vulnerable groups (unaccompanied minors, pregnant women, etc.)
Countries of origin/	Countries of origin Ethnic / language identity Religion	Countries of origin Ethnic / language identity Religion

Doing a socio-demographic mapping requires various information sources. Table 5 suggests some additional international sources for migrant data that are useful for the mapping and assessment.

Table 5: Information sources: overviews and monitoring of migration trajectories
EC, European Commission (http://ec.europa.eu/) • Managing the Refugee Crisis. State of play and future actions, January 2016 • Eurostat Statistics IFRC, International Federation of Red Cross and Red Crescent Societies (http://www.ifrc.org/) • Information Bulletin IFRC Regional Office for Europe Migration response. IOM, International Organization for Migration (http://www.iom.int)

4 Age categories include: < 1 year, 2-5 years, 6-10 years, 11-17 years, 18-25 years, 26-49 years, 50-70 years, 70+. Often, the age breakdown available from the government agency will be much simpler, especially for scenario A.

- Global Migration Data Analysis Centre.

FRA, European Union Agency for Fundamental Rights (http://fra.europa.eu/en)

- Monthly data collection on the current migration situation in the EU.

MdM, Médecins du Monde, (Doctors of the World) (http://www.medecinsdumonde.org/) (https://doctorsoftheworld.org/)

- Crossing Borders: MdM's Response to the Migrant and Refugee Crisis

REACH, Informing more effective humanitarian action (http://www.reach-initiative.org/)

- Situation Overview: European Migration Crisis

UNHCR, United Nations High Commissioner for Refugees (http://www.unhcr.org/cgi-bin/texis/vtx/home)

- Refugees/Migrants Emergency Response - Mediterranean
- subregional operations profile - Northern, Western, Central and Southern
- Regional Refugee and Migrant Response Plan. Eastern Mediterranean and Western Balkans Route. 2016

HEALTH NEEDS AND RISKS IDENTIFICATION – Tool II

The **purpose** of Tool II is to identify the health needs and risks of the refugees, asylum seekers and other migrants in the country by:

- Describing the patterns (frequency and severity) of health needs and problems in the migrant population in specific settings
- Identifying risk factors for these health problems that are present in the settings where migrants are living

It is helpful to analyse health needs and problems by major categories or specialty areas. Annex 1 lists the major categories of health problems of migrants arriving in Europe and some of the risk factors that have been identified in both scenario A and scenario B. A more detailed assessment of some risk factors is described in Toolkit IV, the Accommodation Facility Assessment.

This information is important for the management of health resources. The circumstances of scenarios A and B mean that health services in these situations encounter different patterns of illness. In scenario A it is mostly acute and emergency problems. In scenario B the chronic disease problems are also presented for management.

Health needs and risks assessments should be an on-going process to monitor changes over the course of time. In scenario A, a review every week or two may be necessary to keep up with possible rapid changes in the migrant population. In scenario B, the organisation of the national health information reporting system might be the best guide. As with socio-demographic data, an important constraint on the frequency of data analyses is the capacity for data analysis, especially at local or subnational levels.

Data collection methods

The recommended methods to collect the required information are to conduct interviews and FGDs. Key informants can include social and health professionals working in reception centres, camps, in primary health services, in specialized care, migrant-oriented clinics, or in health administration; they can represent governmental and non-governmental organisations. Representatives from the migrant community should be invited too (e.g. refugees granted protected status or migrants with refugee background). The assessment team should be aware that these informants should represent the migrant population as much as possible,

and be aware of bias. If possible, participatory methods can be useful to reach the target group; incl. children and youth. Carrying out data collection among minors or vulnerable groups requires sensitivity and special skills that must be ensured by the assessment team.[5]

Health Information System analyses

Where health information system data are available and can be analysed, it will be possible to obtain a clear picture of the frequency of different categories of health problems in the migrant population. Special health services for migrants are usually found in situations of arrival and transit as well as for migrants in reception centres and camps and those waiting for the results of asylum applications. Where migrants are receiving care from the national health system it is less easy to separate migrants from others, but in some countries there is a code that is recorded for migrants receiving services. This may be especially useful to assess the extent to which hospital emergency services are being used instead of primary care services for non-emergency conditions.

TOOL II.I: Key information guide to assess contextual health needs and risk factors

The purpose of this approach is to develop a deeper understanding of the actual and perceived health needs of migrants than is possible from information system data. This is also the way to gather information about risk factors in the current living situations of the migrants.

Interviews can benefit from being conducted at national, subnational or local level. Depending on the level and the size an organisation of local services, interviews can be organised by specialty areas (Child health, sexual and reproductive health, non-communicable diseases, mental health, etc.) or in combined groups. Tool II.1 provides a guide on required information to direct questions during interviews and FDGs.

TOOL II.1: Key information guide to assess contextual health needs and risk factors				
Key Questions	Impact	Vulnerabilities	Trends	Information gaps
What are the main *health needs* and *perceived needs** of migrants in this particular setting?	What are the consequences when these health needs are unmet?	Which groups of migrants are particularly vulnerable?	How are these health needs likely to evolve in this setting? (frequency, severity, change)	What additional information is needed to plan action?
What are the main *risk factors* to the health and wellbeing of migrants in the particular context/setting.	What are the consequences when these health needs are unmet?	Which groups of migrants are particularly vulnerable?	How are these health needs likely to evolve in this setting? (frequency, severity, change) Why?	What additional information is needed to plan action?
Which protective factors do you find strengthening the health and welfare of these groups of migrants?	How do they achieve their effectiveness?	Which particular groups of migrants benefit?	How are these protective factors likely to evolve in this setting? Why?	What additional information is needed to plan expansion of these protective factors?
**Health needs must be considered in the different health areas: Child health, sexual and reproductive health, non-communicable diseases, communicable diseases, injuries, mental health, sexual and gender-based violence.*				

[5] See for example 'UNHCR Tool for Participatory Assessment in Operations' (UNHCR participatory assessment) or for specific work with children: 'Photovoice guidance - 10 simple steps to involve children in needs assessments' (Save The Children) (Save The Children Photovoice report)

HEALTH PROTECTION SERVICES MAPPING AND ASSESSMENT – Toolkit III

The purpose of toolkit III is to map and assess to what extent health services are meeting the needs of migrants.

The mapping and assessment can be conducted by using all five tools, or selecting some of them:

- Tool III.1 to assess the knowledge and interpretations of migrant entitlements to care by health care providers and managers;
- Tool III.2 to map primary health care facilities and their capacity;
- Tool III.3 to assess availability of primary health care services;
- Tool III.4 to assess availability of secondary health care services;
- Tool III.5 to assess access to and the quality of those health care services for migrants.

After having identified the health needs and risks of migrants (see Toolkit II), the tools for 'health services mapping and assessment' help to identify:

- What is understood by health care providers and managers regarding the health care entitlements of different groups of migrants to whom they provide care;
- Gaps in the provision of services intended to meet the health care needs of migrants;
- Problems in delivery of those services or in migrants' ability to access them.

Data collection methods

Toolkit III contains tools for quantitative and qualitative mapping of the availability of health care services for refugees, asylum seekers and other migrants and the effectiveness of these services in terms of access and quality. Recommended approaches for collecting information for tools III.1, III.3 and III.5 include individual semi-structured interviews and focus group discussions. Tools III.2 and III.4 should be completed by the assessment team or by at least one observer from their team. (See Table 4 on data collection methods for Toolkit III) For some tools, preparations beforehand by the respondent may be desired, e.g. to get correct numbers of staff.

Follow-up investigations: It is possible that initial interviews or FGDs identify gaps or problems that need some further investigation because the exact nature of the problem is not clear. Usually clarification can be achieved by further interviews or FGDs with either health staff involved, a specialist, or some groups of representative migrants. Often these key informants come up with solutions that are both feasible and acceptable to the people involved.

TOOL III.1: Tool to assess knowledge and interpretation of migrants' entitlements to care by health care providers and managers

The purpose of this tool is to assess the knowledge and interpretation of the national regulations about migrants' health care entitlement by health care providers and managers. This assessment also provides a useful background to tool III.3 which assesses the availability, quality of, and access to different health care services for migrants. It does this because it prepares the participants to define the scopes and quality of care that they think are appropriate for different health areas within national regulations.

Under the time constraints of completing the health services mapping and assessment in the case of Scenario A situations, the respondent may just be the person in charge of the health facility. In Scenario B, this tool will probably be completed by organising focus groups to discuss this tool, together with tools III.3 and III.5.

The interviewer or facilitator of the focus group discussion should be well prepared by having the government's latest regulations about health care entitlements of different groups of migrants and being prepared to explain them (see first action of the tool). In case of a focus group: the names of participants and affiliation should be displayed so that all participants see the information.

TOOL III.1: Stepwise checking of knowledge and interpretation of migrants' entitlements to care by health care providers and managers	
Steps	**Actions and required resources**
Preparation	
1	Have available the government's latest regulations that give details of the national health care entitlements of different groups of migrants. Keep it ready for step 4.
2	Write out the following article on a large sheet of paper or on several small pieces of paper that you can hand out, or display it on a screen/tablets. Article 19 on health care for asylum seekers of the 2013 directive from the European Parliament, to which the country is a signatory: *Health care*[6] *1. Member States shall ensure that applicants receive the necessary health care which shall include, at least, emergency care and essential treatment of illnesses and serious mental disorders.* 2. *Member states shall provide necessary medical or other assistance to applicants who have special reception needs*[7]*, including appropriate mental health care, where needed.*
3	• Hand out pieces of paper to the participants.
Discussion	
1	• Ask the participants to identify the legal status of the migrants for whom they are providing care
2	• Ask each participant to write on the piece of paper the health care entitlements of these migrants for whom they provide health care. • Ask each participant to read out what he or she has written down.
3	• Read out the relevant sections of the government regulations. • Ask the respondents/focus group to discuss how well their understanding of the regulations matches the actual regulations.
4	• Show the participants the wording of the European Parliament directive on health care for asylum seekers. • Ask them whether this EU directive changes the way they understand either a) the government regulations, or b) the scope of care to be provided to migrants.

TOOL III.2: Tool for inventory of primary health care facilities

This tool is particularly important for Scenario A, where a variety of health facilities and service points belonging to different agencies may have been set up to care for large numbers of migrants arriving across borders and moving through one location. The purpose is to help the assessment team to conduct an inventory of the primary health care facilities or service points that are caring for migrants in what may be a humanitarian crisis situation.

[6] Directive 2013/33/EU of the European Parliament and of the Council of 26 June 2013 laying down standards for the reception of applicants for international protection (recast).

[7] Special reception needs are defined in article 21 as "minors, unaccompanied minors, disabled people, elderly people, pregnant women, single parents with minor children, victims of human trafficking, persons with serious illness, persons with mental disorders and persons who have been subjected to torture, rape or other serious forms of psychological, physical or sexual violence, such as victims of female genital mutilation.

These primary health care facilities may be state-owned or set up by national or international NGOs, or volunteer groups. They may be static or mobile primary care facilities, or they may be first aid or service points on a beach or at a train station. If the influx of migrants changes (e.g. increase or decrease), it is possible that the 'supply' of health services delivery changes too, so it is important to regularly update the inventory of primary health care facilities. The best sources of information will be the persons in charge of each primary health facility or service point.

However, the preparation of an inventory of primary care facilities may also be appropriate in a scenario B situation. This is relevant if asylum seekers are housed in the community and are able to seek care from a number of facilities rather than one facility specially designated for their health care. It may be even more important when there are additional facilities set up by national or international NGOs that provide care for undocumented migrants – those that are waiting to register, or those who have been refused a protected status but not deported.

TOOL III.2: Inventory of primary health care facilities		
	Date:	**Name of health facility:** **Name of respondent:**
	Questions	**Responses**
1	Type of facility	*e.g. Mobile/Static; Permanent/Temporary; First aid/Basic package of primary health care services*
2	Ownership/management	*e.g. State-owned/national NGO/international NGO/volunteers*
3	Funding source	*e.g. National government (state budget); NGO; Health insurance; Private funding*
4	Funding amount	*e.g. Envelope of x€; x€ per patient*
5	Location/Address/GPS	
6	Number of outpatient consulting rooms	
7	Number of day beds	
8	Laboratory availability and services provided	
9	Key staff: *number of doctors*	F: M:
10	Key staff: *number of nurses*	F: M:
11	Key staff: *number of midwives*	F: M:
12	Number of full-time equivalent interpreters	F: M:
13	Drugs & supplies	*(i.e. capacity of essential drugs and supplies in terms of days)*
14	Vaccines	*(i.e. availability of vaccines and cold chain)*
15	Source(s) and frequency of resupply	*(i.e. resupply of drugs, medical supplies and vaccines)*
16	Referral agreements and arrangements	
17	Transportation availability	
18	Transportation arrangements	
19	Any particular expectations or constraints of the facility?	
20	Committed to being part of the health coordination team?	

TOOL III.3: Tool to assess availability of primary health care services

The purpose of this tool is to assess the availability of services at primary health care facilities or their capacities to provide them. Specific gaps in services are identified where desired or intended services are absent or only partly available.

Tool III.3 can be used in both Scenario A (shorter version) and Scenario B (longer version). In the left hand column there are items that are in orange: these are the additional items that are included in the longer version for use in Scenario B, where migrants (asylum seekers and refugees) are expected to stay for a longer period.

- In Scenario A, where migrants are usually present for a short time and rarely attend the health facility more than once, we recommend using the basic tool without the additional (shaded) items. The health facilities and service points in Scenario A, run by a mix of government, non-government and volunteer organisations, will, almost certainly, not all be providing comprehensive primary health care, so it is important to document the services that are actually provided by each of them. This allows the assessment team to follow-up and ensures that appropriate referral links and communication systems are established. Information needed to assess the availability can be obtained from the health facility managers or one or two health care providers.
- In Scenario B, health needs that were not met while migrants continued traveling can now receive attention. Therefore, a complete range of services need to be available to these asylum seekers and refugees who seek to settle or stay a long time in the country. Also, longer-term health issues like pregnancy, non-communicable diseases and mental disorders can now have specific care programs established because they represent health needs that have been regularly identified in migrant populations. These are the additional service items that are in orange in tool III.3.

Information to assess availability of the primary health care facilities is best collected by a short straightforward survey beforehand and further detailed by means of FGDs. It is important to get consensus from the focus group whether a specific service is available, partially available or not available in the area. If a gap in health care services is identified during the focus group discussion, it is important to ask the focus group participants for possible solution to close the gap. They are almost certainly the best informed people.

TOOL III.3: Availability of primary health services

Health services requirements	Availability of service			Suggested action(s)
	No	Part	Full	
General clinical services and physical trauma care 1. Outpatient services 2. Triage (four colour system) 3. First aid and basic resuscitation 4. Injury care (open wounds, fracture immobilization)				
Child Health 1. Management of acute childhood illnesses 2. Screening for and outpatient management of malnutrition 3. EPI: Routine immunisations 4. Growth and developmental monitoring and advice				
Communicable diseases 1. Sentinel site of early warning system of epidemic-prone diseases 2. Individual, family and community management of scabies and skin infections, lice and intestinal helminths 3. Diagnosis and management of TB				

TOOL III.3: Availability of primary health services				
Health services requirements	**Availability of service**			**Suggested action(s)**
STIs and HIV/AIDS 1. Investigation and management OR syndromic management of STIs 2. HIV counselling and testing 3. Standard precautions 4. Provision of contraceptives and availability of free condoms 5. Sexual health promotion				
Sexual and reproductive health of minors 1. Age and culturally-appropriate sexual health promotion for minors 2. Access to family planning counselling and contraceptives for adolescents				
Maternal and newborn care 1. Family planning counselling and provision of contraceptives 2. Abortion care 3. Nationally approved protocols for antenatal care 4. Skilled care in childbirth for a clean and safe delivery (24/7) 5. Emergency obstetric care, appropriate to type of facility, or referral (24/7) 6. Essential newborn and postpartum maternal care (24/7) 7. Sufficient female staff (particularly if clients are Muslim) 8. Health promotion program about goals and recommended schedules for pregnancy care 9. HIV counselling and testing, and PMTCT as indicated				
Sexual and gender-based violence 1. Holistic management of rape survivors (medical, psychosocial and forensic) 2. Emergency contraception 3. Post-exposure prophylaxis for STIs and HIV 4. Tetanus and Hepatitis B vaccination 5. Specifically-trained SGBV staff and awareness of all staff of the signals and symptoms of SGBV for referral 6. Publicity at accommodation facilities (near the health facility) about location of services for SGBV 7. Registration of SGBV cases				
Non-communicable diseases 1. Management of acute problems of diabetes, asthma, hypertension and other NCDs 2. Individual assessment and implementation of standard management and follow-up protocols for hypertension, diabetes, asthma, chronic obstructive airways disease, etc. 3. Provision of nutrition and dietary advice that helps with the transition to use of a different mix of available foods and food preparations				
Dental health 1. Management of acute problems				
Mental health 1. Support of acute distress and anxiety 2. Management of severe and common mental disorders 3. Treatment for the damage caused to persons who have been subjected to torture, rape or other serious acts of violence, in particular access to appropriate medical and psychological treatment or care 4. Implementation of screening tests by primary care providers to help identify conditions like PTSD and depression that are especially common among migrants from conflict zones who survived SGBV 5. Access to rehabilitation services for minors who have been the victims of any form of abuse, neglect, exploitation,				

TOOL III.3: Availability of primary health services				
Health services requirements	**Availability of service**			**Suggested action(s)**
torture or cruel, inhuman and degrading treatment, or who have suffered from armed conflicts; appropriate mental health care and qualified counselling is provided when needed 6. Screening of children, especially unaccompanied minors, for PTSD, depression and SGBV, in primary care facility or at school 7. Established protocols for mental health care at primary level and for referral to specialised mental health units with language and cultural interpretation capacity 8. Culturally and linguistically-appropriate information programs about symptoms and "warning signs" of mental health problems and where to seek help				
Environmental health 1. Safe management and disposal of health facility waste 2. Procedures for the management of accidents with infected materials				
Health providers and administrators 1. Trained in appropriate cultural competencies 2. Trained and provided with copies of confidentiality guidelines 3. Trained in the health risks and exposures, physical and mental, of migrants from particular countries or regions 4. Trained on risk factors, signals and symptoms of SGBV				
Language and culture mediators 1. Trained for medical consultations 2. General purpose interpreters				
Client satisfaction and feedback 1. An established mechanism to regularly measure client satisfaction and obtain feedback on services				

TOOL III.4: Tool to assess availability of secondary health care services

This tool is intended primarily for a Scenario A situation, where migrants may be arriving and travelling in locations that are remote from major urban centres. The purpose of the tool is to help the assessment team to assess and monitor the capacity of the local hospital to provide some specific urgent and essential secondary care services that are needed in the arrival/transit situation. Information should be obtained from the senior doctor(s) or the hospital manager of the hospital(s).

For most migrants in a Scenario B situation, it is assumed that there is an existing referral system to hospitals providing services to the general population. The group of migrants that may seem to be exceptional consists of those that have been stranded usually close to borders following what was a Scenario A situation. Access to urgent secondary care is assessed by this tool (III.4). Less urgent needs for hospital care can be met in the same way as for the general population.

TOOL III.4: Availability of secondary health services				
Health services requirements	**Availability of services**			**Suggested action(s)**
	No	**Part**	**Full**	
General clinical services and physical trauma care 1. Presence of specialised doctors, including at least one general surgeon 2. OPD with surgical triage 3. Inpatient services (medical, paediatrics and obstetrics & gynaecology wards) 4. Trauma and surgical care. (At least one surgical theatre, with or without gas anaesthesia) 5. Post-operative rehabilitation for trauma-related injuries. 6. Laboratory services 7. Blood bank service 8. Basic radiology unit				
Child health 1. Management of children classified as severe or very severe disease (i.e. parenteral fluids and oxygen available) 2. Management of severe malnutrition with medical complications				
Maternal and newborn care 1. Comprehensive emergency obstetric care 2. Management of sick and premature newborns				
Mental health 1. Outpatient psychiatric care and psychological counselling 2. Acute psychiatric in-patient care				

TOOL III.5: Tool to assess access to and the quality of health services

The purpose of this last tool of toolkit III is to complement the specific questions of tool III.3 and III.4 with general questions about *access to* and *quality* of the health services provided so that gaps and problems can be identified. It is probably best to complete the list of questions in this tool when closing the focus group discussions for tool III.3. However, it would also be valuable to have input from both health managers and representatives (male and female) of the migrants at an accommodation centre or of migrant associations among those granted refugee or other protected status. Complementary interviews with these key informants about access to and quality of health care services should therefore be considered. Selected results from recent surveys using this tool in ten European countries are shown in Annex 2. Familiarity with these findings should help group facilitators to explore the local experience of FGD participants.

TOOL III.5: Tool to assess access to and the quality of health care
• What are any challenges for your health service related to the migrant crisis? • How do they impact your work as a health care provider? • How do they impact your work as a health care manager? • What particular barriers are affecting access to care for the migrants? • Which groups of migrants do these barriers or difficulties particularly affect? • What particular problems are affecting the quality of care? • Which factors could potentially facilitate access? • Which factors could potentially improve effectiveness?

ACCOMMODATION FACILITY ASSESSMENT – Toolkit IV

The **purpose** of toolkit IV is to help health authorities to assist those in charge of migrants' accommodation facilities in ensuring that an acceptable standard of general health and SGBV protection, safety and security is guaranteed and maintained in the facilities, in order to comply with the European Directive laying down minimum standards for the reception of applicants for international protection and the Minimum Standards for Humanitarian response.[8]

Data collection methods

The recommended methods to collect the required information are to conduct field visits and interviews at accommodation centres.

TOOL IV.1: General health protection at accommodation centres

The purpose of this tool is to help health authorities to assist those in charge of migrants' accommodation facilities to ensure that an acceptable standard of **general health protection, safety and security** is maintained in the facilities.

The tool is intended as a simple checklist of areas of concern to public health and safety, including water, sanitation and hygiene.[9] It elaborates on areas that have been identified as those of significant concern in other similar situations.

The assessment is appropriately carried out by a senior health manager and a senior health inspector appointed by the authorities and linked to the health coordination team (or other person familiar with national standards for institutional health and safety) in collaboration with the persons in charge of the facility. A meeting with representatives of the migrants is recommended. In order to ensure that the concerns and perspectives of women are heard, meetings with men and women separately are considered.

TOOL IV.1: Assessment of general health protection at accommodation facilities				
Health protection requirements for accommodation centres at border or transit zones and other reception accommodation centres	**Degree of standard compliance**			**Suggested action(s)**
	No	**Part**	**Full**	
Water supply, sanitation and hygiene promotion 1. Hygiene promotion: • hand washing, • showers, • personal hygiene (see also non-food items) 2. Water quantity and access 3. Toilets: quantity, privacy and security 4. Solid waste management 5. Drainage 6. Vector control				
Food security and nutrition 1. Daily food provision that meets or passes standards of minimum nutrition requirements 2. Reliable supply of age-appropriate, nutritionally adequate, safe complementary foods for infants and young children and the means to prepare them hygienically				

[8] Directive 2013/33/EU of the European Parliament and of the Council of 26 June 2013 laying down minimum standards for the reception of applicants for international protection (recast). *Official Journal of the European Union, 29.6.2013.*

[9] Inspired by the Sphere Project, 2011. Humanitarian Charter and Minimum Standards in Humanitarian Response (www.sphereproject.org).

TOOL IV.1: Assessment of general health protection at accommodation facilities				
Health protection requirements for accommodation centres at border or transit zones and other reception accommodation centres	**Degree of standard compliance**			**Suggested action(s)**
	No	**Part**	**Full**	
Shelter, security and settlement 1. Guaranteeing an adequate standard of living 2. Guaranteeing protection of family life 3. Taking into consideration gender and age-specific concerns and the situation of vulnerable persons 4. Appropriate security measures to prevent assault and sexual and gender-based violence, including lighting and separate, internally lockable washing and toilet facilities				
Non-food items 1. Clothing 2. Bedding 3. Household items: • Soap, laundry soap and personal hygiene materials, including infant nappies (diapers) and provision for menstrual hygiene, and information on the use of any materials that are unfamiliar • Stoves, fuel • Food preparation and cooking utensils • Eating utensils • Light source				
Minors 1. Ensure access to leisure activities, including play and recreational activities appropriate for their age and to open-air activities				
Staffing and management 1. Persons working in accommodation centres shall be adequately trained and shall be bound by the confidentiality rules provided for in national law in relation to any information they obtain in the course of their work 2. Applicants are involved in managing the material resources and non-material aspects of life in the accommodation centre through an advisory board or council representing residents • Male representative(s) • Female representative(s)				

TOOL IV.2: Sexual and Gender-based Violence protection at accommodation facilities

The purpose of this tool is to help health authorities to assist those in charge of migrants' accommodation facilities to ensure that the requirements for **prevention and management of the consequences of sexual and gender-based violence** are implemented. The requirements are those forwarded in the European Directive laying down minimum standards for the reception of applicants for international protection[10] and in the IASC[11] guidelines for SGBV prevention and response in humanitarian settings.[12]

The following articles on SGBV in the European Directive lay down minimum standards for the reception of asylum seekers:

[10] Directive 2013/33/EU of the European Parliament and of the Council of 26 June 2013 laying down minimum standards for the reception of applicants for international protection (recast). *Official Journal of the European Union, 29.6.2013.*

[11] IASC, GPC. Guidelines for Integrating Gender-based Violence Interventions in Humanitarian Action: Reducing Risk, Promoting Resilience, and Aiding Recovery. 2015.

[12] Keygnaert I., Vangenechten J., Devillé W., Frans E. & Temmerman M. (2010) Senperforto Frame of Reference for Prevention of SGBV in the European Reception and Asylum Sector. Magelaan cvba, Ghent. ISBN 978-9078128-205.

- *Article 17.2: Member States shall ensure that material reception conditions provide an adequate standard of living for applicants, which guarantees their subsistence and protects their physical and mental health.*
- *Article 18.4: Member States shall take appropriate measures to prevent assault and gender-based violence, including sexual assault and harassment, within the premises and accommodation centres.*
- *Article 19.2: Member States shall provide necessary medical or other assistance to applicants who have special reception needs, including appropriate mental health care where needed.*
- *Article 21: Member States shall take into account the specific situation of vulnerable persons such as minors, unaccompanied minors, disabled people, elderly people, pregnant women, single parents with minor children, victims of human trafficking, persons with serious illnesses, persons with mental disorders and persons who have been subjected to torture, rape or other serious forms of psychological, physical or sexual violence, such as victims of female genital mutilation, in the national law implementing this Directive.*
- *Article 25.1: Member States shall ensure that persons who have been subjected to torture, rape or other serious acts of violence receive the necessary treatment for the damage caused by such acts, in particular access to appropriate medical and psychological treatment or care.*
- *Article 25.2: …and shall be bound by the confidentiality rules provided for in national law, in relation to any information they obtain in the course of their work.*

The tool is intended as a simple checklist of areas of concern related to SGBV. The assessment is appropriately carried out by an SGBV expert, a senior health manager or a senior health inspector appointed by the authorities and the health coordination team with SGBV training background in collaboration with the persons in charge of the facility. A meeting with representatives of the migrants is recommended. In order to ensure that the concerns and perspectives of women are heard, meetings with men and women separately are considered.

TOOL IV.2: Assessment of SGBV protection at accommodation facilities				
SGBV Protection requirements for accommodation centres at border or transit zones and other reception accommodation centres	**Degree of standard compliance**			**Suggested action(s)**
	No	**Part**	**Full**	
Prioritise SGBV risk reduction activities in camp planning and set-up 1. Safety issues when selecting site locations so that camps do not exacerbate GBV vulnerability (e.g. proximity to national borders, competition for natural resources, presence of armed groups/forces) are considered 2. Sphere standards to reduce overcrowding, which can lead to stress and enhance the risk for intimate partner violence/domestic violence are adhered to 3. The natural resource base of the area and their accessibility routes during camp planning and site selection are evaluated as safe 4. Reception areas for new arrivals are equipped with a private room where a SGBV specialist can provide referrals for immediate care of victims 5. Safety and privacy in non-collective sleeping areas through the provision of intrusion-resistant materials, doors and windows that lock from the inside and – where culturally appropriate – internal partitions are assured				

TOOL IV.2: Assessment of SGBV protection at accommodation facilities				
SGBV Protection requirements for accommodation centres at border or transit zones and other reception	**Degree of standard compliance**			**Suggested action(s)**
6. Where collective centres are the only option, appropriate family and sex-segregated partitions (paying due attention to the rights and needs of LGBTI persons who may make up non-traditional family structures and/or to be excluded from sex-segregated spaces) are put in place 7. Secured separated male and female washing areas, provide adequate lighting and door locks from inside are ensured 8. Safe and nurturing environments in which children and/or adolescents can access free and structured play, recreation, leisure and learning activities are ensured 9. Temporary separate housing for unaccompanied children until a foster care situation can be arranged is arranged for 10. The camp is designed and laid out in consultation with women, adolescent girls and other at-risk groups 11. Culturally competent community outreach material including basic information about SGBV risk reduction is available and disseminated				
Refugee registration respects the vulnerable 1. Married women, single women, single men, and girls and boys without family members are registered individually 2. Individuals with different gender identities are able to register in a safe and non-stigmatizing way				
Capacity building of staff on SGBV 1. Health workers are sensitised on suspect features as unexplained bruising, fractures, trouble walking or sitting, excessive emotions, extremes in behaviour, attachment troubles, STD or pregnancy in young children 2. Health workers are trained on cultural practices, expected behaviours and social norms that constitute SGBV and/or increase risk of SGBV against girls and boys (e.g. preferential treatment of boys; child marriages; female genital mutilation/cutting; gender-based exclusion from education; domestic responsibilities for girls; child labour; recruitment of children into armed forces/groups; etc.) 3. Health workers are trained to talk about and react appropriately on SGBV including referral				
Prevention of violence from professionals (police, military personnel, humanitarian workers…) 1. A Code of Conduct against exploitation and abuse (SEA) is put in place 2. An SGBV prevention and response policy is implemented 3. An internal complaint system is installed 4. Punishments and legal action are installed				
Provision of medical support to female and male victims 1. The safety and accessibility of existing SGBV-related health services (e.g. safety traveling to/from facilities; cost; language, cultural and/or physical barriers to services, especially for minority groups and persons with disabilities; existence of mobile clinics; etc.) are assured				

TOOL IV.2: Assessment of SGBV protection at accommodation facilities				
SGBV Protection requirements for accommodation centres at border or transit zones and other reception	**Degree of standard compliance**			**Suggested action(s)**
2. Private consultations are assured 3. First aid kits are available: • Post-rape treatment kit: levonorgestrel, antibiotics (azithromycin, cefixime…), Lamivudine/Zidovudine, pregnancy test, bag, guidelines and checklists • Suture of tears/vaginal examination kit: chlorhexidine, polyvidone iodine, lubricant, sutures, compress, gloves, mayo scissors, needle holder, retractor, speculum, forceps, tray 4. Easy access to emergency contraception, PEP, wound care, tetanus and hepatitis B prevention are assured				
Provision of psychosocial support 1. First psychological aid is provided to victims of acute sexual violence and psycho-education on normal psychological reactions to the victimisation is given to them and their peers 2. Watchful waiting is applied until 1 month after the sexual victimisation 3. Confidential counselling by trained psycho-social workers are offered when mental health problems persevere after 1 month 4. Support groups and group activities for female and male victims are organised				
Response system to handle complaints 1. Confidential and blame free reporting is assured 2. Reports of sexual exploitation and abuse are handled quickly and properly 3. Possible legal procedures are explained to victims 4. If desired, victims are referred for legal assistance				

PHASE C: Reporting

SUMMARISING RESULTS: Next step into planning for action

All information and data gathered should be reported to the Health Coordination Team in order to facilitate sharing of information with all relevant stakeholders. Based on this shared ground of information, steps can be taken by stakeholders, particularly by health authorities to develop action plans to implement a public health response and strengthen country health systems which are influenced by the influx of refugees, migrants and asylum seekers.

The purpose of these assessments has been to identify specific gaps in or problems with health and related social services for migrants. Checklist C1 can be of assistance in the task of summarising the main conclusions of the assessment of health needs, risks and available health protection resources. In completing the summaries, it is important to identify whether the gaps and problems are features of the national migrant health program or of specific subnational or local health systems. The important thing is not just to complete the matrix; it is to use it as a checklist to collect the results of interviews and FGDs carried out in each of the assessment dimensions in order to define the specific gaps and problems identified.

Checklist C1: Summary and main conclusions framework								
		Assessment dimensions: Highlighted findings				**Overall conclusions**		
Key question	*Health area*	Health needs and risks identification	Health resources assessment	Barriers to access and quality of care	Accommodation facility assessment	Needing additional information	Importance: What happens if nothing is done?	Suggestions for action (from informants)
What are the health needs and risk factors? **Which health protection resources are <u>not</u> accessible or adequate?**	*SRH*							
	SGBV							
	Child health							
	Mental health							
	NCD							
	Dental							
	Injuries							
	CD/vacci-nation							
	Socio-environmental health							

Even after conducting multiple meetings, focus groups and interviews knowledge gaps are likely to occur. In that event, the assessment team can suggest further studies or research to develop more in-depth knowledge on specific elements/conditions/needs as an integrated part of planning and strategy development. This complementary data collection can be carried out through additional participatory research methods. This data collection should include consulting of national professionals, specialists and administration personnel relevant to the specific field.

For detailed information, guidelines and tools in regard to developing strategic action plans and contingency planning please refer to the SH-CAPAC Work Package 3 guide on development of action plans.

ANNEX 1: Health risk factors by Scenarios A and B[13]

SEXUAL AND REPRODUCTIVE HEALTH (SRH)		
	Scenario A - Arrival / transit	**Scenario B – Asylum seeking/ settling**
STD/HIV TRANSMISSION AND CARE		
Risk factors	-Dependent on region of origin of asylum seekers (Middle East at lower risk than Sub-Saharan Africa)	
Impact		Undertreatment because of fear of reporting HIV infection in order not to affect the asylum claim
SEXUAL AND REPRODUCTIVE HEALTH		
Risk factors	-Lack of hygiene augmenting risk of urinary tract infections and infections of genitals-Lack of access to contraception	-Lack of culturally sensitive sexual health promotion activities -Lack of access to family planning services -Lack of awareness of healthcare providers on cultural practices as FGM, early marriages
Impact	Higher risk of SGBV, unwanted pregnancy and STI's especially the unaccompanied minors being taken out of their protective group they were travelling with	
FAMILY PLANNING AND CONTRACEPTION		
Risk factors	No use or unavailability of family planning methods during journey may lead to unintended pregnancies	Unwanted pregnancy eg because of exploitation or poverty driven sex work
ANTENATAL, INTRAPARTUM AND POSTPARTUM CARE		
Risk factors	-Lack of safe and hygienic labour and delivery setting (e.g. no trained staff, no clean delivery kits) -Lack of care for complications Wish to continue the journey may lead to non-attendance of antenatal and postnatal consultations, limited attention to postpartum depression	-Lack of familiarity or comprehensibility of maternal health services -Some national regulations and legislations restrict access to antenatal and maternal care services -Chronic stress related to migration experiences, asylum procedures, precarious living conditions, heavy work during pregnancy and integration problems

CHILD HEALTH		
	Scenario A - Arrival/Transit	**Scenario B - Asylum seeking/ settling**
NEWBORN AND CHILD HEALTH		
Risk factors	-No record of newborn or child vaccinations -Undernutrition from inadequate diet on the journey	-No record of newborn or child vaccinations -Undernutrition from inadequate diet on the journey
Impact	-Inadequate maternal nutrition may lead to low birth weights -Higher morbidity rates of gastroenteritis and acute respiratory diseases because of poor sanitation and exposure -Higher mortality rates from childhood diseases because of undernutrition and delayed access to medical care -Communicable diseases due to undervaccination	-Higher newborn and child morbidity and mortality rates because of factors associated with the migration process, socio-cultural factors, different lifestyle, low quality housing -Low rate of tetanus-protected refugees, and the frequency of diphtheria-immune refugees was far from sufficient to provide herd immunity

COMMUNICABLE DISEASES AND VACCINATIONS		
	Scenario A - Arrival/Transit	**Scenario B - Asylum seeking/ settling**
TUBERCULOSIS/ MALARIA/ LOUSE-BORNE RELAPSING FEVER/ DIARRHEAL DISEASES/ SCABIES/ CUTANEOUS LEISHMANIASIS		
Risk factors	-Communities affected by war, conflict or	-Communities affected by war, conflict or

[13] Poverty, social and cultural norms, language barriers, substandard living conditions, low health literacy, lack of knowledge on potentially ill-health consequences if not treated, and lack of knowledge on available treatment of options are general risk factors that play a role in all health issues, and are not mentioned separately in this table, but they of course should be taken into account when assessing needs and existing resources.

COMMUNICABLE DISEASES AND VACCINATIONS		
	Scenario A - Arrival/Transit	**Scenario B - Asylum seeking/ settling**
	economic crisis and long, exhausting journeys increase risks for communicable diseases -Crowded and unsanitary conditions of camps -Certain diseases endemic in country of origin	economic crisis and long, exhausting journeys increase risks for communicable diseases -Crowded and unsanitary conditions of camps -Certain diseases endemic in country of origin

NON-COMMUNICABLE AND CHRONIC DISEASES		
	Scenario A - Arrival/Transit	**Scenario B - Asylum seeking/ settling**
CARDIOVASCULAR DISEASES		
Risk factors		-Stress from poor socioeconomic status, everyday living and working conditions -Alterations in family life and chronic stress related to insecurity and homesickness -Poor dietary adaptation
ARTHRITIS		
Risk factors	Travel and/or living conditions	
CHRONIC RESPIRATORY DISEASES		
Risk factors	Tobacco smoking	Tobacco smoking, air quality
DIABETES		
Risk factors	Lack of continuity of care	Nutrition, physical inactivity, stress, ethnic susceptibility, lack of continuity of care

DENTAL HEALTH		
	Scenario A - Arrival/Transit	**Scenario B - Asylum seeking/ settling**
Risk factors		-Language, cultural and financial barriers -Trauma to mouth may be related to torture
Impact		Children as well as adults suffer from poor oral health such as higher rate of decayed, missing, filled teeth

SEXUAL AND GENDER-BASED VIOLENCE (SGBV)		
	Scenario A - Arrival / Transit	**Scenario B – Asylum seeking/ settling**
PREVENTION		
Risk factors	-Lack of protection in (overcrowded) refugee camps or registration centres -Separation of unaccompanied minors from their protective group because of law -Growing number of refugees living in urban and other non-camp settings -Lack of social control -Violence from professionals (police, military personnel, humanitarian workers,…)	-Unsafe infrastructure of reception facilities -Lack of prevention policy -Lack of code of conduct of staff and asylum seekers -Lack of participation and leadership of female asylum seekers in lay-out infrastructure and prevention policy and measures -Increasing stress of asylum procedure and process leading to domestic violence, child abuse and sexual violence -Unequal attention to female and male asylum seeker empowerment -Lack of possibility to be intimate in private for couples -Previous untreated victimisation and or traumatisation
HOLISTIC CARE FOR VICTIMS OF SGBV		
Risk factors	-Lack of competences in staff to recognize, treat and confidentially document SGBV, FGM, forced marriages and honour-related violence -Lack of availability of specialised staff, infrastructure (e.g. mobile clinics) and equipment to provide emergency SGBV treatment -Lack of capacity in staff/ services to apply the principles of child-friendly care when engaging with girl and boy survivors	-Lack of competences in staff to recognize, treat and confidentially document SGBV, FGM, forced marriages and honour-related violence -Lack of capacity in staff/ services to apply the principles of child-friendly care when engaging with girl and boy survivors -Lack of safety and accessibility of existing SGBV-related health services -Lack of specialised sexual assault referral centres or treatment units providing holistic care

MENTAL HEALTH		
	Scenario A - Arrival/Transit	**Scenario B - Asylum seeking/ settling**
DEPRESSION		
Risk factors	Cumulative traumatic events	-Current stress and lack of resources -Lack of refugee status
Impact	It is estimated that 8-25% of refugees in high-income countries are affected by depression, with most of them additionally having PTSD	
SUICIDAL BEHAVIOUR		
Impact	Suicides and suicidal attempts are nearly two times more common in asylum seekers than the host population in high-income countries.	
POSTTRAUMATIC STRESS REACTIONS		
Risk factors	-Traumatic events (being close to death, forced separation from family members, murder of family or friend, threatened to be physically tortured, being tortured, imprisonment, SGBV -Trauma domains (human rights abuses, traumatic losses, lack of necessities, separation from others -Time in detention is positively associated with severity of distress	-The stress of settling to a new culture, living in poverty, meeting intolerance and racism lack of resources -Unemployment, weak social network, weak social integration into the society and weak social integration in the immigrant ethnic group -Past (potentially traumatic) experiences and present distress and adjustment difficulties
POSTTRAUMATIC STRESS DISORDER		
Risk factors	-Exposure to fighting and hostility -History of trauma before the conflict -SGBV	-Symptom severity of PTSD and depression was significantly associated with lack of refugee status and accumulation of traumatic events -Untreated SGBV experiences
Impact	Can be comorbid with other psychiatric disorders, e.g. anxiety disorders, depression or agoraphobia. It is estimated, that 13-25% of the refugees resettled in high-income countries suffer from PTSD	
AGGRESSION OR TEMPER TANTRUMS IN CHILDREN		
Risk factors	- Experience of: conflict, first-hand destruction of their homes and communities, surviving forced displacement, family separations, exposure to physical, psychological and sexual violence, recruitment by armed groups, lack of access to basic services.	- Exposure to violence in homes, communities and schools, due to separation from friends, families and neighbours, and lack of basic services

ANNEX 2: Recently identified challenges in access to health services

Typical recent problems identified by health staff providing care for refugees, asylum seekers and other migrants

Scenario A: Arrival/Transit Countries	**Scenario B: Destination Countries**
The number of migrants challenge capacity of health services • Lack of health facilities where migrants arrive or transit • Insufficient primary health care providers or social workers • Insufficient mental health professionals Hospital emergency facilities swamped because: • Migrants do not know where to go or what they are entitled to, • Lack of coordination of national, NGO and volunteer primary care services with emergency services. Quality of care challenged because: • Lack of language and cultural interpreters • Lack of training in cultural competence for staff • Absence of health and vaccination records • Frequently no opportunity for follow-up care • Short hospital stays to keep up with travel companions • Lack of familiarity with certain health problems or the presentation of mental health problems Vulnerable groups • Management of unaccompanied minors • Care for pregnant women • Victims of sexual and gender-based violence Health conditions in camps • Overcrowding and exposure leading to nutritional, gastrointestinal and skin problems • Sexual and gender-based violence • Repressive police and army personnel. Identification and burial of dead bodies.	Complexity of administrative procedures for access to care, different procedures depending on status of the migrant, and frequent long delays in the registration process. • Confusion on the part of health managers and providers • Stress on providers because of the legal restrictions on types of care. • Access wrongly denied to migrants on occasions. • Information provided to migrants often inadequate. Quality of care issues • Resources of primary care facilities near reception centres may be inadequate if large numbers of migrants seeking care. • Lack of language and cultural interpreters • Lack of training in cultural competence for staff • Lack of female health staff for caring for women. • Lack of health and vaccination records Sexual and reproductive health • Access to pregnancy and delivery care according to status of migrant • Sexual and gender-based violence is common in asylum seekers, both women and young men Mental Health • Inadequate capacity to care for the large number of traumatised refugees among asylum seekers. • Difficulties in distinguishing between physical, psychological and social issues.

***Source**: SH-CAPAC project WP4. In order to gather information on the new challenges for health services related to the current refugee crisis a series of interviews and focus groups with health providers and managers and social services staff have been conducted in 10 EU countries between February and March 2016: Austria, Belgium, Italy, Spain, Greece, Hungary, Slovenia, Netherland, UK and Denmark (for more information and details on results see WP4 report on resource packages)*