Co-funded by
the Health Programme
of the European Union

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

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

August 24th, 2016

User's guide

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

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

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

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

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

This report is part of the project '717275 / SH-CAPAC' which has received funding from the European Union's Health Programme (2014-2020). The content of this report represents the views of the authors only and is their sole responsibility; it cannot be considered to reflect the views of the European Commission and/or the Consumers, Health, Agriculture and Food Executive Agency or any other body of the European Union. The European Commission and the Agency do not accept any responsibility for use that may be made of the information it contains.

Table of contents

List of figures

List of tables

List of acronyms

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

Glossary

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

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

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

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

1 Why do we need a health coordination framework?

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

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

1.1 Rights and entitlements to health

Not all migrants have the same entitlement to health care. Yet, WHO defines health as *a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity* (WHO, 1948).

With the Universal Declaration of Human Rights (UDHR, 1948), the *enjoyment of the highest attainable standard of health* was put forward as a fundamental right of every human being. The human right to health applies universally and was codified into binding law by the International Covenant on Economic, Social and Cultural Rights (ICESCR) and the International Covenant on Civil and Political Rights (ICCPR) in 1966. In 2000, the UN Committee on Economic, Social and Cultural Rights (CESCR) issued "General Comment 14", an authoritative explanation of the Article 12.1 on the right to health of the ICESCR. It states in paragraph 12 (b) that governments have legal obligations to ensure that *"health facilities, goods and services are accessible to all, especially the most vulnerable of marginalised sections of the population, in law and in fact, without discrimination on any of the prohibited grounds"*, defined as *"race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth, physical or mental disability, health status (including HIV/AIDS), sexual orientation, civil, political, social or other status"* (§18). In addition, the CESCR specified that States have an obligation to respect the right to health *"by refraining from denying or limiting equal access (…) for all persons, including (…) asylum seekers and illegal immigrants, to preventive, curative and rehabilitative health services*". **All 27 EU Member States ratified this "International Bill of Human Rights"** which integrates the human right to health defined in UDHR, ICESCR and ICCPR.

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

Furthermore, the **European Directive on Minimum Standards for Reception of Asylum Seekers** (2013/33/EU) contains several stipulations on ensuring health care access for asylum seekers and more specifically emergency care and essential treatment of illnesses and of serious mental disorders (Art 19.1), necessary medical and other assistance to applicants with special needs, including mental health care (Art 19.2), assessment of vulnerable persons such as minors who have been victim of torture, rape or other serious

forms of psychological, physical or sexual violence, such as victims of female genital mutilation (Art. 21) and applicants with special needs (Art 22), treatment for victims of sexual and gender-based violence and torture (Art 25.1), minors who have been victim (Art. 23.4) and prevention of SGBV in the reception facilities (Art 18.4).

Besides, EU Member States need to guarantee applicants' subsistence and protection of their physical and mental health (Art. 17.2), ensure adequately trained staff, bound by confidentiality rules (Art 18.7), ensure necessary basic training of staff with respect to both male and female applicants (Art 29.1), and provide free legal assistance (Art. 26.2).

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

Refugees, asylum seekers and migrants often require a health response that combines crosscutting issues. These include sexual and reproductive health, including maternal and child health, mental health and psychosocial support, injuries, and sexual and gender-based violence treatment and prevention. The different types of migrants face different health challenges at the different moments of their passing through or stay. They also display health-seeking behaviours that reflect their culture and the access to health care they had in their country of origin. This behaviour is in turn influenced by stress and conditions of the journey, causing some migrants to delay health care.

In addition to these more individual challenges related to the migrants' profiles, there are organisational challenges, such as the availability, accessibility and quality of health services, caregivers' attitude and understanding of the law and bureaucratic barriers. Societal challenges, such as the myriad of entitlements to health care and geopolitical negotiations on a common European approach to the refugee influx. also severely impact the potential health response.

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

1.3 Setting the scene for a coordinated health response

The current context requires that prompt action is taken to guarantee health care to all refugees, asylum seekers and other migrants present in the European Union Member States.

Contextual elements to take into account are:

- The crisis is dynamic, influenced by changing politics, seasons and the evolution of major conflicts triggering it. New political agreements, such as the EU-Turkey statement of 18 March 2016 to address the migrant crisis and EU-Turkey cooperation, indicate the need for preparedness to respond rapidly to a changing context. In addition, each European country presents its particularities in terms of culture, governance, and political situation that impact on the response offered.

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

- The EU Member States are dealing with a protracted crisis with increased impact on various local sectors, including health, which is aggravated by insufficient planning of a long-term, integrated multi-sectoral response. The presence of and interaction with international actors can make this response complex and challenging.
- The Member States' legal and policy frameworks do not always alleviate barriers of access to health care. A gap exists between the recognition of the universal right of all to health care and its adherence in several EU Member States.
- Migration in itself is not a health risk, but the migration process can often bring circumstances posing important health risks and challenges.
- Migrants' health goes beyond the traditional management of communicable diseases and is closely linked with the social determinants of health.
- The profile of the displaced population has become very gender and age diverse indicating an increased need for sexual, reproductive and child health services, as well as geriatric care.
- The health needs we are observing are demonstrating a compounded effect of acute critical health needs that warrant humanitarian interventions, as well as health needs that require access to regular comprehensive health care and public health interventions, provided by the countries' health systems.
- Many of these migrants are survivors of different types of violence. Some are victims of physical violence needing prostheses. There are victims of psychological trauma needing specialised treatment. There are others in need of specific clinical, psychosocial and forensic actions in response to sexual violence experiences. Sexual violence is also a specific reason for claiming asylum and a priority health concern. It requires both prevention and response interventions at all stages of migration and in all types of reception facilities.
- A number of migrants have serious chronic conditions (e.g. cancer, diabetes…) whose treatment should be continued.
- Gaps exist in the national health information and disease surveillance systems. These, in turn, increase the risk of vaccine preventable diseases and outbreaks, especially in the crowded conditions of reception or detention centres.
- Sometimes unnecessary mandatory health checks have been imposed in some Member States. The right balance needs to be found between ethics and people's rights versus security pressures.

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

In conclusion, the above points emphasise the necessity of a highly flexible, **coordinated response** that anchors migrants' health in a human rights framework and harnesses all partners, stakeholders and goodwill at national, local and municipal level.

Improved coordination of all these stakeholders and actors addressing the migrants' health needs results in a strengthened, high-quality and comprehensive health response.

1.4 The aim of this health coordination framework

This health coordination framework aims to provide individual EU Member States with a **tool for strategic guidance** to establish or strengthen a coordination mechanism. Such a coordination mechanism aligns the health response for migrants with the national health system under the leadership of the Ministry in charge (e.g. Ministry of Health, Ministry of Asylum and Migration, Ministry of Interior…).

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

Figure 1: Coordination of the health response

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

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

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

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

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

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

5. Monitoring and evaluating the health response to the refugees, asylum seekers and other migrants through consolidation of information collected and periodic reporting

See chapter 3.1 (5)

6. Leading the communication and advocacy[2] efforts in support of the health response to these populations.

See chapter 3.1 (6)

This health coordination framework is part of a set of tools, each one addressing one or several of the elements mentioned above. These tools are being developed in separate work packages (WP) to which reference is made below (see separate documents developed by work packages 2, 3, 4 and 5).

2 Health coordination mechanism

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

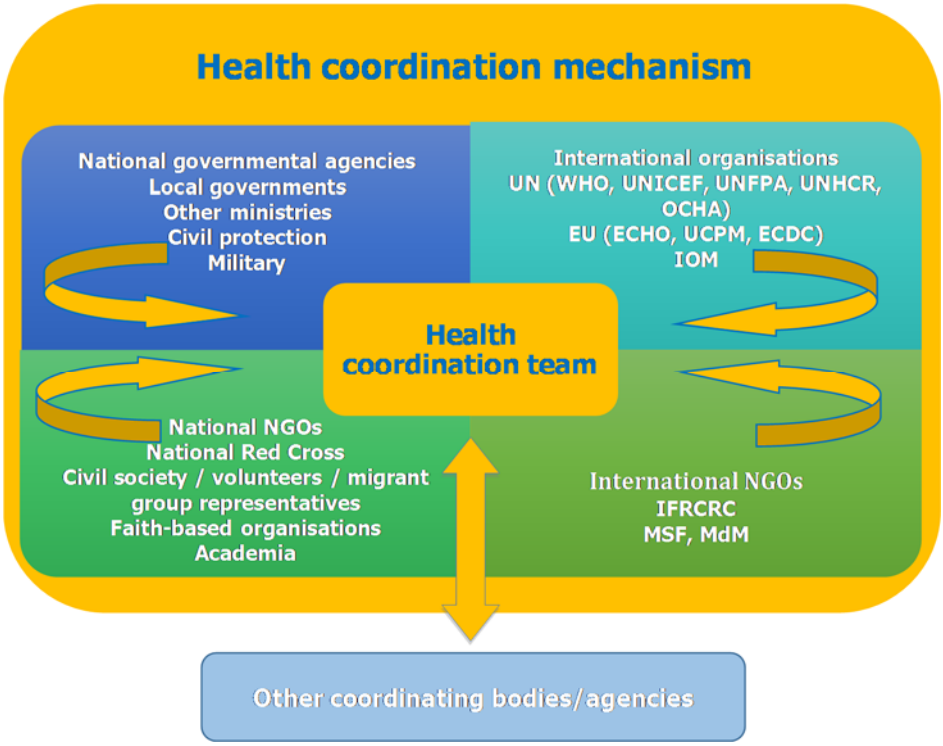
2.1 Who should be part of the health coordination mechanism?

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

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

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

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



2.2 Type of health coordination mechanism

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

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

2.3 Activation of the health coordination mechanism

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

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

Table 1: Enablers for a successful health coordination team

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

3 Health coordination team

3.1 Composition of the health coordination team

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

It is suggested to ensure a core group comprised of:

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

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

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

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

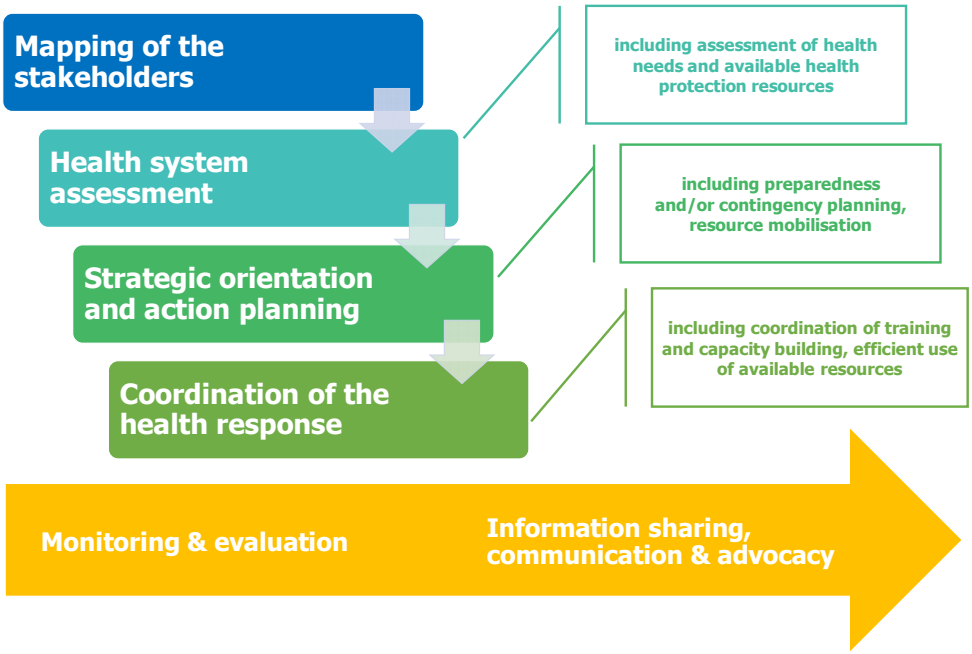
Basic principles of the health coordination team

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

3.2 Tasks of the health coordination team

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

Figure 3: Tasks of the health coordination team



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

1) Mapping of the stakeholders

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

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

WHO?	WHAT?	HOW?
	☐ Understand their mandates, expectations and constraints ☐ Gather information, guidelines and tools from stakeholders	

2) Health system assessment

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

1) Access
   - to health services
   - opening hours, especially for women and girls
   - communication (interpreters, pictograms, local facilitators)
2) Staff
   - availability of female and male staff, local staff?
   - training in culturally sensitive communication
   - training in specific areas, such as SGBV and psychosocial support
3) Safety and confidentiality
   - private consultation rooms
   - professional confidentiality
   - women and child friendly safe spaces (especially for unaccompanied minors)
   - security personnel
   - provision of legal advice and protection
4) Risk reduction (can be initiated immediately without assessment)
   - WASH: provision of appropriate water and sanitation taking into consideration the gender perspective
   - appropriate lighting in facilities, especially sanitary
   - presence of Minimal Initial Services Package (MISP) at facilities
   - application of SGBV guidelines
5) Environment
   - community awareness/education programs/public information campaigns
   - use of local field workers
6) Services
   - type of services available, including referrals
   - specific attention to services for reproductive health, including BEOC, SGBV
   - vaccination according to norms [emphasis on measles, mumps, rubella (MMR) and polio]
   - screening for CD as per country of origin
   - surveillance, especially TB
   - psychosocial support
   - care for unaccompanied minors
7) Information management (collect data for action)
   - data collection disaggregated by age and sex
   - identification of vulnerable populations
   - data analysis at local and central level for decision making
   - data management and reporting format

- respect of confidentiality

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

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

3) Strategic orientation and action planning

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

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

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

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

4) Coordination of the health response

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

The different types of migrants face different health challenges at the different moments of their passing through or stay. They also have different levels of (entitlement to) access to care that need to be taken into account.

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

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

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

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

In addition, it is important:

1) to ensure the respect and use of national policies, norms and standards (support development/revision of guidelines, if needed, using recognised international best practices) and
2) to coordinate training and capacity building in areas identified as priorities; this training should also cater for the mental and physical wellbeing of the health staff and caregivers who are facing various stressful situations.

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

5) Monitoring and evaluation

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

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

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

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

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

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

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

- *Communicable diseases:*
  - For children < 5 years
    - Number of new cases of gastro-enteritis
    - Number of new cases of respiratory tract infections

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

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

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

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

- *What to report?*
    - o Data analysed and consolidated by the health coordination team, including some key indicators (to be agreed on by the HCT and stakeholders) and other information provided by stakeholders;
    - o Progress reports of stakeholders involved in the various health coordination tasks (assessments, planning, implementation, capacity building);
    - o Progress made by the health coordination mechanism

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

Key points of Monitoring and Evaluation:

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

6) Information sharing, communication & advocacy

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

Communication is aimed at a wider audience, internally (such as line ministries) but also externally at the media and the public. It should be reported in an appropriate language and highlight positive aspects of the interventions that may benefit the general population. This includes risk communication[5].

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

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

WHO?	WHAT?	HOW?
Health coordination team, national coordinating body, stakeholders, the media	□ Ensure feedback (e.g. based on the periodic monitoring and evaluation reports) to national coordinating body, other relevant line ministries and stakeholders, including UN and EU □ External communication to media and public (e.g. through website) □ Risk communication □ Highlight advantages to the general population □ Respect confidentiality[6]	□ Importance of having a communication specialist in the team

4 Concluding remarks

The guidelines for a health coordination framework provided above are part of Work Package 1 of the SH-CAPAC project and are still a work in progress. This draft of the health coordination framework incorporates EU Member States' inputs given at the workshop in Ghent on 23-24 February 2016 and feedback from SH-CAPAC partners during the meeting in Trnava on 6 April 2016, the workshops in Copenhagen (May 2016) and Reggio Emilia (June 2016) as well as the country missions (Bulgaria July 2016), (others to add).

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

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

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

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