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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**

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

Deliverable 1.1

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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 discussed at the SH-CAPAC workshop involving representatives of EU Member States on 23 and 24 February 2016 in Ghent, Belgium and was further discussed at the SH-CAPAC meeting on April 6 2016 in Trnava, Slovakia. Recommendations from the workshop and meeting were integrated in the document. The framework 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 presented during field missions in the second half of 2016 (e.g. Bulgaria, South Aegean, Catalunya Slovakia, Andalusia and Athens) 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/>.

The coordination framework was developed by Jacqueline Gernay, Ines Keygnaert, Birgit Kerstens and Daniel López Acuña from the Andalusian School of Public Health and the University of Ghent.

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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 |
| ICESCR | 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 aims at supporting individual EU MS in defining the fundamental elements that ought to be present in the development of such health coordination.

The Universal Declaration of Human Rights (1948) puts the *enjoyment of the highest attainable standard of health* forward as a fundamental right of every human being. The entitlements to health are codified in several international covenants which are ratified by all 28 EU Member States. Moreover, the right to health care is also included in the Charter of Fundamental Rights of the European Union. Finally, 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 (see background document for more details).

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

A mapping of the health care response to the recent influx of refugees, asylum seekers and other migrants in 19 European Union Member States¹ 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 (see background document for more details on the challenges).

The 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. In order to achieve this, 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 is required. **Improved coordination of all stakeholders and actors addressing the migrants' health needs results in a strengthened, high-quality and comprehensive health response.**

1.2 The aim of this health coordination framework

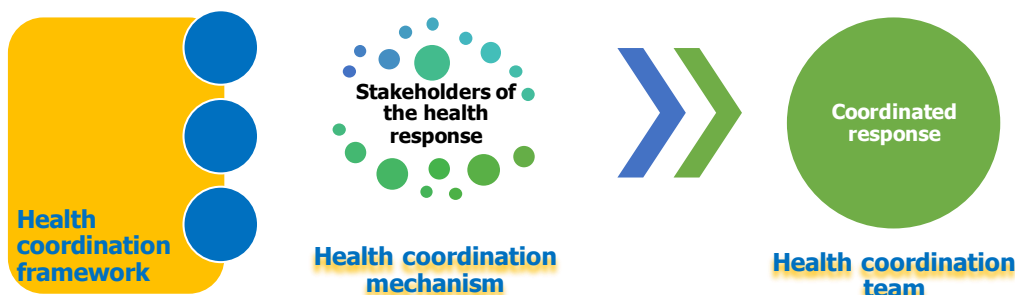
This health coordination framework aims to provide individual EU Member States with a **tool for strategic guidance** to establish or strengthen a coordination mechanism. Such a coordination mechanism aligns the

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

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 advocacy² 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 addressing one or several of the elements mentioned above. These tools were developed in separate work packages (WP) to which reference is made below (see separate documents on the health system assessment, the development of the action plan, the resource package and the training course).

2 Health coordination mechanism

The health coordination mechanism is activated 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?

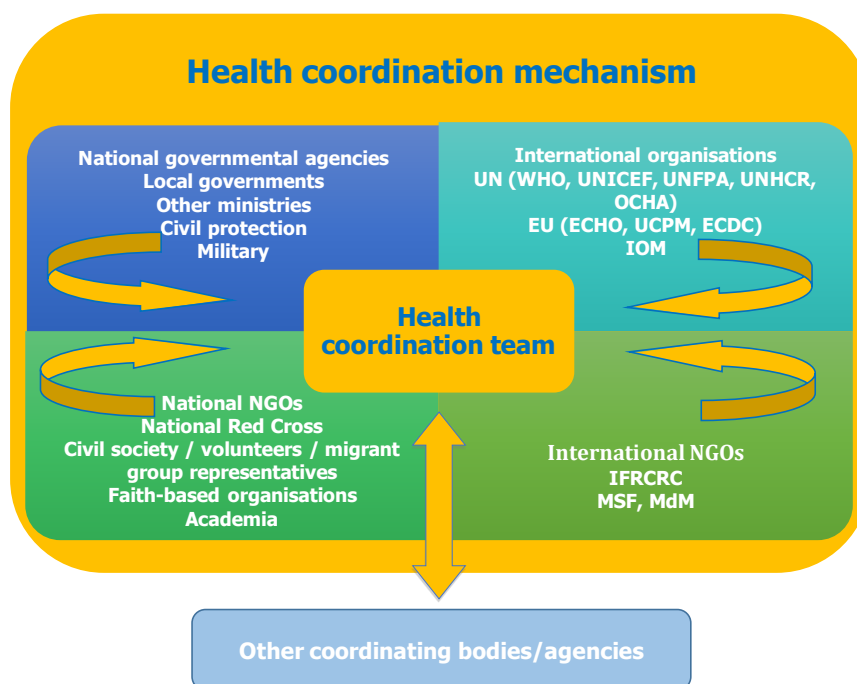


The health coordination mechanism brings together all stakeholders involved in the health response to the recent influx of refugees, asylum seekers and other migrants in order to coordinate their actions in a more efficient way. Figure 2 illustrates the potential partners of the health coordination mechanism, 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 at national level or subnational level, and can focus on internal stakeholders mainly (i.e. different ministries, national agencies, academia...), more on external stakeholders or 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 <ul style="list-style-type: none"> <input type="checkbox"/> Chairs the meetings of the health coordination mechanism (co-chairing possible) <input type="checkbox"/> Chooses a suitable venue for the meetings <input type="checkbox"/> Sets realistic agenda, with "smart" objectives <input type="checkbox"/> Hands out information before or during the meetings <input type="checkbox"/> Ensures recording of minutes with action sheets (who is responsible for what) <input type="checkbox"/> Keeps meetings short <input type="checkbox"/> Sets date for the next meeting <input type="checkbox"/> Is open to new partners <input type="checkbox"/> Follows up on former agreements | <ul style="list-style-type: none"> <input type="checkbox"/> Focus on problem solving/action and not just information sharing among members of the health coordination mechanism <input type="checkbox"/> 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 | <ul style="list-style-type: none"> <input type="checkbox"/> Especially important for cross-cutting issues: SRH, SGBV, mental health, WASH... <input type="checkbox"/> Ensure free flow of information <input type="checkbox"/> WHO can liaise with UNCT, if it is part of the health coordination mechanism <input type="checkbox"/> Identifies possible contingencies that could impact on the health needs of the refugees and the required responses (i.e. acute influx) | <ul style="list-style-type: none"> <input type="checkbox"/> Invite representative(s) to the health coordination mechanism meetings <input type="checkbox"/> Designate someone from the health coordination team to attend the respective meetings, as relevant <input type="checkbox"/> 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) <input type="checkbox"/> Consider simulation exercises |
| 4. Ensure regular feedback to all partners involved | The health coordinator <ul style="list-style-type: none"> <input type="checkbox"/> Sends out minutes and action sheet within 24-48 hours after the meeting <input type="checkbox"/> 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 <input type="checkbox"/> Ensures feedback from the next hierarchical level to the coordination mechanism | <ul style="list-style-type: none"> <input type="checkbox"/> Designates who takes minutes and circulates them. <input type="checkbox"/> 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 management and communication expert, 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.

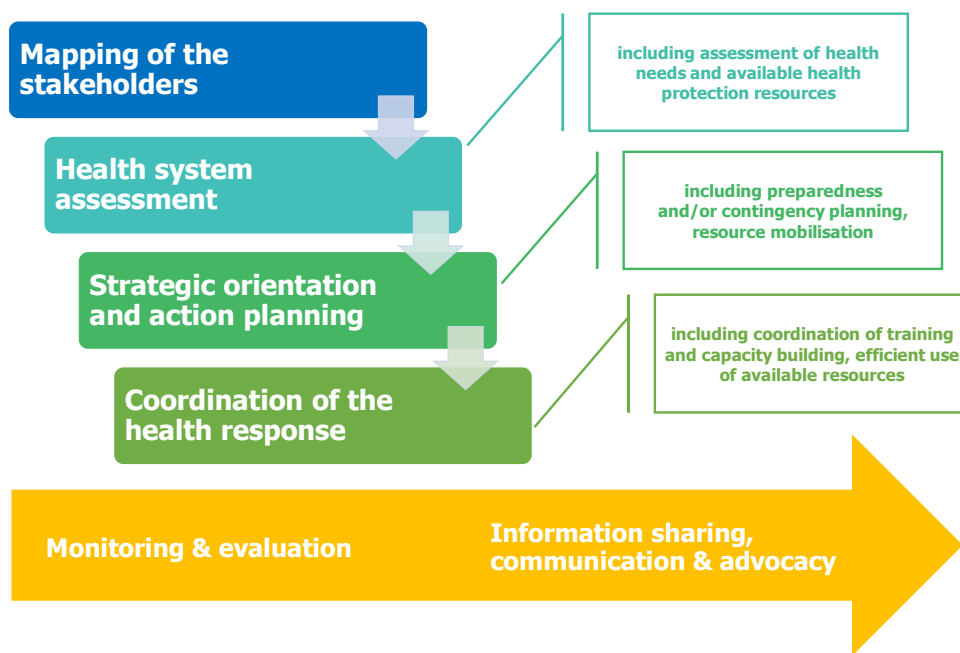
The coordinator is designated by the ministries/authorities in charge of the corresponding level; (s)he is someone with proven leadership skills, knowledge of and experience with migrant crisis and with a public health background. The health information management expert is someone with epidemiological 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.

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 programmes, 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 | <ul style="list-style-type: none"> <input type="checkbox"/> Identify (sub)national and international actors <input type="checkbox"/> Map who is doing what and where <input type="checkbox"/> Conduct a simplified resource mapping exercise in order to have a rough estimate of the | <ul style="list-style-type: none"> <input type="checkbox"/> Gather info through use of simple form or round table talk (especially at local level where resources are scarce) <input type="checkbox"/> Consider use of a tool: e.g. <ul style="list-style-type: none"> o WHO assessment |

| WHO? | WHAT? | HOW? |
|------|--|------|
| | available financial and human resources <input type="checkbox"/> Understand their mandates, expectations and constraints <input type="checkbox"/> 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 programmes/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) | <input type="checkbox"/> Needs assessment <input type="checkbox"/> Assessment of available health protection resources <input type="checkbox"/> Gap analysis and identification | <input type="checkbox"/> 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 health system assessment.
- Development of action plans to respond to the health needs identified.
- Development of preparedness³ 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 introduced 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 | <input type="checkbox"/> Strategic plan <input type="checkbox"/> Action plan <input type="checkbox"/> Preparedness and contingency plan <input type="checkbox"/> Respect of norms and standards <input type="checkbox"/> Capacity building and training plan | <input type="checkbox"/> For planning: see guidance provided by SH-CAPAC action plan and resource package <input type="checkbox"/> 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 background document). 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 |
| Settling migrants | | | | |

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 |
|-------------------------------|---|---|---|--|
| 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 agency lead 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 agency lead | 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 standards⁵ 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 | <ul style="list-style-type: none"> <input type="checkbox"/> Health response by population segment with special emphasis on SGBV prevention and response, mental health, comprehensive PHC <input type="checkbox"/> Special attention to unaccompanied minors <input type="checkbox"/> Focus on integration into the national health system | <ul style="list-style-type: none"> <input type="checkbox"/> For resource packages: see guidance provided by SH-CAPAC resource package <input type="checkbox"/> Other SH-CAPAC tools (e.g. online training) could be considered if appropriate <input type="checkbox"/> Ensure that financial and human resources are in line with strategic and action plan of the health response <input type="checkbox"/> 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.

⁵ I.e. support development/revision of guidelines, if needed, using recognised international best practices).

| WHO? | WHAT? | HOW? |
|--------------------------|---|---|
| Health coordination team | <ul style="list-style-type: none"> <input type="checkbox"/> Define the minimally required information to be collected, stored and disseminated for the benefit of the health coordination mechanism and other stakeholders <input type="checkbox"/> Collect information from other teams, e.g. health assessment team, and stakeholders to feed into periodic monitoring and evaluation reports <input type="checkbox"/> Regularly update and consolidate the minimally required information <input type="checkbox"/> Focus on information for action that will inform national and decentralised health planning <input type="checkbox"/> Internal feedback (through the periodic monitoring and evaluation reports) to all partners of the health coordination mechanism and to national coordinating body | <ul style="list-style-type: none"> <input type="checkbox"/> Retrieve relevant information on health status and needs of refugees, asylum seekers and other migrants from national health information system <input type="checkbox"/> 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 <input type="checkbox"/> 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 are 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.
 - Plus other diseases to be determined by the context.
 - ❖ Number of new scabies cases.
 - ❖ Number of suspected TB cases.
 - ❖ Plus other diseases to be added as per context with request to report any outbreak.
- *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 cardio-vascular disease.
 - ❖ Plus other diseases to be added as per context.
- *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.
- *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).
- *Risks.*
- *HRH needs including translators.*
- *Accommodation safety, security.*
- *Status of the activities proposed in the action plan.*
- *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?*
 - 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;

- Progress reports of stakeholders involved in the various health coordination tasks (assessments, planning, implementation, capacity building);
 - 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:
 - 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?
 - 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 communication⁶.

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.

⁶ 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 | <ul style="list-style-type: none"> <input type="checkbox"/> 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 <input type="checkbox"/> External communication to media and public (e.g. through website) <input type="checkbox"/> Risk communication <input type="checkbox"/> Highlight advantages to the general population <input type="checkbox"/> Respect confidentiality⁷ | <ul style="list-style-type: none"> <input type="checkbox"/> 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. This 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 in July 2016, South Aegean and Catalunya in September 2016, Slovakia in October 2016 and Andalusia and Athens in December 2016).

The health coordination framework assumes a dynamic use, considering the nature of the refugee influx. 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 until end of December 2016 to establish such a health coordination mechanism and/or to strengthen the current coordination arrangements in the respective countries.

⁷ 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.