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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

ADDRESSING THE HEALTH NEEDS OF REFUGEES, ASYLUM SEEKERS AND OTHER MIGRANTS INTO THE EUROPEAN UNION COUNTRIES; *SOME BACKGROUND INFORMATION*

Working document

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CESCR	UN Committee on Economic, Social and Cultural Rights
EU	European Union
ICESR	International Covenant on Economic, Social and Cultural Rights
IOM	International Organization for Migration
MS	Member State
NGO	Non-governmental organization
UDHR	Universal Declaration of Human Rights
UNHCR	United Nations High Commissioner for Refugees
WHO	World Health Organization

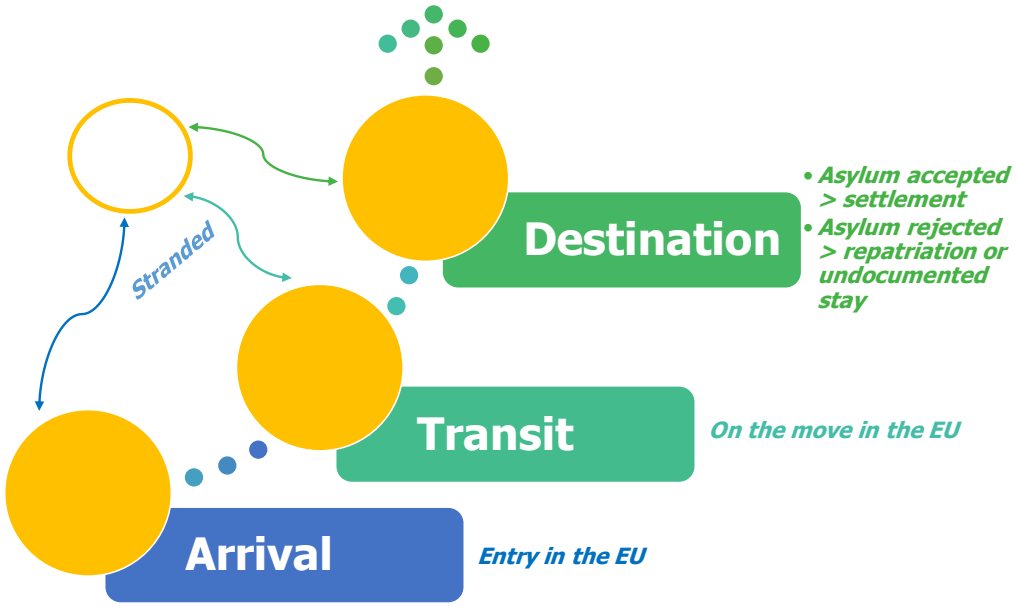
1 The recent influx: a complex situation of diverse groups and migratory trajectories

The European Union is at the heart of an expanding range of increased migration streams. This influx generates the presence of 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 (see annex 1 for sources consulted). This ranges from newly arrived migrants, migrants in transit not claiming asylum, asylum seekers, migrants having been granted refugee or protected status, migrants who strand on their journey and migrant who become and remain undocumented. Each category of migrants comprises people of different gender and ages, including unaccompanied minors.

1.1 Variations in the migratory trajectory

Many migrants of the current influx arrive in one of the 'first entry' EU countries but continue their journey to their preferred country of destination which is chosen by refugees and asylum seekers themselves, or by those transporting them. Figure 1 shows the different stages of the migration trajectory. Concepts as **arrival, transit and destination** are not clear cut and they offer a lot of grey zones both from migrants and countries, i.e. depending on circumstances a group of migrants may change of being in transit to be stranded. The legal status linked to the migration trajectory stage as well as to the outcome of the asylum seeking procedure play an essential role in migrant's access to health care.

Figure 1: Migratory trajectory



Many arriving have to survive an arduous journey involving smuggling, exploitation, crossing deserts, mountains, seas and unfriendly European nations. At a rough estimate there might be 50.000-100.000 people "on the move" at any one time. The legal status of these migrants is usually precarious. As unauthorised entrants they are in principle 'irregular migrants'. In some countries unauthorised entry is a criminal offence, in others only an administrative one. However, article 31 of the 1951 Geneva Convention prohibits imposing penalties on such migrants "provided they present themselves without delay to the authorities and show good cause for their illegal entry or presence". Countries vary greatly in the way this article is implemented. As soon as migrants apply for asylum, their presence in the country becomes legal; but if they then move on to other countries, it is likely to become irregular again.

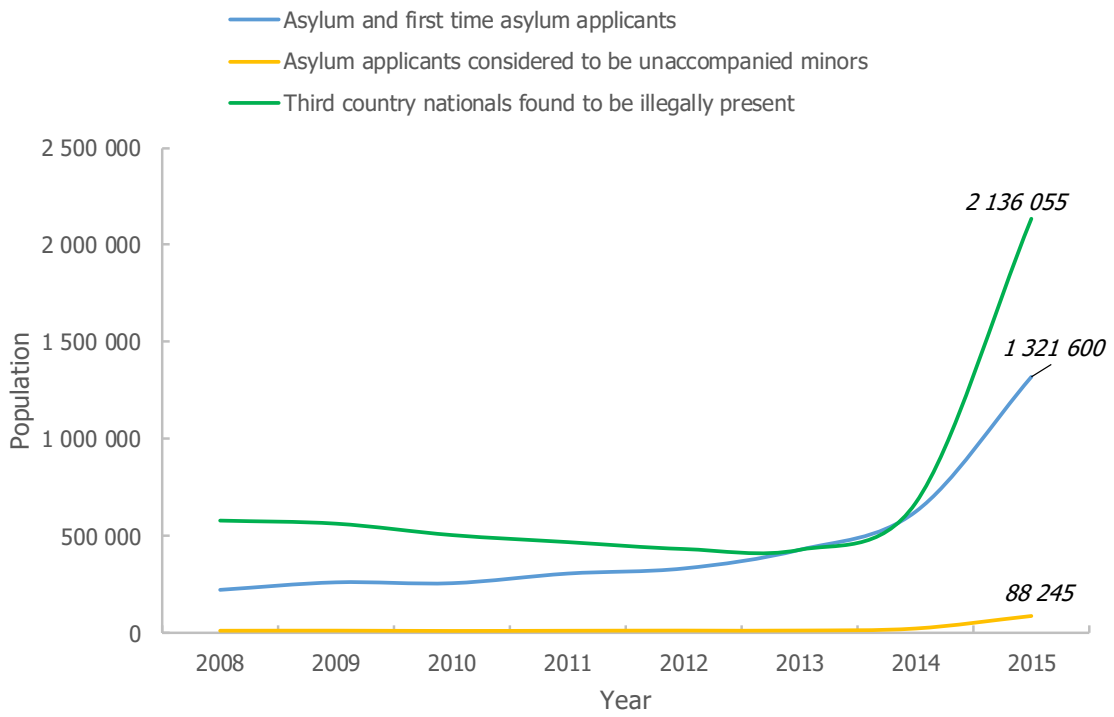
It seems likely that the chance of obtaining international protection, the conditions of asylum, the presence of relatives and ethnic networks, the language, and likely future prospects all play a role in deciding upon the destination country. This may change when a compulsory system of redistribution is put in place. Asylum seekers and other migrants at their destination eventually acquire protected status, become (or remain) undocumented migrants, or – less commonly – return home. This group will merge with migrants already in the country.

Although "migrants on the move" are a different target group from "migrants at their destination", the same country may harbour both. There are also liminal situations between these phases. Between "being on the move" and "becoming an asylum seeker" there may a period of administrative limbo in which migrants have been admitted to the country but not to the asylum procedure (e.g. Germany's asylum system has a backlog of hundreds of thousands.) An asylum seeker may be granted protected status but still be unable to integrate into the host society because of lack of housing outside the asylum seeker centre.

1.2 Characteristics of the recent influx of refugees and asylum seekers into the EU

It is important to note that the current influx consists of migrants who, in most phases of their journey, lack authorisation for their entry into or residence in a country. Their legal situation is very different from that of the 51 million other 'regular' migrants already residing in the EU (17 million EU migrants and 34 million third country nationals).[1] The number of third country nationals found to be illegally present in EU Member States was estimated to be around 2,1 million in 2015 (Figure 2).

Figure 2: Evolution of asylum applicants into European Union



Source: EUROSTAT (2016). Statistics 6 June 2016. http://ec.europea.eu/eurostat.

Up to 2012 a gradual increase in the number of asylum applicants can be noted within the EU, after which the number of asylum seekers rose to 431.000 in 2013, 627.000 in 2014 and close to 1.3 million in 2015 (Figure

[1] Source: http://ec.europa.eu/eurostat/statistics-explained/index.php/Migration_and_migrant_population_statistics

2). The five largest groups of first time asylum applicants by citizenship were: Syrians, Afghan, Albanians, Kosovans and Iraqis. Eighty-three per cent of the first time asylum seekers in the EU-28 in 2015 were less than 35 years old, with nearly 3 in 10 applicants were minors aged less than 18 years old. Thus, more than 88.000 of the asylum applicants are considered to be unaccompanied minors. The distribution of first time asylum applicants by sex shows that more men than women were seeking asylum last year. Among the younger age groups, males accounted for 55 % of the total number of applicants. In 2015, fifty-two per cent of first instance asylum decisions in the EU-28 resulted in positive outcomes (i.e. refugee or subsidiary protection status granted), or in an authorisation to stay for humanitarian reasons. With fourteen per cent the share of positive final decisions based on appeal or review was considerably lower.[2]

In the last months the number of arrivals has dropped in most EU Member States, but remains high compared to the same period in 2015. The decrease is mainly due to deal agreed between the EU and Turkey whereby irregular immigrants to the EU would be turned back to Turkey, in exchange for increased support for the migrant response in Turkey.[3]

1.3 Variations between EU Member States

Based on the above migration trajectory, European countries can be divided into two categories: (1) entry and transit countries and (2) destination countries, with largely different legal situations as result for the migrants (Table 1).

Table 1: Categories of countries and corresponding legal status of migrants

(1) Arrival and transit countries
Arrival countries most affected are Greece and Italy, but changing political circumstances and seasonal variations can lead to shifts in migration routes. Greece is having to shoulder the burden of accommodating and caring for large numbers of migrants, including providing them with health care. Most migrants travel northwards if they can. Many remain, however, so Greece faces a large increase in numbers of asylum seekers, as well as irregular migrants. **Transit countries** are characterized by a large influx, but at the same time a large outflow of migrants, and can be placed under great – but temporary – strain. Only immediate and stopgap forms of health care – first aid – can be administered to migrants in transit, unless they are so incapacitated that they are unable to travel further. Transit countries currently include Greece, Croatia, Slovenia and Austria. The Baltic States and Poland have long been transit countries for migrants arriving via Russia. Belgium, France, Germany and Denmark may be transit countries for migrants trying to reach the UK and Sweden respectively.
(2) Destination countries
Traditional destination countries tend to be relatively wealthy countries with a history of granting asylum such as Sweden, Germany, the UK, Belgium and the Netherlands. The migratory pressure experienced by these countries can be considerable, but it is of a different kind to those described above. In several of the destination countries listed, reception and accommodation facilities (including health services) have already reached or exceeded the limit of their capacity. These countries may be familiar with the typical health needs of asylum seekers, but unable to meet them adequately because of restrictions on entitlement, poor accessibility of services and inadequate resources for overcoming linguistic and cultural barriers. **New destination countries** are experiencing an increase in asylum applications and numbers of irregular migrants but with few previous experience of providing asylum. Most of these countries are in Eastern Europe, but Spain and Portugal also fall in this category. Such countries have in the past received extremely small numbers of asylum seekers. They are now faced with the problem of scaling-up provisions and acquiring new skills and resources.

[2] Source: http://ec.europa.eu/eurostat/statistics-explained/index.php/Asylum_statistics

[3] Source: http://www.acaps.org/themes/refugeemigrant-crisis

1.4 Health needs during migratory trajectory

The large numbers of people arriving in and migrating though Europe have different backgrounds, are in different physical, mental and social conditions, and positioned differently in terms of (e.g.) gender, age, educational level and socioeconomic status. The health problems they experience and health risks they are exposed to differ in kind and degree, calling for an *intersectional rather than a generalising approach* to analyse the problems in each phase.

There is nothing new about the health needs of these groups: quite a lot is known already about their needs and the services available, the only thing new is the large recent increase in their numbers in certain countries and to some extent the composition of the groups which affects the patterns of their health needs.

> ***Intersectionality*** *recognizes that individuals and groups are shaped by multiple and intersecting identities. These identities often inform an individual's world view, perspective and relationship to others in society. An intersectional perspective or framework encourages policymakers and social change leaders to identify the ways in which race, class, gender, ethnicity, sexual orientation, ability and status influence public policy outcomes at the national, state and local levels. This approach can also inform advocacy efforts aimed at increasing equity and equality in society.*

Their health needs are notwithstanding considered an issue of public health importance. The deteriorated purchasing power of these population groups, among others things, leads to rising malnutrition rates. Their access to care other than emergency care is limited. Gaps exist in the national health information and disease surveillance systems. These, in turn, increase the risk of vaccine preventable diseases and epidemic outbreaks. Hundreds of thousands of children should keep on track with their vaccination schedule. The profile of the displaced population indicates an increased need for sexual, reproductive and child health services, as well as geriatric care. Sexual violence is also a specific reason for claiming asylum and a priority health concern, which requires specific interventions. Many of these migrants are survivors of violence and have serious medical conditions. Some are amputees needing prostheses, victims of trauma needing specialized treatment or cancer patients. Hence the health needs observed are *a compounded effect of acute critical health needs that warrant humanitarian interventions as well as health needs that require access to regular comprehensive health care and public health interventions provided by the countries' health systems.*

Health needs change and accumulate during the trajectory of flight/migration. This means, first of all, that it is important to address health needs according to their context 1) across the countries (countries of first arrival/transit and destination countries) and 2) within each country according to which step of the trajectory of flight the assessment concerns (arrival, asylum process, settlement). Secondly, it means that awareness of the cumulative effect of health needs during this trajectory calls for early and coordinated specialized action: vulnerable groups may become increasingly vulnerable during flight. Thirdly, it means that health protection during the final stages of a flight/migration trajectory must be targeted based on the complexity of (physical, psychological and social) unmet health needs that have arisen (and potentially keep rising) during the trajectory.

2 Access to health for refugees, asylum seekers and migrants

2.1 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 sexual and gender-based violence 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).

Mapping of the health response

In preparation of the development of a health coordination framework (see chapter/module X), a mapping exercise was conducted of the health care response to the recent influx of refugees, asylum seekers and other migrants. Health representatives from nineteen European Union (EU) Member States were approached in January-February 2016 to update or complete a prefilled profile of their country describing the influx, the type of first assistance services provided, the existence of a health coordination mechanism and the involvement of key actors in provision of health services (see template in annex 2). Twelve countries returned an updated profile: Austria, Belgium, Bulgaria, Croatia, Denmark, Greece, Malta, the Netherlands, Poland, Portugal, Romania, and Slovakia (hyperlinks to be added).

The mapping exercise has thus informed the development of a set of frameworks and tools which address the need for a coordinated health response, help to conduct needs assessments, support the planning of appropriate actions, and provide resource packages increase access to health care and training for more culturally-sensitive services. These frameworks and tools can be consulted as stand-alone guidance documents.

2.2 First entry assistance services

Analysis of the twelve completed country profiles shows that most countries provide primary health care in reception and/or registration facilities which are governed by national, regional or local governments, through their Ministry of Health, Ministry of Interior, Ministry of Foreign Affairs, the police or the army. In some countries (e.g. Romania), all migrants are registered and screened for their health condition and infectious diseases, giving treatment according to their needs.

In arrival countries (e.g. Greece) NGOs provide a health card/booklet and first aid to refugees, including hygiene and/or health kits. Their first entry assistance includes basic medication for non-communicable diseases and a wide range of services such as screening for serious health problems, curative clinical care (mobile or stationary), clinical management of sexual and gender-based violence. In case of serious life-threatening conditions, referral to hospitals is made or emergency care is provided under national regulations and standards, e.g. for comprehensive emergency obstetric care, in countries such as Romania and Slovakia. Ambulance services are usually available and accessible. In some countries (e.g. Romania) IOM provides subsequent non-emergency medical assistance until the protection status of the refugees and asylum seekers is confirmed by the immigration authorities. Some NGOs provide basic health care services to the refugees at the entry points.

First assistance services in destination countries (e.g. Belgium, Denmark, the Netherlands) often include accommodation, clothes and hygiene parcels, medical and psychological screenings, health care and psychosocial support, childcare, vocational training, and various volunteer-based activities.

2.3 Health services provided: where, what and who?

2.3.1 Health services provided in arrival and transit countries

Table 2 shows that many actors provide services for people arriving in European countries (e.g. Greece, Italy) after a long journey of travel and migration: IOM, UNHCR, national ministries, international NGOS such as Red Cross, Médecins du Monde, Médecins sans Frontières, and civil society and volunteer organisations. Many of these organisations were/are also active in the transit countries, e.g. Bulgaria, Croatia, and Slovakia.

Some countries (but none of the 12 with completed profiles) have restricted access to health care for those arriving without legal authorisation, but most arrival and entry countries provide a basic health package of primary standard health care, with referrals to secondary or tertiary health facilities in case of severe health risk. In Romania e.g. IOM provides health care services at the Emergency Transit Centre in Timisoara. IOM interpreters are available upon request to support the migrants and refugees. The interpreters also assist during medical interventions (e.g. in the transit winter centre in Slavonski Brod in Croatia last winter and/or in local hospitals).

Table 2: Location, type and key actors of the health response in arrival and transit countries

WHERE? Location of response	WHAT? Type of health response	WHO? Key actors in the health response
Recent arrivals		
Mainly in reception, accommodation or detention centres, managed by governments or Red Cross	Sometimes first basic medical screening at the dock (i.c. Greece) Psychosocial support	Red Cross NGOs IOM UNHCR Civil society organisations Volunteers

WHERE? Location of response	WHAT? Type of health response	WHO? Key actors in the health response
	Primary standard health care, with referrals to secondary or tertiary health facilities in case of severe health risk (emergency rooms available in some centres) Specialised medical healthcare for babies and children (NGOs) Interpreters	 (NGOs) (IOM)
People in transit		
Mainly in reception facilities Hospitals (i.c. in emergency rooms)	Ambulatory care Primary standard health care, with referrals to secondary or tertiary health facilities in case of severe health risk (emergency rooms available in some centres)	Red Cross NGOs

Many migrants with chronic conditions do not have health booklets with them which makes prompt treatment often challenging.

2.3.2 Health services provided in destination countries

Although some countries restrict access to health care for asylum seekers, the 'traditional' destination countries provide primary, secondary, tertiary health care as they do for their citizens or residents. In general, children get more and easier access than adults. For undocumented migrants access to health care is sometimes restricted, e.g. Portugal only provides urgent medical care, maternal, reproductive and child care, immunization and treatment of communicable diseases that pose a danger to public health. Undocumented migrants therefore often experience unmet health care needs, often also caused by lack of awareness regarding entitlements of undocumented migrants among health professionals, like e.g. Belgium where undocumented migrants are entitled to preventive and curative care but where health care provider interpret this 'urgent medical care' in a strict (emergency) sense.

NGOs, professional associations, international organisations such as Médecins du Monde, Red Cross, IOM, UNHCR… are usually the ones giving assistance to newcomers in several countries.

Table 3: Location, type and key actors of the health response in destination countries

WHERE? Location of response	WHAT? Type of health response	WHO? Key actors in the health response
Asylum seekers & refugees granted status		
○ Reception facilities (collective centres) ○ Emergency rooms ○ Hospitals	○ Basic health package of primary, secondary, tertiary, health care, with exceptions and restrictions in some countries (xxx)	○ National/local government ○ NGOs
Undocumented migrants		
○ Primary health care centres and hospitals ○ Emergency rooms	○ 'Standard' health provision, mainly ambulatory ○ Sometimes limited choice of health care provider ○ Sometimes restricted access for specific screening and treatment	○ Ministry of Health/Regional or local health authority ○ NGO ○ Red Cross

Some countries offer welcome / reception facilities for **unaccompanied minors** and give them the right to access health care as children with the nationality of their country. Other countries restrict health services to unaccompanied minors until age assessment has been performed and asylum procedure started.

2.4 Challenges for health service providers

Refugees and asylum seekers often require a health response that combines crosscutting issues such as 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 not only 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 the mapping exercise, and in order to gather information on the new challenges for health services related to the current refugee influx, a series of **interviews and focus group discussions** have been conducted in 10 EU countries between February and March 2016.

The major findings of the interviews and focus groups discussions were:

- Delivery of health care to migrants is seriously hampered by the complexity of legal and administrative procedures that have to be executed to guarantee access to care. Care providers are insufficiently familiar with rules that apply, some of them act randomly. Some restrictions exist, some payments are required for certain services and some treatments and drugs cannot be prescribed;
- Linguistic and cultural barriers are systematically identified as one of the major challenges. In many Member States no or insufficient professional interpreters or intercultural mediators are available. Care is often provided on the basis of poor communication and understanding of cultural differences;
- Lack of health records hampers the continuity of care. No adequate systems for exchange of medical information between EU Member States exist. It is often impossible to trace patients in movement from one country to another;
- Living conditions in the arrival camps were criticized. Because of the economic crisis in Greece, hospitals have limited resources to provide pamper, food and clothes to the patients. In countries were a lot of care is provided by NGOs the quality of care may vary;
- Lack of organization, abundance of NGOs, lack of knowledge on cultural differences and media pressure have created unjustified fears among native citizens, particularly where health resources were limited or underfunded;
- Even though most of migrants do not suffer severe health problems (with the exception of some arrivals to the shorelines), health professionals have to be alert to recognize the few cases of diseases that are uncommon in the receiving countries but may be so in the countries of origin;
- The collected information also shows that pregnant women, unaccompanied minors, victims of torture and people with mental post traumatic disorders pose special problems. Due to the factors mentioned above, mental health care uses to be poorly delivered.

2.5 Barriers to health access

Emergency humanitarian aid is usually provided by a combination of NGOs and mainstream health services. 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 mainstream health services, 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 (see chapter 2.1). *Laws can thus provide a serious barrier* to accessing adequate health service provision. The resources may be available, but access to them by certain migrant groups may be limited (see chapter 2.4).

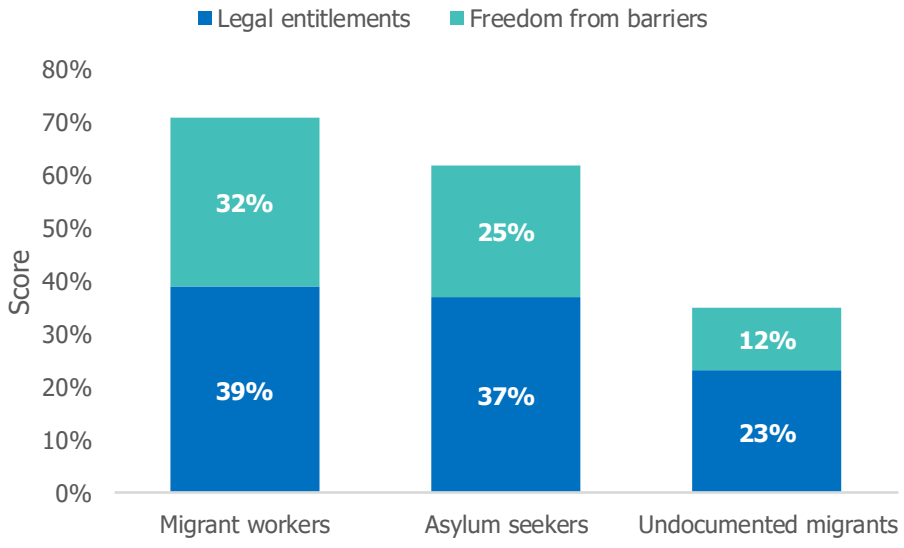
In addition, there are several kinds of *non-legal barriers* that can arise between service providers and their (potential) beneficiaries. The following can be distinguished:

- 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.

At individual level, staff may simply be unwilling to help – though it should be remembered that many cases also occur of staff giving more help than a migrant is entitled to.

A lack of 'cultural competence' or 'sensitivity to diversity' in the actual delivery of care will also constitute a barrier. The MIPEX study has made a comprehensive overview of access to health services in European countries for three categories of migrants: (regular) migrant workers, asylum seekers and undocumented migrants. Figure 3 shows how serious the problem of limited entitlement to care is.[4] A score of 100% indicates complete equity with national citizens, while 0% means that migrants are totally excluded from health care coverage. Even fully legal migrants enjoy only 72% entitlement, and this percentage decreases across the categories to 35% for undocumented migrants. As the level of legal entitlement goes down, so does the number of administrative barriers increase.

Figure 3: Access to health care services for categories of migrants



Source: MIPEX. http://www.mipex.eu/health

In addition to administrative barriers there are also the other types of barriers mentioned above, as well as the lack of responsiveness to migrants' special needs ('diversity sensitivity'), all of which further impede the delivery of good health care to migrants. For this reason, the accessibility of care should be regarded as at

[4] In measuring entitlements, account is also taken of the administrative barriers – difficult documentation and discretionary judgements – which may prevent a migrant from exercising a legal entitlement.

least as important (if not more) than its availability. Usually the services exist, but nearly all governments are reluctant to allow migrants to benefit fully from them. Often such policies are based on a mistaken belief that providing adequate health services to migrants will create an unstoppable flow of them into the country. However, evidence is lacking that health service provision is an important 'pull' factor compared to conditions of living and employment prospects.

3 Need for coordinated and effective health response

In addition to 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; as well as societal challenges such as the myriad of entitlements to health care and geopolitical negotiations on a common European approach to the refugee influx that severely impact the potential health response. Responding to these needs requires an enormous coordinated effort of EU Member State governments, Red Cross societies, (inter)national NGOs, the European Union, the UN agencies (especially UNHCR, WHO and UNICEF) and the International Organisation of Migration (IOM).

3.1 Existence of coordination mechanisms

Countries that have been traditionally destination countries for refugees, asylum seekers and other migrants often have an institutional response mechanism (e.g. Organization for the Reception of Asylum seekers in country X, State Agency for Refugees in Belgium; Office for the Protection of Refugees and Stateless in country Y; xxx). The twelve profiles completed show that at governmental level mainly Ministries of Health, Ministries of Interior or Public Health institutes are involved in the coordination of the health response.

Most countries with less experience with refugees or asylum seekers or new destination countries are currently in the process of creating the response mechanisms with high level meetings, e.g. Croatia and Greece.

3.2 Available resources for health response

The mapping exercise demonstrated that financial resources available for responding to the health needs of refugees, asylum seekers and other migrants are often not disclosed or that detailed is information unavailable.

Funding sources for recent arrivals, people in transit, asylum seekers come mostly from national governments, IOM, international and national NGOs (Médecins sans Frontières, Médecins du Monde, Red Cross…), and civil society organisations. Funding sources for people with refugee status granted and for undocumented migrants are usually provided by national governments, health insurance, and own contributions of the migrants.

3.3 Reasons for coordination of the health response

Analysis of these twelve profiles demonstrated that the health response of the EU Member States so far remains *fragmented*: the involvement of many different partners, not all acting in harmony, results in overlapping, duplication and unmet health needs because of the lack of adequate coordination, both within a Member State, at Member State and at European level.

Contextual elements to take into account are:

- The influx of refugees and asylum seekers 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.

- The EU Member States are dealing with a protracted crisis with increased impact on various local sectors, including health, aggravated by insufficient planning of a long-term integrated multi-sectoral response.
- The Member States' legal and policy frameworks do not always alleviate barriers ensuring access to health care. A gap exists between the recognition of the universal right of all to health care and its adherence in several EU Member States.
- Migration in itself is not a health risk but the migration process can often bring circumstances posing important health risks and challenges.
- 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 rather 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 and there are others in need of specific clinical, psychosocial and forensic actions in response to sexual violence experiences. Sexual violence is also a specific reason for claiming asylum and a priority health concern, which requires both prevention and response interventions at all stages of migration and in all types of reception facilities.
- A number of migrants have serious chronic conditions (e.g. cancer, diabetes…) the treatment of which should be continued.
- Migrants' health goes beyond the traditional management of communicable diseases and is closely linked with the social determinants of health.
- 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 conclusion, the above points emphasise the necessity of a highly flexible **coordinated response** anchoring migrants' health in a human rights framework and harnessing all partners, stakeholders and goodwill at national, local and municipal level. The absence of a coordination process may weaken the health system and its governance in the long run because of fragmentation of the health responses.

4 The nature of the SH-CAPAC project

SH-CAPAC is a project launched on January 1st, 2016 to support EU Member States under particular migratory pressure in their response to health related challenges. The project is aimed at building capacity in areas of coordination practices, needs assessments, planning actions to strengthen the public health response of local health systems, improving access to health care, and developing health workers' competencies for the delivery of migrant/refugee sensitive health services.

This project is being carried out by the following institutions: Andalusian School of Public Health – EASP (Spain, coordinator), Azienda Unità Sanitaria Locale di Reggio Emilia (Italy), Trnava University in Trnava (Slovakia), Jagiellonian University Medical College (Poland), International Centre for Reproductive Health / University of Ghent (Belgium), Academic Medical Centre/University of Amsterdam (The Netherlands) and University of Copenhagen (Denmark).

The health needs of a vulnerable population of at least 1,000,000 people who have entered the EU in 2015 is an issue of public health importance. This population may amount to two million refugees, asylum seekers and other migrants at the end of 2016. The health needs we are observing are a compounded effect of acute critical health needs that warrant humanitarian interventions as well as health needs that require access to regular comprehensive health care and public health interventions provided by the countries' health systems.

The deteriorated purchasing power of these population groups, among others things, lead to rising malnutrition rates. Their access to care other than emergency care is limited. Gaps exist in the national health information and disease surveillance systems. These, in turn, increase the risk of vaccine preventable diseases and epidemic outbreaks. Hundreds of thousands of children should keep on track with their vaccination schedule.

The profile of the displaced population indicates an increased need for sexual, reproductive and child health services, as well as geriatric care. Sexual violence is also a specific reason for claiming asylum and a priority health concern, which requires specific interventions. Many of these migrants are survivors of violence and have serious medical conditions. Some are amputees needing prostheses, victims of trauma needing specialized treatment or cancer patients.

Responding to these needs requires an enormous coordinated effort of EU Governments, Red Cross societies, NGOs, the European Union, the UN agencies (especially UNHCR, WHO and UNICEF) and the International Organization of Migration (IOM).

The project is directed at supporting countries' health systems and public health infrastructures in the following nineteen EU Member States:

Austria	**Belgium**	**Bulgaria**	**Croatia**		**Denmark**	**France**
Germany	**Greece**	**Hungary**	**Italy**	**Malta**	**Netherlands**	**Poland**
Portugal	**Romania**	**Slovakia**	**Slovenia**		**Spain**	**Sweden**

4.1 Beneficiaries

Ultimate beneficiaries:

- Registered and unregistered refugees, asylum seekers and other migrants entering the European Union as a consequence of conflict, violence, or persecution in origin countries (mainly but not exclusively from Syria, Afghanistan and Iraq).as well as other migrants who are fleeing other kinds of hardship (poverty, climate change,,.) consequences of adverse life in "failed States".

Direct beneficiaries:

- National and regional health authorities of health systems of each EU Member State faced with the challenge of providing a coordinated response to the current influx of refugees, asylum seekers and other migrants, entering the EU space temporarily or permanently.
- Health care workers, from health professionals to administrative staff from local health systems, community health centres and local hospitals in government institutions, NGOs and Red Crescent facilities, who are responsible for the provision of health services, the organisation and management of public health interventions, and the conduct of health assessments in connection with the refugee, asylum seekers' and other migrants' population.

4.2 Objectives

The general objective of the project is to **support Member States under particular migratory pressure in their response to health related challenges.**

Specific Objective 1: Support Member States, in close collaboration with WHO, IOM, OCHA UNHCR, and other relevant international stakeholders, in the establishment of national and international health sector coordination mechanisms (similar to the architecture of the humanitarian health cluster) for implementing a coherent and consolidated national and international response to the health needs of the refugee asylum seekers and other migrants population especially in Member States of the Western Balkans' route and of the Mediterranean coast under migratory pressure.

Specific Objective 2: Support Member States in the **analysis of health challenges and unmet health needs** that the massive flows of refugees, asylum seekers and other migrants pose, as well as in conducting periodic **assessments of the health care response and public health interventions needed** (to be implemented by governments, Red Cross and NGOs) by the refugee and asylum seeker population.

Specific Objective 3: Support Member States in developing action plans for **implementing a public health response and for reinforcing their health systems in order to respond** to the challenges of the refugee, asylum seekers and other migrant influx.

Specific Objective 4: Support Member States in **promoting and ensuring access** of the refugee, asylum seekers and other migrants populations to health care and public health interventions through the development and dissemination of a **resource package** to reorient local strategies and plans.

Specific Objective 5: **Build national capacity through training of trainers** in affected countries who can implement training activities for health workers, so they can develop intercultural competences and have a clear understanding of a migrant sensitive health care delivery model, respecting human rights and dignity.

4.3 Methods and means

- ✓ Developing the necessary instruments and tools through a division of labour among the members of the consortium.
- ✓ Carrying out regional advocacy and capacity building activities (seminars and workshops), organized by the members of the consortium with the participation of relevant stakeholders from the target countries.
- ✓ Conducting missions/site visits to those target countries, which are interested in receiving technical assistance from the consortium, to develop country specific activities within the scope of the project.
- ✓ Coordinate with the national health authorities in the target countries, as well as with other relevant national stakeholders (i.e. Red Crescent and Red Cross and NGOs) involved in responding to the health needs of the refugee population.
- ✓ Coordinate with the international organizations working to respond to health needs of refugees, asylum seekers and other migrants in the target countries, especially WHO, IOM, UNHCR, OCHA, IFRC and the EC.
- ✓ Coordinate with other grantees under this call for optimisation and coordination of resources and impact.

4.4 Expected outcomes

- ✓ Have a framework for coordinating a coherent national and international response to meet the health needs of the refugees, asylum seekers and other migrant's population States and implement it in at least 6 target countries.
- ✓ Have an instrument for the assessments of health challenges posed by the massive refugee flow and of the health care response and public health interventions needed for the refugees, asylum seekers and other migrants' population and applied it in at least 8 affected countries.
- ✓ Have a framework for implementing a public health response and strengthen a country's health system in order to address the needs posed by the refugees, asylum seekers and other migrants' influx and support its formulation in at least 8 affected countries.
- ✓ Develop and disseminate a resource package to reorient local strategies and plans for promoting and ensuring access of the refugee, asylum seekers and other migrants populations to health care and public health interventions and have an adoption of tools and measures contained in the resource package in at least 8 countries targeted.
- ✓ Have a framework developed by the consortium for a migrant-sensitive health care delivery model to be implemented in entry, transit and destination countries and to have health workers (health manager, health care professional and administrative staff) in target countries trained using the SH-CAPAC training contents.

Annex 1: Sources consulted

European Commission (2016a). Managing the Refugee Crisis - State of play and future actions. January 2016. http://ec.europa.eu/dgs/home-affairs/what-we-do/policies/european-agenda-migration/background-information/docs/eam_state_of_play_and_future_actions_20160113_en.pdf

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EUROSTAT (2016). Statistics 02/02/2016. http://ec.europa.eu/eurostat

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Frontex (2015). 710 000 Migrants entered EU in first nine months of 2015. http://frontex.europa.eu/news/710-000-migrants-entered-eu-in-first-nine-months-of-2015-NUiBkk

International Federation of Red Cross and Red Crescent Societies (2016a). Information Bulletin - IFRC Regional Office for Europe Migration response. February 2016. http://www.ifrc.org/docs/Appeals/16/IB6_Migration%20response_Europe_010216.pdf

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International Organization for Migration (2015). Mediterranean Update. Missing Migrants Project: 13 November 2015. http://missingmigrants.iom.int/sites/default/files/Mediterranean_Update_13_November.pdf

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

UNHCR, The UN Refugee Agency (2016). Refugees / Migrants Emergency Response – Mediterranean. http://data.unhcr.org/mediterranean/country.php?id=105

UNHCR (2015a). 2015 UNHCR regional operations profile – Europe. http://www.unhcr.org/cgi-bin/texis/vtx/page?page=49e48e996&submit=GO

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World Health Organization – Europe (2011). Increased influx of migrants in Lampedusa, Italy. Joint report from the Ministry of Health, Italy and the WHO Regional Office for Europe mission of 28–29 March 2011. http://www.euro.who.int/data/assets/pdf_file/0004/182137/e96761.pdf?ua=1

Annex 2: Template of the country mapping profile

Programme co-funded by the EUROPEAN UNION

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

READER'S GUIDE:

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

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

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

Sources consulted:

- xxx
- xxx

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

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

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

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

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

2. HEALTH CARE RESPONSES	
Please correct or complete the information where possible.	
Health care coordination at national/regional level	A. **Existence of a national coordination mechanism of the health response**: YES/NO *(Please complete)* B. **Explanation**: *(if yes, please describe how the mechanism works and who participates; if no, please describe why there is no coordination)*
First entry assistance services	

Response to 'An Agenda for Action' as agreed during the High Level Meeting on Refugee and Migrant Health in Rome in November 2015:

Cross the appropriate 'Yes', 'No' or 'There is no information available' option in the blue boxes. Additional information or sources can be mentioned underneath the box.

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

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

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