World Health Organization
REGIONAL OFFICE FOR Europe

Toolkit for assessing health system capacity to manage large influxes of refugees, asylum-seekers and migrants

With the support of

UNHCR
The UN Refugee Agency

International Organization for Migration (IOM)
Organisation internationale pour les migrations (OIM)
Organización Internacional para las Migraciones (OIM)

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Abstract

In recent years, the WHO European Region has seen a marked increase in arrivals of mixed flows of refugees, asylum-seekers and migrants. Their journey to Europe is often long and treacherous, with numerous health and safety risks along the way. It is imperative that the health needs of these vulnerable groups be addressed by transiting and receiving countries using human rights principles and with careful coordination across sectors.

The toolkit for assessing health system capacity to manage large influxes of refugees, asylum-seekers and migrants was developed by the WHO Public Health Aspects of Migration in Europe (PHAME) project of the Migration and Health Programme because refugees, asylum-seekers and migrants arriving in large groups present a particular set of individual and public health needs, and assessment of preparedness and capacity requires a specialized approach. The aim of the toolkit is to support national ministries of health in leading multisectoral collaboration to optimize the capacity of the health sector to manage large influxes of refugees, asylum-seekers and migrants, consequently improving their health and reducing health inequities.

Keywords

MIGRANTS, REFUGEES, HEALTH SYSTEM CAPACITY, PREPAREDNESS, RESPONSE

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Foreword

The toolkit for assessing health system capacity to manage large influxes of refugees, asylum-seekers and migrants comes at a crucial time. Migration is a growing worldwide phenomenon: an unprecedented situation that constitutes not merely a humanitarian crisis in our Region, but a crisis of humanity. Over the past 70 years, the WHO European Region has experienced a major increase in migration, with a current peak of over one million migrants arriving in Europe in 2015 alone. This influx requires an urgent and coordinated response which respects the fundamental right of health for all and places a special emphasis on the most vulnerable people. In line with the 2030 Agenda for Sustainable Development of the United Nations, in which countries pledged that "no-one will be left behind", migrants are recognized as vulnerable people. Thus, there is an urgent demand for evidence-based public health interventions to address the health needs of migrants that could save a significant number of lives and reduce suffering and ill health.

In 2012, the WHO Regional Office for Europe established the Public Health Aspects of Migration in Europe (PHAME) project with the financial support of the Ministry of Health of Italy. In order to protect the health of migrants and of the host population, the WHO PHAME project aims to assist Member States in responding adequately to the public health challenges of migration. Member States have repeatedly called for a technical guide to assessing health system capacity and preparedness at the initial phase of migrant arrival; consequently, this tailored toolkit was jointly developed with the European countries at the front line of the crisis. Close collaboration with Member States and interagency partnerships made it possible to develop this distinctive and effective self-assessment toolkit. Not only was the mutually driven development supported by agencies including the Office of the United Nations High Commissioner for Refugees (UNHCR) and the International Organization for Migration (IOM); it has also been piloted in a number of Member States in recent years, namely Albania, Bulgaria, Cyprus, Greece, Hungary, Italy, Malta, Portugal, Serbia, Spain and the former Yugoslav Republic of Macedonia.

This toolkit is a good example of the application of Health 2020 policies to an existing and devastating scenario. The toolkit provides a basis for the preparation of migrant-sensitive health systems and makes a strong case for investment and action through whole-of-government and whole-of-society approaches. It gives national ministries of health the opportunity to lead a multisectoral collaboration to optimize their health system preparedness and capacity. The area of migration and health is a highly complex and multifaceted one, in which many different stakeholders interact. In due course, it will also be essential to adopt an intersectoral approach of jointly identifying and addressing health system gaps in collaboration with other actors, including ministries of the interior, education, social affairs and employment, and with civil society, in order to address the social determinants of health of refugees, asylum-seekers and migrants.

Dr Zsuzsanna Jakab
WHO Regional Director for Europe

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Acronyms

CDC	United States Centers for Disease Control and Prevention
ECDC	European Centre for Disease Prevention and Control
EWARN	Early Warning Alert and Response Network
Frontex	European Agency for the Management of Operational Cooperation at the External Borders of the Member States of the European Union
IFRC	International Federation of Red Cross and Red Crescent Societies (Red Cross)
IOM	International Organization for Migration
PHAME	WHO Public Health Aspects of Migration in Europe (project)
SAR	search and rescue
UNHCR	Office of the United Nations High Commissioner for Refugees

Executive summary

In recent years, the WHO European Region has seen a marked increase in arrivals of mixed flows of refugees, asylum-seekers and migrants. Many of them are fleeing conflict, persecution and/or poverty and deprivation. Their journey to Europe is often long and treacherous, with numerous health and safety risks along the way. It is imperative that the health needs of these vulnerable groups be addressed by transiting and receiving countries in accordance with human rights principles and with careful coordination across sectors.

The toolkit for assessing health system capacity to manage large influxes of refugees, asylum-seekers and migrants was developed by the PHAME project of the Migration and Health Programme, WHO Regional Office for Europe, which is funded by the Italian Ministry of Health, in recognition of the fact that refugees, asylum-seekers and migrants arriving in large groups present a particular set of individual and public health needs, and that assessment of preparedness and capacity requires a specialized approach. The PHAME project was launched by the WHO Regional Office for Europe in 2011 to support the work of stakeholders who are responsible for providing high-quality health care for refugees, asylum-seekers and migrants, and to develop expertise and capacity in migration and health. Since 2012, the WHO PHAME project has led several joint country assessments in collaboration with the ministries of health of Member States in the Mediterranean and south-east Europe subregions.

The arrival of large numbers of refugees, asylum-seekers and migrants at some border points and shores along new migratory routes, or after rescue at sea, is one of the most significant social processes occurring in Europe today, and will continue to be so in the future. These large and localized arrivals pose some specific challenges because of the rapid and intense demand for health services they may impose on local systems. In this respect, they can be considered a special case in the context of the agenda for the broader health of migrants addressed by World Health Assembly resolution WHA61.17 on the health of migrants, and its general framework for action (Madrid 2010) *(1)*. The way in which host countries respond to this phenomenon will determine health and human rights outcomes for refugees, asylum-seekers and migrants, as well as the host populations. The WHO PHAME project, with the support of UNHCR and IOM, has developed this toolkit to support national and subnational health authorities in leading multisectoral collaboration to optimize the capacity of the health sector to manage large influxes of refugees, asylum-seekers and migrants, thereby improving their health and reducing health inequities.

Introduction

This toolkit is designed to assess health system capacity to cope with large influxes of refugees, asylum-seekers and migrants, focusing specifically on the initial phase. The initial phase is defined as the period leading up to arrival and the period immediately after placement in the first accommodation facility. It does not include evolving needs associated with long stays in first accommodation or evolving risks over the course of settlement or repatriation.

The 1951 Convention relating to the Status of Refugees defines a "refugee" as someone who "owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion, is outside the country of his nationality, and is unable to, or owing to such fear, is unwilling to avail himself of the protection of that country" (see Article 1A(2)). Refugees are forced to flee because of a threat of persecution and because they lack the protection of their own country *(2)*.

The term "asylum-seeker" refers to a person asking for international protection under international refugee law, but whose claim has not yet been finally decided on by the country in which he or she has submitted it. Not every asylum-seeker will ultimately be recognized as a refugee, but every refugee is initially an asylum-seeker *(3)*.

A migrant, in comparison, may leave his or her country for many reasons that are not related to persecution, for instance for the purposes of employment, family reunification or study. A migrant continues to enjoy the protection of his or her own government, even when abroad *(2)*.

At the international level, there is no universally accepted definition of the term "migrant". The distinction between refugees, asylum-seekers and migrants is recognized in the title of this publication, and has been agreed with UNHCR and IOM. However, for the purposes of this toolkit, the term "migrant", as used throughout the document, includes both internal and international migrants, refugees and asylum-seekers, family members of previously settled migrants, victims of human trafficking, internally displaced persons, returnees and undocumented migrants (see Annex I). Migrants may remain in the home country or host country ("settlers"), move on to another country ("transit migrants") or move back and forth between countries ("circular migrants", such as seasonal workers).

The term "large" applied to influxes of refugees, asylum-seekers and migrants is a relative term, referring to arrivals of such groups of a size and nature which overwhelms the response capacity of the receiving country, and which requires the mobilization of national and sometimes international resources.

Migration and health within the Health 2020 European policy framework

The WHO Regional Office for Europe describes the genesis and aims of Health 2020:

> "The 53 countries of the European Region approved a new value- and evidence-based health policy framework for the Region, Health 2020, at the session of the WHO Regional Committee for Europe in September 2012. Health 2020 focuses on improving health for all and reducing health inequalities, through improved leadership and governance for health" *(4)*.

Health 2020 is designed to align the work of multiple sectors while maintaining a focus on the individual, thereby promoting basic health and human rights for all *(5)*. Preparedness and response capacity for dealing with emergencies is one of the four priority areas of the Health 2020 policy framework *(6)*. Within this framework, assessing health system preparedness and response in the acute phase of a large influx of migrants is the first step in developing migrant-sensitive health systems and policies. Given the multisectoral and multifaceted nature of migration, tackling its public health implications and responding to the diverse health needs of migrants implies addressing the social determinants of health, and therefore strengthening collaboration across sectors including health, interior, education, social affairs or employment, as well as taking into consideration the various phases of migration, at countries of origin, transit and destination.

Europe as a whole, particularly the countries near north Africa and the Middle East, but also the

eastern countries of the WHO European Region, are increasingly confronted with sudden and irregular arrivals of large groups of people. Some of them are fleeing armed conflict, others migrate on a voluntary basis in search of a better life, and still others are trafficked into Europe. In 2015 alone, over one million migrants entered Europe, in addition to over 2.5 million who had taken shelter in Turkey by the end of the year. These numbers, along with the persisting conflicts in the Middle East, suggest that the public health implications of migration to Europe need to be adequately addressed both in the present and in the near future. Social and political unrest in many countries within and beyond these regions is likely to continue, bringing with it an uprooting of lives and livelihoods, and placing people and families in these areas in a vulnerable situation. Furthermore, countries in the eastern part of the WHO European Region are continuously confronted with large flows of economic migrants. Political and economic conditions in these countries and in other parts of the world are also likely to continue triggering movements of people in search of work and other opportunities in Europe.

The events of recent years have demonstrated the speed with which migration crises can evolve, and the impact they can have in terms of both the numbers of people affected and the rapidity with which people can move from one part of the world to another. These events highlight the ways in which sociopolitical circumstances in one part of the world can challenge the border control policies, procedures and preparedness of host countries. The patterns of migration pose specific challenges to health systems that require understanding of the context and a nuanced and informed approach to refugee and migrant health – an approach which will, by the very nature of migration, differ from country to country.

Migration can be a sensitive topic for Member States. Most policies and regulations fall under the mandate of national governments, and are therefore subject to different political approaches. Regardless of the political climate, the public health aspects of large-scale movements of migrants are a matter of concern to the general population. The development of tools to address the specific public health needs associated with large influxes of people can be instrumental in the following ways: (i) to put in place life-saving interventions; (ii) to reduce mortality and morbidity in refugee and migrant populations; (iii) to ensure refugees' and migrants' health rights; (iv) to minimize the negative impact of the migration process on migrants' and the host population's health outcomes; and (v) to reduce disparities in health status and access to health services between migrants and the host population *(7)*.

Responding quickly and efficiently to arrivals of large groups of people from abroad can be complex, resource-intensive, and socially disruptive when host countries are not fully prepared. In the context of the current sociopolitical and economic conditions in the regions bordering Europe, European countries need to be prepared for potential future events in order to mitigate the impact such events may have on migrants and host communities alike, and to promote equity in health and wellbeing in the spirit of Health 2020.

Purpose of the toolkit

The toolkit for assessing health system capacity to manage large influxes of refugees, asylum-seekers and migrants has been developed to support countries in better preparing and adapting to the public health challenges associated with these phenomena, and consequently contributing to the reduction of morbidity, mortality and health inequity in migrants and in populations experiencing large influxes of people.

The toolkit is designed to assess a country's capacity to cope with large influxes of migrants. It is focused on the period leading up to arrival and the early period after placement in the first accommodation facility. It does not include evolving needs associated with long stays in first accommodation or evolving risks over the course of settlement or repatriation.

The toolkit is meant for use as a living, flexible package which can be adapted to the national context, including the movement of large groups of migrants by sea or overland.

The toolkit is not intended to replace the comprehensive toolkit for assessing health-system capacity for crisis management, published by the Regional Office for Europe in 2012 *(8)*. Rather, it should be used as a rapid, specialized operational reference for health authorities and partners at the national, subnational and local levels, to assess and optimize health system capacity for response to a large influx of migrants.

Aims

This toolkit covers the acute phase of a large influx of migrants, including transit and continuing until the early period after arrival and placement in their first

accommodation facility. The aims of the toolkit are as follows:

- to support health authorities and partners to identify gaps, build on existing capacities and develop informed health interventions for arrivals of large groups of migrants;
- to promote intersectoral coordination and collaboration in the development and implementation of the health sector response.

Toolkit structure

The toolkit is divided into three parts. **Part 1** provides information on the current context of migration to Europe by people travelling in large groups utilizing irregular modes of travel, the factors which influence the health of those undertaking this kind of journey, and the basic functions ("building blocks") of the health system. **Part 2** is a guide for assessors on how to conduct an assessment, from preparation to post-assessment activities. **Part 3** provides interview guides for semistructured interviews with various stakeholders. The interview guides cover the chronological phases of the migrants' journey and the respective governmental and nongovernmental institutions involved. A glossary of terms used in the toolkit, relevant declarations and agreements and a list of resources can be found in Annexes I, II and III, respectively.

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Part 1.

Context, challenges and health risks

Part 1. Context, challenges and health risks

Understanding the causes: the social determinants of migrant health

Social determinants of health are central to all other aspects of health. They affect the choice to migrate and the health status and risks that migrants travelling in large groups and in irregular conditions face prior to their journey, while travelling, upon arrival, and after resettlement or repatriation. Social determinants are reflected in people's living conditions prior to travel, the means of travel, the length of the journey, and in the way in which countries respond to an influx of migrants.

People leave their homes and livelihoods for a variety of reasons – some flee political instability, war or human rights violations *(9)* while others seek stable work, a more secure living situation and opportunities which are not available in their home countries *(10)*. Armed conflict and prolonged political and economic instability in regions close to or within the WHO European Region are triggering large population movements, making individuals and families vulnerable to human trafficking and exposing them to serious health risks. Children, young people and women are particularly vulnerable to trafficking and exploitation, even after arrival and settlement in host countries *(11)*.

The health risks that migrants face are determined by the context preceding the travel and are exacerbated by social exclusion and marginalization *(1)*. Uncertain legal status, language and cultural barriers, lack of access to information about their rights and about available services limit their access to care and the quality of care they receive *(12)*. In transit countries they often face discrimination in the workplace and unsafe working conditions, and live in overcrowded housing in unsafe neighbourhoods *(13)*. Education and access to information are particularly important determinants of refugee and migrant health, as these serve as barriers to access to services, health promotion, integration and, ultimately, wellbeing *(14)*. These factors lead to an increased risk of noncommunicable and communicable diseases, occupational injury and psychological distress, all of which in turn increase migrants' vulnerability even further *(15)*.

The social determinants of health of migrants travelling in large groups and in irregular conditions vary according to context. Preparedness must therefore include knowledge and intelligence about migratory trends, the socioeconomic and political situation in the countries of origin and transit routes, means of travel, length of the journey, the search and rescue at sea (SAR) resources and capacity, registration and asylum procedures and accommodation facilities for newly arrived migrants. While local, national, international and bilateral agencies can provide much of this information, a complete and accurate understanding of the health risks that migrants face requires that they should be included as participants in the assessments, in order to learn about their journey, the transit countries and the health risks they have faced. As the migrants have made the journey themselves, they possess expertise that no other institutions or agencies have, and which is essential for adequate planning and preparedness. Including migrants in the assessment also promotes their right to participate in their health care, and increases their personal agency, which may in turn improve their social and health outcomes *(16)*.

A solid understanding of the context-specific social determinants of refugee and migrant health is essential in order to minimize health risks and promote optimal health outcomes for migrants, response teams and the host communities. It requires an inclusive, intersectoral and multidisciplinary approach to migration, with strong collaboration and effective coordination and systems of evaluation and accountability.

Using human rights, and hence social determinants, as the platform for assessment, preparedness and response to sudden, large influxes of migrants will improve the quality and effectiveness of health interventions and will ensure a morally and ethically sound approach to migration and health.

The emerging challenge of sudden large movements of migrants

Until recently, the European Union as a whole had developed an international image of sustained economic development with strong humanitarian principles. Its geographical proximity to regions going through difficult political and social transitions makes Europe attractive to migrants. At the same time, the falling fertility rates that are now characterizing most European countries may prompt the need for much larger inflows

of people in order to correct current demographic and labour imbalances *(17)*.

The health, social and economic implications of population movements of the type the European Union is experiencing are complex, challenging and long-term in nature. Large-scale movements of migrants occur by sea, by land and even by air, depending on the socioeconomic and political context of the migration. Therefore, European countries need to be prepared for events such as these and to develop health and social services based on epidemiological evidence and historical experience. The health rights of both the newcomers and their host populations should form the basis for planning.

Refugees, asylum-seekers and migrants

The distinction between a refugee, an asylum-seeker and an economic migrant is not always an easy one to establish, particularly in the early phase of an arrival of a large group. (In this report, for convenience, all three groups are referred to as "migrants".) In all large population movements, there is a mix of people who feel forced to flee for reasons of chronic poverty and those who flee political persecution or personal insecurity. Regardless of the legal and administrative challenges in differentiating between refugees, asylum-seekers and economic migrants, all people have health rights afforded by the Universal Declaration of Human Rights *(18)* and the International Covenant on Social, Economic and Cultural Rights *(19)*.

Preparing for the future

Responding quickly and efficiently to sudden and large influxes of people arriving from abroad can be complex, resource-intensive and socially disruptive if host countries are not adequately prepared. It is therefore important that countries are in a position to plan for future events in the knowledge that:

- Europe is likely to continue attracting a mix of migrants;
- the ethical imperatives of receiving migrants will tend to overcome all other considerations, and European countries will continue to accept them, if only for a relatively short time;
- it will often be difficult to distinguish between asylum-seekers, refugees and economic migrants;
- actions taken to prepare for such events will mitigate the impact on host countries if/when large groups arrive;
- planning will make the reception and accommodation of large numbers of people more resource-efficient;
- lack of preparedness has significant implications for the health, welfare, education and security of the host country population as well as those of the new arrivals, and is thus a human rights issue for all parties.

Preparations

Preparations for arrivals of large groups of people should be made using evidence-based methods that are open to evaluation. On the basis of recent experiences in southern and eastern Europe, a number of important tasks are involved.

Identifying the context

The extent to which countries should plan for large influxes of people will depend in large part on the geographical location of the receiving country in relation to potential countries of origin and transit. European countries must consider the socioeconomic and political context and epidemiological situation in the areas of the world from which migrants originate.

Forecasting critical incidents

Monitoring and forecasting sociopolitical and natural crises that are likely to prompt large movements of people to Europe are essential for adequate preparation of interventions to meet the needs of migrants and their potential host communities. Forecasting sociopolitical events is best achieved by international collaboration between multiple sectors, including the health sector, specialized nongovernmental organizations and academic institutions.

Forecasting the health implications of critical incidents

A central consideration of forecasting is the way and extent to which mass and sudden movements of people are likely to affect (i) the health of the people who move; (ii) the health of those with whom they come into contact in transit and receiving countries; and (iii) the health and social systems of the host communities.

Planning for emergency care

Major movements of people are often associated with monitoring of communicable diseases, as indicated by the principles of the International Health Regulations (2005) *(20)*, and with medical emergencies of some kind and access to care. These can occur while on the move, during transit, upon arrival, and while migrants

are in accommodation facilities. Planning for medical emergencies and disease prevention involves assessing past movements, past events, predicting potential future needs and determining the facilities and human resources needed and available to handle them. It includes a needs assessment of local facilities and the development of a referral system for life-saving care. The planning process must also include planning for emergency transportation and the time and distance between arrival, transit, exit points and temporary or permanent accommodation facilities and the relevant health facilities. Particular consideration should be given to planning for pregnancy- and delivery-related complications, hypothermia, cardiovascular events and accidental injuries. In order to maximize resource allocation for public health interventions, it is important to establish a mechanism to monitor where migrants arrive and which routes they take in order to identify priority locations, and thus which health facilities to support. This mechanism also needs to be able to accommodate the fluidity of migration and changes in mobility patterns.

Planning for non-emergency health-care needs

In addition to acute problems such as trauma, migrants with chronic diseases, mental health or health conditions often experience interruptions in treatment which can lead to both emergent and non-emergent health needs on arrival. Forecasting the health-care implications of crises is a complex process that calls for an assessment of (i) national and subnational health policies governing the acceptance and health care of migrants; (ii) the potential number of people involved, their gender and age characteristics and anticipated health profile as well as the routes they take: landing/entry points, movement corridors, transit points, etc.; (iii) the type and scope of health-care resources available in potential host communities; (iv) other resources that exist, including nongovernmental organizations and bilateral agencies; (v) the additional resources that may be needed and where these will come from; (vi) institutions to which patients can be referred when they cannot be managed locally; and (vii) transportation needs for patients, health workers and supplies.

Planning for maternal and infant health needs

The specialized needs of women and girls are sometimes neglected in responses to large influxes of migrants, although they are considered among the highest priority interventions during humanitarian emergencies. Failure to meet the health and hygiene needs of women and adolescent girls leads to unnecessarily traumatic experiences and can result in additional health risks and poor health outcomes. Simple interventions enabling safe menstrual hygiene management, such as the provision of hygiene kits containing sanitary products, can make a major difference. More complex issues arise for pregnant women. Pregnant women are particularly vulnerable and at risk of complications as a result of conditions surrounding their uprooting and the ways in which they are forced to travel *(21)*. Undocumented migrant women, who typically tend to lack access to affordable health services in host communities, endure similar conditions and can be expected to face similar risks. Higher rates of preterm delivery and postpartum depression are also common, and pose significant health risks for infants *(22)*. Vaccination of newly arrived migrants of all ages protects both the individuals receiving the vaccines and the newborns and infants in close proximity to them.

Unaccompanied minors

In recent years, Europe has received significant numbers of unaccompanied children and adolescents. It is estimated by IOM that children accounted for 20% of arrivals by sea and around 30% of all deaths in the Aegean Sea in 2015 *(23, 24)*. These children may have begun the journey with guardians and been separated from them or orphaned, they may be trafficked, or they may simply be travelling alone. Regardless of their reason for travel, unaccompanied minors are at significant risk for deprivation, trafficking and exploitation during their journey, upon arrival and even after resettlement. Systems for the identification and protection of this vulnerable population, including placement in designated facilities with skilled staff, and the provision of age-appropriate care and activities are an essential part of the response to an influx of migrants.

Planning for psychosocial support

Psychosocial care is one of the most neglected areas of response to sudden large movements of people. Individuals in need of care can be difficult to identify and are often perceived as difficult to treat. Forced movement is full of traumatic events of all kinds, including loss of one's home and belongings, separation from loved ones, lack of control over where to go or how to travel, witnessing of violence and death, and experiencing hunger, uncertainty of what will happen even after arrival in the destination country, potential hostility from the host community, and fear of being sent back. The situation is frequently compounded further by a lack of locally available psychosocial health

personnel, cultural mediators or a referral system to deal with acute care needs. Preparedness for potential psychosocial needs and adequate resources to cope with arrivals of migrants are two key components of the health-sector response to a large influx of migrants.

Forecasting and planning sites and shelter needs

Shelter is a critical determinant for survival in the initial stages of a disaster. Beyond survival, shelter is necessary to provide security, personal safety and protection from the climate and to promote resistance to ill-health and disease *(25)*.

The type, quality and availability of shelter can be a major determinant of the physical and psychosocial health of migrants. Preparedness depends on the number of migrants, the place of arrival and transit and the time period over which groups arrive and transit. Preparation should be guided by: (i) forecasts and estimates before arrivals begin; (ii) shelter needs according to climate, migrant demographics and anticipated communicable disease epidemiology; (iii) availability of emergency shelter options; and (iv) monitoring of mobility patterns and routes to identify locations for response. A shelter plan or strategy should not only provide basic shelter and protection, but also ensure that every single aspect of infrastructure and services is included, functional and accessible *(25)*.

Planning for water, sanitation and hygiene

Providing access to adequate sanitation facilities and sufficient amounts of safe water for hydration, food preparation and hygiene are critical for the prevention of communicable disease outbreaks. This is of particular importance in settings where large numbers of people are accommodated in areas with limited space (e.g. in transit centres, registration centres, communal accommodation, etc.) and in settings where medical assistance is provided. Good planning and management under such conditions requires evaluation of (i) the potential number of people likely to arrive and the routes they take; (ii) capacities and conditions at existing water, sanitation and hygiene facilities, as well as waste collection and disposal management systems; (iii) availability of alternative sanitation, hygiene and waste disposal facilities, including an assessment of available space for installing additional facilities; (iv) the type of accommodation (tents, other temporary structures, or permanent structures); (v) the quantity and quality of water that can be provided by existing water sources, the availability and quality of alternative and complementary water sources, and the need for treatment and disinfection to provide safe drinking-water that meets national or international standards; (vi) options for the safe disposal of human waste that avoid human contact and prevent contamination of drinking-water sources; and (vii) availability and supply chains for soap and menstrual hygiene products.

Planning for nutrition and food safety

Migrants can be at heightened risk of food insecurity. The conditions during travel are unstable, and access to adequate and safe food may be compromised. Inadequate food and nutrition support can have consequences for maternal and infant health, child survival, child development and long-term outcomes. Inadequate support for breastfeeding and reliance on formula feeding despite limited access to water, hygiene and sanitation facilities place infants at risk for poor nutrition and infectious diseases *(26)*. Planning for arrivals of large groups of migrants must include the capacity to provide safe and adequate supplies of food, support infant and young child feeding practices and provide nutrition support.

Forecasting indirect health implications

The psychosocial and physical burden on rescue teams, health personnel and civilians involved in the rescue and care of migrants can be difficult to identify and is often forgotten. The success of safe temporary settlement of migrants depends in large part on the continued capacity of these actors, who may experience burnout, psychological trauma and feelings of despair. Inadequate support for response teams may lead to feelings of hostility towards the migrants, who are unaware of the load placed on the staff.

Forecasting direct and indirect economic implications

Arrivals of large groups of people bring both immediate costs such as shelter, food and medical care and hidden and longer-term costs such as disruption of local industry and social structures and increased cost of services. Multisector strategic planning is essential to minimize the potential negative impact on the local economy and on subsequent host community cooperation in migrant care and resource allocation.

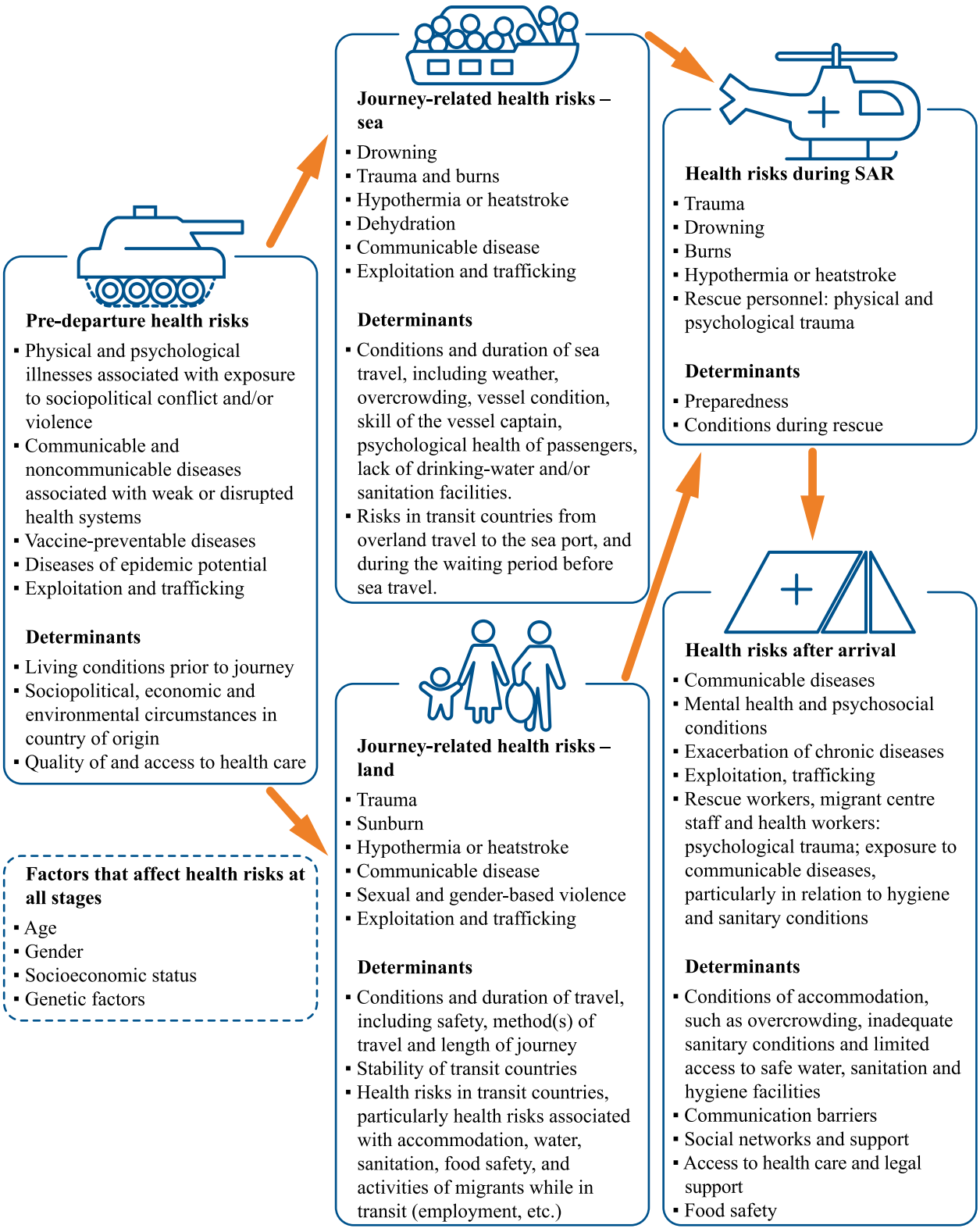
Forecasting social tensions

Communities hosting large groups of migrants may develop fears of communicable disease epidemics, concerns about an increased risk of terrorism and criminality, and anger over a perceived government policy of positive discrimination in favour of migrants.

A carefully planned public communication strategy is therefore crucial to minimize hostile reactions from host communities and to secure their cooperation during the response effort.

Fig. 1 summarizes the health risks related to sudden large influxes of migrants. Migration poses a broad range of health risks which vary according to the stage of migration as well as the age and legal status of the migrant (refugee, trafficked person, or economic migrant). The greatest health risks are experienced by the people undertaking the journey. However, there are also risks for the personnel involved in the rescue, care and placement of migrants and for the population at the host site.

Fig. 1. Health risks related to sudden large influxes of migrants



Conclusions

The WHO European Region as a whole is confronted with a number of migration challenges that call for careful planning and optimizing of health system capacity. Conflicts and economic crises are likely to continue displacing large numbers of men, women and children, forcing them to flee in search of a more secure place and a better life in Europe. It is imperative that countries are prepared for the public health and humanitarian needs that such movements will require. Adequate standards of care for these groups are not only important for population health, but are fundamental to protecting and promoting their human rights as well as those of the host communities. Preparedness and response need not be difficult, but they will require commitment, multisectoral collaboration, effective coordination, robust epidemiological data and migration intelligence, careful planning, training and, above all, adherence to the principles of human rights.

Health system building blocks in the management of large influxes of migrants

WHO says that "a health system consists of all organizations, people and actions whose primary interest is to promote, restore or maintain health" *(27)*. The WHO health system framework is organized into six functions, or "building blocks", which are necessary for a health system to achieve its goals. These health system building blocks were identified by WHO in order to articulate clearly how it will assist in national health system strengthening. The functions are interdependent; the activities and effectiveness of each function are related to those of the others. The framework is meant to be applied to individual countries, and it provides a useful structure for assessment of national health systems. A key aspect of the health system framework is that it takes into account the effects of policies and activities across all sectors on the health of individuals and of the population. This approach facilitates intersectoral collaboration for health, which is a critical part of health promotion and one of the priority areas of Health 2020. The six health system functions are reviewed here in relation to large influxes of migrants.

Leadership and governance

Leadership and governance are critical to the functioning of all other aspects of the health system *(27)*. Strong leadership and good governance are complex; they require political commitment and accountability as well as careful and transparent management of the health system, taking into account the influence of policy over activity across all sectors. Well informed strategic policy frameworks are necessary, together with appropriate regulations, structures for coordination of activities, and strong partnerships with other sectors, institutions and organizations. Strategic communication is essential in order to ensure transparency and accountability before the general public.

A number of treaties, directives and policy measures have been created and adopted to assist countries in establishing good leadership and governance in health (see Annex II). These include European Council Directive 2001/55/EC (2001) on minimum standards for the provision of temporary protection in the event of a large influx of displaced persons *(28)*, the Migrant Workers (Supplementary Provisions) Convention, 1975 (No. 143) of the International Labour Organization *(29)* and the 2000 protocol to the United Nations Convention against Transnational Organized Crime, against the smuggling of migrants *(30)*. The Health 2020 policy framework, adopted by the 53 Member States of the WHO European Region in 2012, outlines some ways in which governments can strengthen community capital, enhance social inclusion and thereby promote community resilience. The International Health Regulations (2005) provide definitions for legal status, health risks, health states and conditions with a potentially high public health impact, and which therefore require careful evaluation *(31)*.

Policy areas of particular importance to refugee and migrant health include international protection (access to territory, access to asylum procedures) and access to health services, education, housing, citizenship, employment, discrimination, social protection and the criminal justice system *(32, 33)*. All policy decisions and subsequent interventions should be based on current information about health systems in the countries of origin, transit and arrival, and there should be a well defined communications strategy for sharing information with the public *(8)*. Health systems with good governance demonstrate relevant policy with adequate human and financial resources to implement it, strong partnerships with clearly allocated accountability and mechanisms for ongoing monitoring and evaluation.

In the event of a large influx of migrants, a clear and well functioning command and control system is extremely important for coordination and collaboration between ministries, sectors and institutions. Strong

collaboration and well coordinated action serve to improve effectiveness and efficiency of the emergency response mechanism, contain and minimize risk, and avoid gaps and duplication of efforts.

During the assessment, focus should be placed on the following:

- review of the hierarchy of legal documents and legislation on health and migration;
- review of national legislation in the context of international treaties and conventions on migration to which the country is a party;
- evaluation of the command and control system, which includes:
  a. identification of the partners involved in responding to large influxes of migrants;
  b. identification of the chain of command and scope of authority of each partner, including delegated authority;
  c. the degree and effectiveness of coordination and communication within the structure;
- review of regulations on health activities implemented by non-institutional entities;
- implementation of the International Health Regulations (2005).

Health workforce

The health workforce (human resources for health) includes all health workers engaged in activities to protect and improve the health of a population. The increasing diversity of populations due to migration has underscored the need for culturally sensitive practice in health services and the awareness of health risks and health needs of people arriving from different parts of the world. As migration is generally managed by public authorities, countries with a well developed private health sector or privatized health system should have regulated systems in place for the coordinated involvement of the private sector and nongovernmental organizations in the response to a large influx of migrants.

The involvement of health personnel who are trained to work collaboratively with public health services is crucial. The health workforce involved in caring for migrants should be skilled in dealing with urgent and emergent situations, and with people from different epidemiological backgrounds, cultures and with different linguistic skills, who have endured traumatic experiences.

A fair distribution of a sufficient number and mix of skilled, culturally competent, responsive and productive staff is therefore essential in the provision of health care for migrants, and is closely linked to the service delivery function of the health system. In addition, during such situations, the existence of mechanisms for the rapid mobilization of additional trained health staff is a key component of successful interventions, and must be carefully assessed.

During the assessment, focus should be placed on the following aspects:

- health workforce number, distribution and competencies;
- availability of interpreters and cultural mediators, which is crucial during all phases of the response, from search and rescue to accommodation, in order to provide effective life-saving interventions and to ensure efficient and appropriate use of the available resources;
- administrative procedures and capacity for the deployment of additional health staff, as necessary;
- continuing education programmes, including training in cultural competence and simulation training of the response to an arrival of a large group of migrants;
- familiarity of health staff with emergency surveillance systems and other emergency management systems that form part of the preparedness and response mechanism for large influxes of migrants;
- availability of occupational health services for response staff.

Medical products, vaccines and technologies

The WHO Regional Office for Europe notes: “A well-functioning health system ensures equitable access [for all] to essential medical products, vaccines and technologies of assured quality, safety, efficacy and cost−effectiveness, and their scientifically sound and cost-effective use” *(27)*. The rational use of medical products, vaccines, and technologies is particularly relevant during the early phase of the response to large influxes of migrants, where sound knowledge and sensitive attitudes and techniques in working with migrants are crucial.

Two areas of particular importance are immunization and emergency health needs. National laws supported by clear and consistent guidelines for immunization are essential to ensure communicable disease prevention and control in populations arriving with

uncertain immunization status. Standardized migrant immunization cards are available in several languages. These are not only important during arrival and first assistance, but also later on when migrants travel to other countries or return to their country of origin. It is therefore imperative that migrants receive a copy of immunization cards and any other records of medical care they have received *(34, 35)*.

Upon arrival of a large group of migrants, the emergency health needs and the supplies needed to address these needs will vary depending on the context. In order to provide optimal care, minimize health risks to migrants and health staff, and avoid catastrophic health outcomes, SAR and early response teams require appropriately stocked emergency medical kits. Self-contained, emergency health kits can be designed on the basis of a risk assessment, and should contain supplies for conditions such as hypothermia, trauma, dehydration and communicable diseases.

During the assessment, focus should be placed on the following aspects:

- standards and procedures for medicine management;
- immediate availability of essential medicines, which should be identified should be identified on the basis of a risk assessment;
- maintenance of cold chain, as necessary;
- medical product regulations and procedures for identifying and responding to cases of failure to meet regulation standards;
- availability of immunization and health promotion material presented in a way that is understandable for people with variable literacy and who speak different languages;
- presence of interpreters and cultural mediators to support public health activities, such as immunization, in order to obtain genuinely informed consent;
- regulations and clearly defined logistical arrangements for prepositioning and/or rapid transport of medical supplies;
- availability of emergency health kits designed on the basis of a risk assessment;
- presence of sufficient laboratory capacity (based on risk analysis) to cope with a possible sudden increase in demand, including sufficient supplies in designated laboratory institutions, clear identification of reference laboratories and referral chains, and procedures in place for collaboration with private laboratories as necessary.

Health information

WHO says that:
"A well-functioning health information system ensures the production, analysis, dissemination and use of reliable and timely information on health determinants, health system performance and health status" *(27)*. Good governance is not possible without a strong health information system.

During the arrival of a large influx of migrants, routine public health surveillance systems may be overwhelmed and struggle to meet health information needs, in terms both of the quality of data collected and of the speed and clarity with which this information is made available to response partners and the public. There should be a unified health information system with standardized data collection and reporting tools used by all partners. Communication is an important component which includes transmission of information about the situation, needs and activities to a variety of groups, including partners, donors, patients and other stakeholders. It also involves the dissemination of information to the local population and the media. Public outreach is a crucial element of an effective emergency response.

During the assessment, focus should be placed on the following aspects:

- the coherence and strength of systems for data collection, storage and analysis, including information-sharing between countries of origin, transit and destination;
- the existence and use of systems for the dissemination of information, including a risk communication strategy for public outreach, which are particularly important to avoid fear, alarmist behaviour and hostility from the host community;
- the ways in which health information guides action for health;
- the provision and maintenance of up-to-date standardized health cards for migrants, which they keep and carry with them, and which provide information on their immunization and health status;
- the means used to ensure confidentiality for migrants, since they may have fled political persecution.

Health financing

Health financing refers to the way in which financial resources are generated for health systems, how they are allocated and, ultimately, how financial resources for health are used *(36)*. In health systems that seek

to promote health equity, health financing policy focuses on ways to ensure universal coverage. In order to achieve universal coverage, health financing policy must: (i) have a system to raise funds sufficient to meet the population's health needs; (ii) remove financial barriers in access to care that exclude poor and marginalized groups; and (iii) provide an equitable and efficient mix of health services for the population.

Well planned and adequately resourced interventions lead to improved health outcomes, reduced hospitalization and lower overall costs. For the response to large influxes of migrants, cost containment is best achieved by sound risk assessment and the use of evidence-based interventions in a timely and appropriate manner. Policies and financing for migrant health, especially primary health care, are not a burden on the health system, but an investment *(1)*.

During the assessment, focus should be placed on the following aspects:

- health finance planning;
- flexible administrative procedures, including the identification of changing finance needs during emergency response, and the mechanisms used to acquire and disburse additional funds if needed;
- creation of an emergency financial reserve in case of a sudden mass influx of migrants;
- monitoring/control of finance disbursed (to avoid corruption);
- health services provided by nongovernmental organizations, international organizations and other providers, and associated (international) financial support for such services.

Service delivery

Service delivery refers to the "process of delivering safe and effective health interventions of high quality, both equitably and with a minimum wastage of resources, to individuals or communities in need of them" *(37)*. Effective service delivery is particularly dependent on good leadership and governance, well functioning health information systems, the availability of required medical products, vaccines and technologies, and adequate health promotion strategies.

Migration has resulted in increasingly diverse societies – in terms of ethnicity, language and culture, and also in terms of the health needs and social determinants of health *(1)*. In the event of a large influx of migrants, several institutional and non-institutional partners may be involved in the response effort. An effective coordination mechanism with a clear chain of command, clearly defined responsibilities and the use of agreed standards and protocols is a crucial element for successful operations. This is important in order to avoid managerial confusion, duplication of work, wastage of resources and delays or failure to provide care for those in need. Health services should be provided in a manner sensitive to cultural diversity.

During the assessment, focus should be placed on culturally sensitive health services for large influxes of migrants. Specific areas of focus include the following:

- operational functions, including coordination of partners and allocation of responsibilities. Particular focus should be placed on the command and control system, awareness of staff about the chain of command, communication protocols, referral networks, etc. Mapping of health service providers including private, public and nongovernmental organizations;
- cultural mediation (including both language and cultural aspects);
- continuing education programmes, including training in cultural competence and sensitivity to the health needs of migrant populations, with a particular focus on migrants arriving suddenly and in large groups;
- the existence and use of protocols for triage, diagnosis and care of specific diseases or syndromic illnesses, vaccination and referral;
- mechanisms to mobilize additional health staff rapidly as needed;
- barriers in access to care for migrants. This should include, as a minimum, the cultural, linguistic, financial and structural barriers to access to care;
- availability and training in the use of personal protective equipment;
- mechanisms to facilitate early enrolment in treatment and ensure continuity of care throughout the journey taken by migrants.

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Part 2.

Guide to carrying out the assessment

Part 2. Guide to carrying out the assessment

Preparation for the assessment

The assessment should be led by the ministry of health in a framework of intersectoral collaboration, involving officials of relevant ministries, other stakeholders and, if required, international experts.

A **desk review** should precede the assessment. The aim of the review is to gather and analyse existing information on the country's demography, the national health system structure, the existing legal framework, the history and trend of refugee and migrant influxes, the health issues in the countries of origin of potential migrants, and the health risks posed by their mode of travel. The desk review is used to tailor the assessment to fit the national context.

Based on the information collected during the desk review, the organizers of the assessment should **identify the profile of experts needed** to carry out the assessment. The members of the assessment team should ideally represent different institutions, organizations and sectors. Because of the complex and intersectoral nature of migration and displacement, this multidisciplinary collaborative approach helps to ensure that all aspects are captured during the assessment.

Depending on the context, the **length of the assessment** may be from three to 10 days, and the number of assessors will range from three to eight people. The process is initiated through an agreement among the national health authorities and partners on the **assessment design**, including the meetings and interviews to be conducted, the participants and the sites which will be visited. **Assessment sites** should be selected on the basis of the risk analysis and the desk review.

The ministry of health appoints one national focal point, the national assessors and the assessment team leader. The basic competencies of the team should include public health, health systems and emergency preparedness and response. Specific competencies may be required in fields such as epidemiology, disease surveillance and immunization, depending on the national context and patterns of migration. Particular attention should be paid to the intersectoral nature of the assessment and involvement of experts from other ministries as required, as refugee and migrant health is heavily influenced by decisions, management models and regulations made by non-health government authorities, such as the ministry of the interior, the ministry of labour and the civil protection authorities.

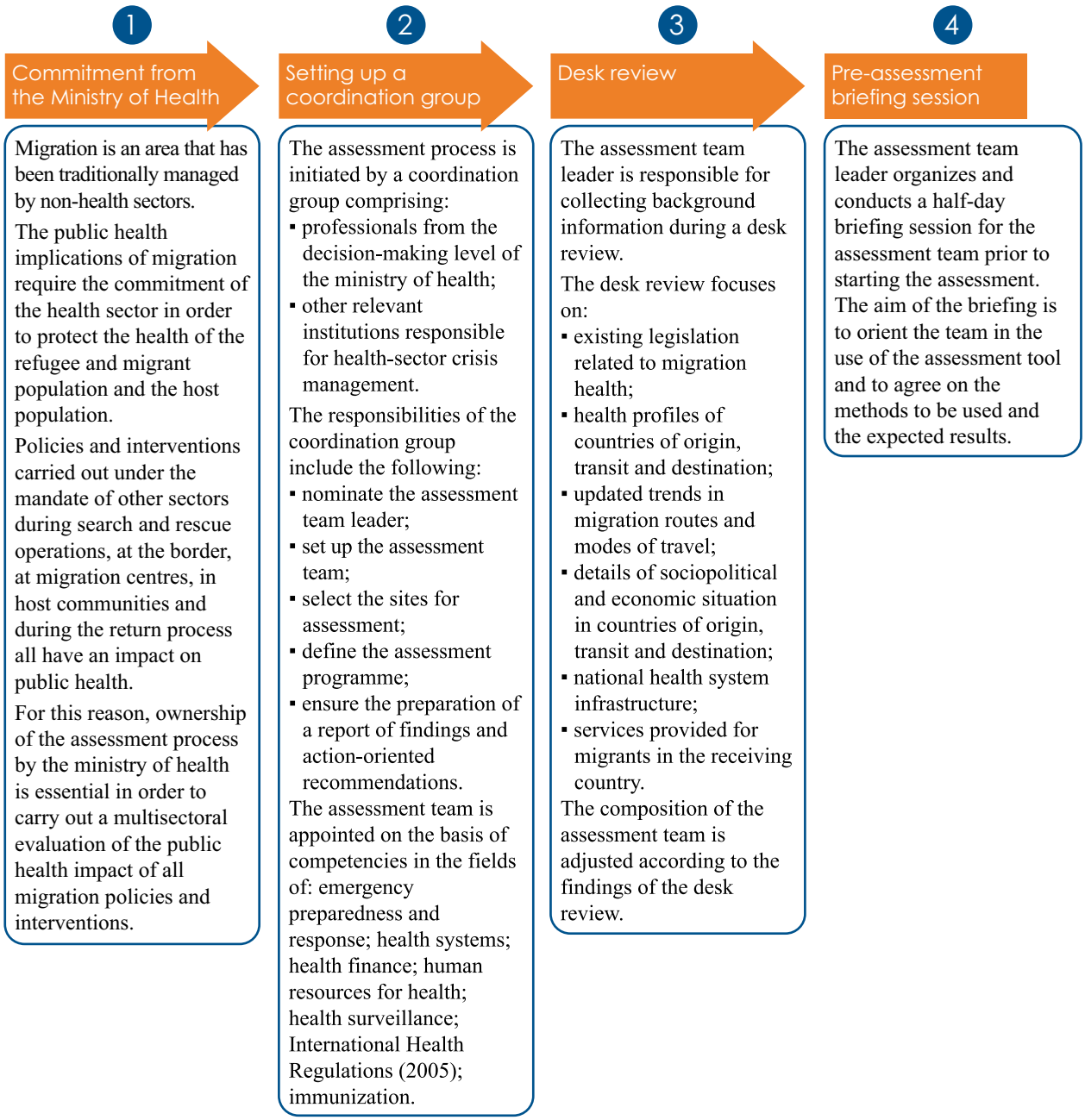
As the leader of the exercise, the ministry of health should begin collaboration with other ministries well in advance of the anticipated start date in order to ensure that: (i) all parties understand and agree upon the aim of the mission; and (ii) the relevant permissions are obtained before the assessment is undertaken. A transparent and timely preparation process will build trust among partners and facilitate the securing of permissions for access to refugee and migrant accommodation centres and access to sensitive places and information. Fig. 2 provides an overview of the steps required to prepare the assessment, and Box 1 shows a relevant case study.

Desk review

The desk review should be performed prior to the stakeholder meetings and site visits. The purpose of the review is to use existing information in order to gain a solid understanding of the existing health system infrastructure, the legal framework under which this operates and the context in which migration may, or does, occur in the country of arrival.

Intersectoral collaboration is necessary for planning and responding to the arrival of large groups of migrants. In addition to the national legislation on health, the existing legislation on migration, emergency planning and human rights is important when planning and allocating responsibility for different elements of the emergency response. To this end, information on legislation, ministry mandates, existing programmes and current migration-related activities should be obtained from the relevant ministries and carefully studied during the desk review, in addition to intelligence on migration trends and information on the existing health infrastructure.

Fig. 2. Preparing for the assessment



Review topics

Available information should be gathered on the following topics:

- national legislation and international treaties relating to health, migration and human rights to which the country is a party or signatory;
- the organization of the national, regional and local health systems;
- the organization of national emergency response mechanisms;
- identification of stakeholders and their role in the response to a large influx of migrants;
- characteristics of the health workforce, including numbers and geographical distribution of health workers of all grades, training in cultural competence and the availability of cultural mediators to assist in the care of migrants;
- demographics of the country;
- historical trends in migration;
- recent and potential migration routes, including countries of origin and likely landing sites in the host country;
- health issues in the country of origin of recent migrants and potential migrants;
- health issues in the transit countries of recent migrants and potential migrants;
- health risks posed by the mode of travel of migrants;
- previous response to large influxes of migrants (if applicable), including strengths in the existing system and noted gaps in preparedness and capacity;
- communications plans of the health sector at national and subnational levels;

- review of media reports on migration and, specifically, on the influx of large groups of migrants.

Further resources

Resources for the desk review are listed in Annex III.

Box 1. Preparing for an assessment: the Spanish experience

In July 2014, an assessment of the capacity of Spain to manage large influxes of migrants was conducted. The preparation for the assessment and the lessons learned are presented here.

Desk review: May–July 2014

Spain has received sudden, large influxes of migrants for more than 20 years. During this period, the country has developed an infrastructure for collaboration between institutions working on reception and assistance for migrants upon arrival. Multiple institutions are involved, including the Ministry of the Interior, the National Health System, the Ministry of Employment, the Ministry of Defence, civil protection authorities, bilateral organizations and nongovernmental organizations. The accumulated experience was documented in a variety of places, including legal documents, the grey literature, academic literature, reports of international institutions, epidemiological surveillance data and media reports.

Identifying stakeholders: July 2014

The desk review was useful for identifying the main stakeholders working with large influxes of migrants and guiding decisions on the sites to be included in the assessment. A provisional list of stakeholders was developed, which included a broad variety of institutions across all levels, from local health units in migration centres to the National Coordinating Centre for Health Alerts and Emergencies. The list of stakeholders involved in the assessment was finalized after consideration of the time constraints of the assessment and the sites which had been included.

Assessment team composition and skills

The assessment team included academics from the universities of Alicante and Valencia and experts in public health field work, all of whom contributed a variety of competencies necessary for the assessment. The skill set of the team included social science research in migration, qualitative research techniques, health science research, epidemiology and public health medicine.

Adapting the toolkit

The assessment team met in Alicante one week before the assessment. The purpose of the meeting was to brief the team on the main findings of the desk review and to adapt the toolkit questions to the Spanish context. During the meeting, interview techniques and other methods of data collection were discussed, and the assessment design was agreed upon. Additional questions were developed to explore the 2006 Cayuco crisis in the Canary Islands, which had been identified during the desk review.

Strengths

The combination of skills and backgrounds of the assessment team members proved useful during data collection, particularly in terms of facilitating the in-depth interviews. Important skills needed for the assessment included communication and engendering trust and mutual respect, the use of open-ended questions, active listening, probing techniques, maintenance of neutrality and the use of positive closing questions.

Areas for improvement

Some interviews were performed by a large group of people, which in some occasions limited the ability of the team to create a climate of trust with the participants. Additionally, some interviews were conducted in English, creating a language barrier and limiting discourse. Finally, it was not possible to organize formal interviews with migrants. The input of migrants would have provided important insight into the experience of migration and the risks involved. In future assessments, these interviews will be anonymized in order to protect the migrants and their families.

Carrying out the assessment

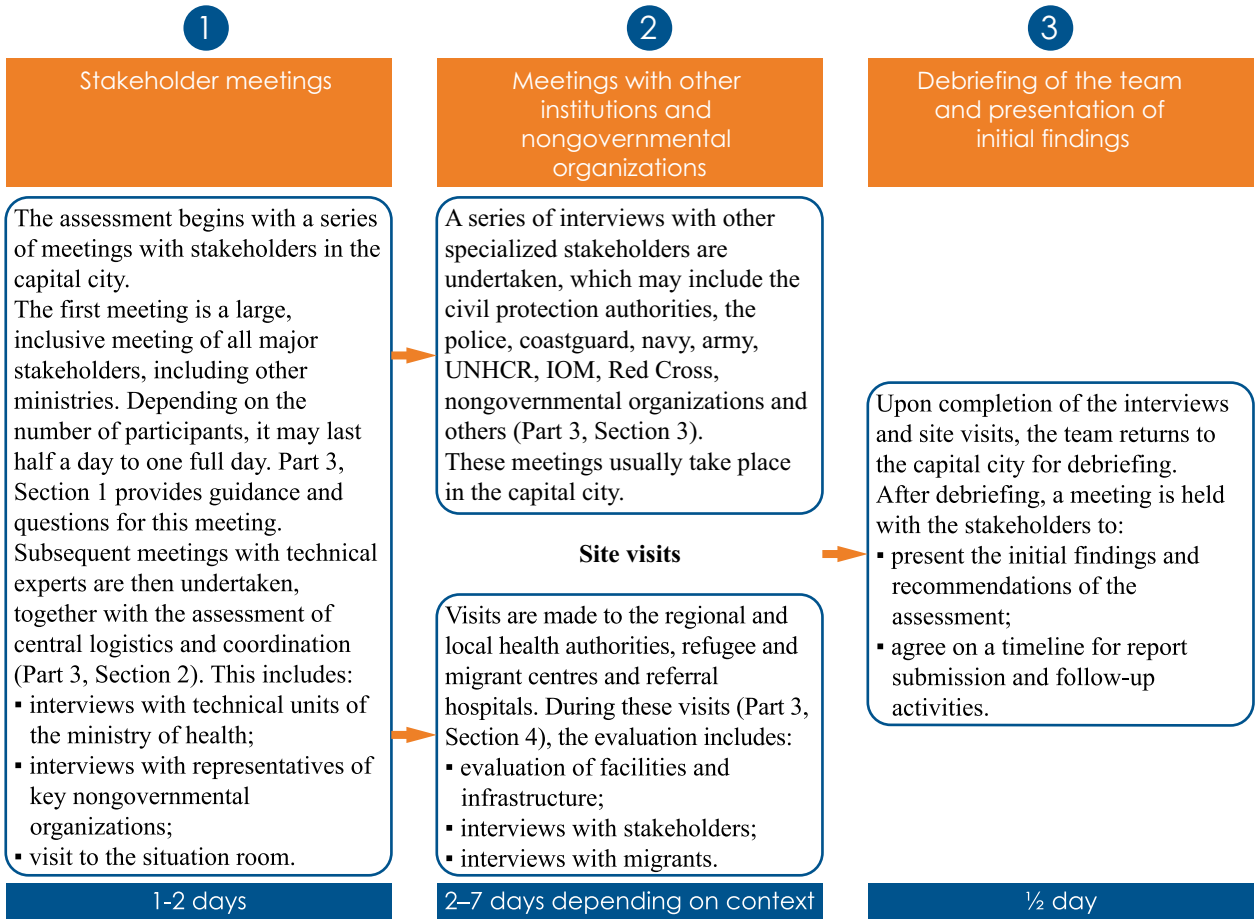
A stakeholder meeting is usually organized in the capital city on day 1, and is followed by a series of site visits over the following days.

The assessment team leader, guided by the questions in the toolkit, should lead semistructured, in-depth interviews with key informants during the site visits. Additional team members attending the meetings and interviews take notes and may pose additional questions. For technical and/or logistical reasons, the assessment team may be divided into smaller teams, each one tasked with assessing different aspects of the health system or visiting different sites of the country.

A debriefing should take place on the last day of the assessment to allow the team to discuss its preliminary findings, observations and recommendations. After the debriefing, the findings and recommendations are presented to the national health authorities. This is done in order to provide immediate initial feedback on the key findings, and to agree on a timeline for report submission and follow-up activities, including presentation of the report and setting up a working group.

Fig. 3 provides an overview of the steps required to carry out the assessment.

Fig. 3. Carrying out the assessment



Setting up and carrying out interviews

The desk review precedes the assessment and is used to guide the design and schedule of all subsequent activities. Qualitative, semistructured, in-depth interviews form the bulk of the assessment. The interviews take place in a variety of settings, including the capital city and site visits to the national situation room, refugee and migrant accommodation facilities, clinics and hospitals, offices of partner organizations, and SAR team facilities where applicable. In addition to understanding the current protocols and capacity, the site visits are also an opportunity to assess the infrastructure, layout and organization of the different parts of the response mechanism, and to observe the activities that are ongoing at the time of the visits. The choice of interview participants and assessment sites is dependent on the findings of the desk review, and should be decided upon in collaboration with partners across sectors.

Qualitative research, particularly on sensitive topics, requires an open-minded approach that is flexible and which allows for exploration of topics introduced by the participants. The interviews should be led by a single individual, with one or two (maximum three) other assessment team members present to take notes. Smaller interview teams and a quiet and confidential setting will help to facilitate open sharing by participants of their experiences, views on strengths and limitations of the response mechanism, and needs and ways to improve the services. The purpose and scope of the assessment should be explained to the participants and site leadership before beginning data collection, and care should be taken to ensure that all participants understand that the assessment is not meant to single out individuals or to apportion blame, but rather to analyse processes and identify successes and areas in need of improvement, so that the necessary improvements can be made and best practices shared with other Member States. The assessment team should remain neutral throughout; care should be taken to avoid judgement of the participants or comments on their responses. Open-mindedness, flexibility, responsiveness and neutrality are important factors for interviews at all levels, from ministry experts to individual migrants.

The confidentiality of all migrants should be preserved. Photographs which can identify individuals should not be taken unless permission is given, or their faces must be blurred if these photos are to be published. Names and any other identifiers of participants should be removed in all reports, communications and publications. Strict maintenance of the confidentiality of migrants is extremely important, because some are fleeing situations of danger and/or persecution. Compromising their confidentiality may place them at risk.

The questions included in the assessment interview guides (see Part 3) are developed solely as a guide; they do not cover specific issues that vary among countries and across contexts. Incorporation of context-specific challenges and successes is crucial to the success of the assessment (see Box 2). The tool should thus be supplemented with questions that explore the specific experiences of the country, the sites that are included in the assessment, and the participants. Some questions may be developed by the assessment team before the interview takes place. However, sufficient time should be given during the interviews for further exploration of the participants' answers, in order to gain a deeper and more accurate understanding of their responses and of the overall situation in regards to influxes of large groups of migrants. In order to ensure that sensitive and accurate information is obtained, the findings from each interview and site visit should be compared with previous findings, and any discrepancies should be explored.

Box 2. Carrying out the assessment: different contexts, different challenges

Potential contextual factors affecting assessments

- Geography:
  - small-island nation
  - nation with coastal border
  - landlocked country
- Mode of travel, routes, entry/crossing and transit points:
  - refugee and migrant influxes by sea
  - refugee and migrant influxes by land
  - refugee and migrant influxes by both sea and land

These factors influence SAR focus (navy, coastguard, Frontex,* border police or army)

- Area of influx:
  - arrivals in a small, geographically defined area
  - arrivals in diverse areas and/or geographically remote locations, which may require long journeys by car across the country and overnight stays to reach arrival sites
- Assessment team
  - size
  - leadership structure
  - composition (national staff, nongovernmental organization partners and international staff)
- Detention
  - Availability of contact with migrants depends on accommodation facilities and the possible existence of detention policies barring access to migrants.

Possible lessons for future assessments

- There is a need for strong national leadership by the ministry of health in the assessment and for collaboration with other ministries, bilateral organizations, nongovernmental organizations and academic institutions.
- International staff should be involved when needed and upon request by the ministry of health, in an advisory role.
- A large assessment team with a variety of expertise and competencies is an advantage in conducting assessments. However, the assessors must establish clear roles and responsibilities for each of the team members prior to undertaking the assessment in order to ensure a smooth process and avoid confusion.
- Asking the same questions of different interview participants is useful to allow for triangulation of the findings from the various meetings and to validate them internally. Triangulation of the findings also serves to verify consistency in the interpretation of laws and directives among the various institutions.
- The assessments are instrumental to enhancing horizontal dialogue and collaboration between ministries in both countries.
- Permission for access to migrants and their inclusion in the assessment should be ensured prior to undertaking the assessment.

* Frontex: European Agency for the Management of Operational Cooperation at the External Borders of the Member States of the European Union.

Writing the report

The purpose of the assessment report is to describe the situation of a country in terms of its capacity to respond to the public health needs and challenges of large influxes of migrants in the acute phase. The audience of the report includes key policymakers, public health professionals and other relevant governmental and nongovernmental stakeholders across sectors. As such, the report should identify best practices and gaps in preparedness and capacity, and it should provide concrete recommendations based on the assessment findings. All sources of information should be carefully referenced using high-quality, first-hand sources. Care should be taken when citing media reports (newspapers, magazines, television and radio) as these sources may present politically motivated views. Recommendations should be made in consideration of international guidelines, legal frameworks and regulations that are relevant to the national context, and should highlight specific achievable objectives.

The report is based on the findings of the desk review, the semistructured interviews and the field visits conducted during the assessment using the toolkit.

Report structure

The final report should not exceed 25 pages in length, and should follow the structure of the WHO health system framework. This structure allows for a comprehensive and in-depth analysis that is also straightforward. The six functions ("building blocks") of the WHO health system framework are as follows:

- leadership and governance LG
- health workforce HW
- medical products, vaccines and technologies MPVT
- health information HI
- health financing HF
- service delivery. SD

To facilitate the process of organizing the information gathered during the assessment under the six WHO functions, each question has been colour-coded and the initials of the relevant functions are listed after each question. The health system functions are reviewed in detail in Part 1 above. See also the section "Mapping of questions with health system functions" below, which shows the function(s) covered by each question, duly colour-coded.

The following is a suggested structure for the report:

1. acknowledgements, which recognize all actors' contributions and help the reader to understand the composition of the assessment team and the number and profile of the stakeholders involved in the assessment;
2. abbreviations, which include all abbreviations used throughout the report in alphabetical order;
3. executive summary, which provides the reader with an overview of what is included in the full report. The executive summary should not be confused with the conclusions;
4. introduction, which gives an overview of the migration situation and related public health challenges in the country, the rationale of the mission, and a brief description of the assessment team;
5. methodology, which explains the way the assessment is carried out, including the composition of the assessment team, the stakeholders interviewed, the sites visited, and the main constraints experienced during the assessment;
6. results of the assessment with regards to each of the six functions of the WHO health system framework;
7. conclusions, which review the purpose of the report and highlight the key findings and action-oriented recommendations.

A first draft of the report should be submitted to the relevant national authorities for comments and suggestions, and the feedback should be incorporated into the final publication.

Examples of assessment reports are available in the "Publications" section of the migration and health website of the WHO Regional Office for Europe *(38)*.

After the assessment

Completing an assessment is the first step towards improving the health system response and capacity to deal with a large influx of migrants. In order for the assessment to be useful, the findings must be disseminated, and measures must be taken to address areas in need of strengthening.

After the report has been completed, a meeting is held with the main stakeholders, including the ministries, bilateral organizations, nongovernmental organizations and civil society organizations, and others

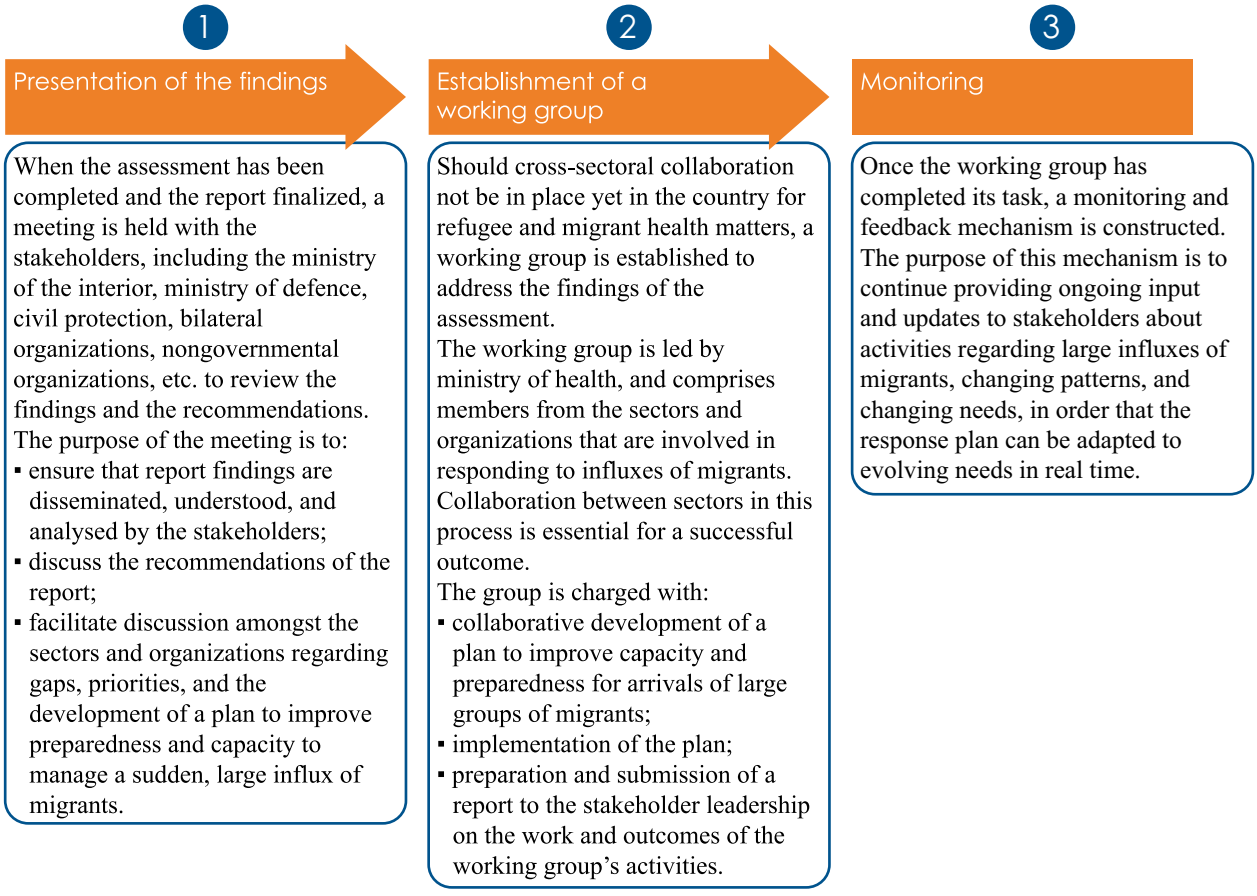
involved in responding to influxes of migrants. At this meeting, the report is presented and the findings and recommendations are discussed, with specific focus placed on achievable objectives. Should intersectoral collaboration not yet be in place in the country, a working group is established to use the assessment findings and renewed collaboration between sectors to develop and implement a plan to improve country preparedness and capacity to respond to the health aspects of a large influx of migrants. The working group reports back to the stakeholders and a monitoring system is set up to ensure that the response plan remains up to date in the event of changing needs or circumstances. A follow-up assessment may be conducted to evaluate the impact of changes made and identify areas in need of further strengthening.

Box 3 below provides an example of the impact an assessment can have, and Fig. 4 provides an overview of the steps required for the assessment.

Box 3. Implementing assessment recommendations: the case of Sicily

Owing to its geographical position, Italy is one of the points of entry into Europe for migrants departing from Africa and the Middle East. Over the last decade, Sicily and the tiny island of Lampedusa have been affected by a series of refugee and migrant influxes culminating in the large sudden influx of 60 000 migrants on Lampedusa in 2011. In the following years, repeated influxes of migrants continued to affect not only Lampedusa but also the entire coastline of Sicily, posing critical management, coordination and logistic challenges. During the period 2011–2013, the WHO Regional Office for Europe worked jointly with the Ministry of Health of Italy to conduct a series of assessments in Lampedusa and throughout Sicily to understand the public health impact of the migrant influxes and, the emergency preparedness and response activities implemented by the regional health system. The toolkit for assessing health system capacity to manage large influxes of refugees, asylum-seekers and migrants was piloted for the first time during the assessment that took place in Sicily in October 2013. One of the key recommendations of the assessment report was for the establishment of a single, comprehensive regional health contingency plan for large influxes of migrants, covering all health aspects of the emergency response from SAR to initial reception in migrant centres. The Health Directorate of the Sicily Region decided to fulfil the recommendation establishing a working group aimed at drafting the contingency plan. The plan was drafted during the month of June 2014 with a consultative process involving regional and district Ministry of the Interior and Ministry of Health authorities, health service managers, the Civil Protection, the Red Cross and nongovernmental organizations. It was endorsed by the Regional Government of Sicily in September 2014 and became operative at the end of that year.

Fig. 4. After the assessment



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Part 3.

Interview guides

Part 3. Interview guides

Section 1. Stakeholder meeting

Introduction

The stakeholders referred to in this toolkit include ministries, government institutions and nongovernmental and civil society organizations which contribute in the response to large influxes of migrants from the pre-arrival period until the period in which migrants are placed in temporary accommodation facilities. **This tool does not assess capacity for migrants in long-term accommodation. Accordingly, only stakeholders involved in acute-phase planning and response are included in the stakeholder meeting.**

The stakeholder meeting is usually organized in the capital city on the first day of the assessment. The meeting can last up to half a day, depending on the context, system complexity, and the number of representatives present from ministries and organizations.

The scope of the meeting is to share information, analyse health risks, and obtain an overview of the health system preparedness and response plan in the event of a large influx of migrants. The meeting begins with a joint, rapid health risk analysis. Consensus is reached on the main health risks that the country must be ready to address, and then a series of questions are explored regarding the health system response plan and capacity.

To facilitate the gathering of information, the refugees' and migrants' journey is divided into four chronological phases: departure, journey, reception, and accommodation (Fig. 5). The questions provided are a guide for assessors to analyse health risks and response for each phase of the journey. Additional issues that are identified during the joint health risk analysis should also be explored during the assessment.

The scope of the meeting is:

- to reach a consensus on the health risks that the country must address in the event of large influxes of migrants;
- to obtain an overview of the intersectoral preparedness and coordinated response plan;
- to promote interministerial and intersectoral dialogue about large-scale migration.

Health risks in all phases of the journey are increasing in parallel with the overall rise in migration of large groups of people. Certain groups, such as children, pregnant women, and the elderly are particularly vulnerable and have specific health risks associated with migration. Details on procedures and services for these specific groups should be collected during separate meetings and during site visits.

Fig. 5. Phases of the migrant's journey, from departure to accommodation

Departure – Journey – Reception – Accommodation

Health risks

It is important to analyse the health risks in the countries where migrants begin their journey, as these may pose a risk to the health status of the migrants, the people involved in eventual rescue operations and the population of the host country. The health risks of individuals at the time of departure are related to the overall health, social, political, economic and environmental contexts in the countries where they begin their journey. Poverty, conflict and protracted political, economic or environmental crises affect the physical and psychological well-being of migrants. Health systems are affected by these same forces to varying degrees, and migrants may have had limited or no access to basic health services prior to their journey. In particular, the health risks encountered by migrants in the departure phase may be related to the following factors:

- level of immunization coverage and the potential risk for vaccine-preventable diseases;
- strength of surveillance and outbreak control systems, and related risk of communicable diseases;
- existence of communicable disease epidemics;
- access to maternal health services and risk of pregnancy-related illnesses and birth complications;
- availability and/or accessibility of essential medicines and subsequent absence of, or interruption in, treatment of chronic diseases;
- potential postponement of elective surgical procedures;
- food insecurity;
- prevalence of malnutrition;
- gender-based violence;
- conflict-related trauma;
- torture.

Questions

1. Are country health profiles and statistics in the countries of origin of migrants known and available to emergency managers and relevant health staff?
   - Are these data regularly consulted?
   - Are these data used for planning preparedness and response to large influxes of migrants?
   - If not, why not?
2. Does your country have an embassy in the country of origin of current or potential migrants?
3. Does the embassy collect information on events that might trigger large movements of people?
4. Are there other sources of data on migration and health risks?

Discuss the concerns of participants regarding intelligence on departure-related health risks.

Departure – **Journey** – Reception – Accommodation

Health risks

Analysis of the health risks that migrants face during their journey is critical in order to guide the health system in planning for preparedness and response to arrivals of large groups. The nature of these risks depends greatly on the living conditions experienced by migrants as they pass through transit countries, potential exposure to public health threats during their journey and their mode of travel. On their way to European countries, migrants travel through countries located at the borders of the European Union with north Africa, Turkey and eastern Europe. The final part of their journey may be either by sea or by land.

The duration of the journey from the country of departure and the length of stay in transit countries may vary from a few days to several months or even years. During this period, migrants may be exposed to the same health risks described in the departure phase, but specific to the countries of transit. Furthermore, migrants may also be exposed to new health risks. In transit countries, they are often accommodated in precarious, overcrowded settlements with poor hygienic conditions and limited or no access to health services. Hazardous travels in overcrowded boats and/or exhausting overland journeys with dangerous border crossings pose various additional health risks, particularly for children, pregnant women and elderly people. SAR operations, especially those conducted at sea, can be complex and dangerous for migrants and rescuers alike. The risk of exploitation and human trafficking is present throughout the entire journey, and is particularly high for unaccompanied minors.

Some of the health risks that migrants may be exposed to during the journey include:

- physical trauma
- psychological trauma
- dehydration
- nutritional disorders
- hypothermia
- communicable diseases
- burns
- heat-related illness
- cardiovascular emergencies
- birth-related illness
- drowning
- gender-based violence
- violence and torture
- untreated chronic diseases.

Questions on health risks in transit countries

5. Are the current trends of migratory routes to (the country of assessment) known? Do these include routes for human trafficking?
6. Are the health profiles and statistics of transit countries known?
   - Are these data regularly consulted?
   - Are these data used for planning preparedness and response to large influxes of migrants?
   - If not, why not?
7. Are relevant disease fact sheets (in appropriate languages) on journey-related health risks made available to individuals and teams involved in responding to arrivals of large numbers of migrants?

Discuss additional concerns of participants regarding intelligence on journey-related health risks and information-sharing on health risks of migrants during transit through other countries.

Questions on search and rescue operations at sea and/or on land

8. Describe how and by whom SAR operations are initiated. LG
9. Are trained health personnel present during SAR operations? HW
10. Are first-aid medicines, shelter, water and food available during SAR operations? MPVT
11. What resuscitation equipment is available during SAR operations? MPVT
12. How is the initial medical triage organized? Where is it performed? Describe its nature and scope. SD
13. Describe the communication procedures between the SAR team and the main command structure for emergency referrals and in preparation for reception. HI
14. How are suspected cases of communicable diseases managed? LG SD
15. What kind of personal protective equipment is available for SAR personnel? MPVT
16. Are records available for SAR operations conducted in recent years? HI
17. Are SAR personnel trained in psychological first aid for survivors? HW
18. Is psychological support available for SAR personnel themselves? SD

Discuss additional concerns of participants regarding SAR operations.

Departure – Journey – **Reception** – Accommodation

Health risks

The reception of a large influx of migrants arriving by land or sea is often a complex operation with major health implications. Before departure and during the journey, migrants are exposed to a series of health risks that can result in illness, and they may require urgent treatment upon arrival in the European Union. In addition, the mode of arrival may pose additional health risks. For instance, disembarkation operations may lead to physical trauma, or adverse conditions at first reception may result in additional psychological distress. Regardless of the means of arrival, any first reception point must be able to address the immediate health needs of migrants and ensure that medical triage, first aid and hospital referrals are conducted in a coordinated fashion. A smooth and effective process is also important for the prevention and control of communicable diseases.

Questions

19. Have geographical areas at risk of a large influx of migrants been identified? LG HI
20. Have the health institutions and services located in the potential reception areas been recently assessed in terms of the type of services available and extra reception capacity? HI SD
21. Has a hospital referral and networking system been planned? LG SD
22. Is there a system in place with clearly defined mechanisms for activation, coordination, command and control of the operations at the first reception point? LG
23. Describe the system for managing medical activities at the scene, including staff and equipment, for the following functions: LG
    - life-saving interventions
    - referral systems/pathways
    - communicable disease control
    - chronic disease care
    - trauma and surgical care
    - maternal health care
    - child health care
    - psychological health and psychosocial support
    - health education
    - hygiene promotion.
24. Has a standardized triage algorithm been defined and disseminated to all relevant stakeholders? LG SD
    - Are the reception staff trained in the use of the standardized algorithm?
25. Are specific arrangements in place for the pre-hospital handling of patients with diseases with epidemic potential? LG SD
26. Do procedures exist for the provision of trained personnel and equipment to provide life support and critical care during patient transport to hospitals outside the affected area (including equipment such as ventilators, incubators, etc.)? LG HW MPVT

Questions

27. How is a migrant's age determined? LG
28. Does a mechanism exist to mobilize additional emergency health staff as needed? HW
29. Are interpreters available to assist in the reception, triage and care process? HW SD
30. Are all the relevant parties informed of the referral process (SAR, reception, medical transport and hospital personnel)? LG
31. Is occupational health for staff addressed (infection control, vaccination of health workers and stress management measures)? LG SD
32. How are arrivals at multiple and variable entry points handled? LG
33. What mechanisms are in place for continuity of care? SD
34. How are personal medical records managed when patients move from reception to temporary accommodation? LG HI
35. Are local mechanisms in place for the storage and disposal of large numbers of corpses? LG
36. Is there a designated communication focal point at the reception site charged with supplying information to the media? HI

Discuss additional concerns of participants regarding reception operations and health risks.

Departure – Journey – Reception – **Accommodation**

Health risks

Crowding and inadequate water and sanitation systems in centres where migrants are accommodated after reception can exacerbate psychological stress and facilitate the transmission of communicable diseases. Communicable diseases for which migrants are at high risk during the accommodation phase include acute respiratory infections, diarrhoeal diseases or other infectious diseases transmitted by the faecal-oral route, tuberculosis, HIV/AIDS, and skin infections such as scabies. Additionally, the living conditions and associated health risks compound other psychological stressors that migrants face, including language barriers, coping with the experiences of the journey, limited ability to communicate with loved ones, and uncertainty about the future. This toolkit is not designed to assess the long-term health risks of accommodation. Accordingly, the assessment covers intersectoral capacity and preparedness for accommodating migrants in the short term and the ability of the system to respond to the immediate physical and psychological health needs of migrants after placement in temporary accommodation.

Questions

37. Are health services planned/adapted within the centres or within urban areas? SD
38. Describe mandatory health screening arrangements (for tuberculosis, HIV, etc.), if any. SD
39. Describe voluntary health screening arrangements (for tuberculosis, HIV, etc.), if any. SD
40. Is treatment available for migrants who have been screened? SD
41. Is there a system for provision of human resources, medical supplies and medical records for the migrant accommodation centres? LG MPVT
42. Is an emergency surveillance system (Early Warning and Response Network (EWARN) or similar) defined and ready for use? LG HI
43. Are migrant health variables, such as country of birth, country of origin, length and type of journey, reason(s) for migrating, included in the emergency surveillance system? HI
44. Has a shelter and settlement response plan been defined, including identification and preparation of sites and types of shelter needed? LG
45. Are mechanisms in place to ensure adequate water supply, sanitation, disposal of food waste, disposal of non-food waste such as basic hygiene items, vector control? SD
46. Are there facilities for isolation of sick migrants pending the results of diagnostic investigations for communicable diseases such as tuberculosis? SD
47. Are there separate facilities for isolation of sick migrants during treatment for communicable diseases such as tuberculosis, scabies, etc.? SD
48. Are legal services provided? LG
49. Are facilities for communication made available so that migrants can communicate with loved ones in their countries of origin? LG
50. Which ministries are involved in the management of longer-term settlement of migrants? LG
51. Are local communities of migrants involved in assisting newly arrived migrants? LG
52. Describe the management of unaccompanied minors. LG
53. Describe the registration process. LG

Discuss additional concerns of participants regarding the first reception of migrants, facilities, health risks, health care and needs.

Section 2. Meetings with relevant ministry of health technical divisions, departments and units

Introduction

The stakeholder meeting is intended to elicit an overview of the existing health system capacity to manage large influxes of migrants. After the stakeholder meeting, details of specific aspects of the preparedness and response mechanism are collected in a series of separate meetings with the relevant technical entities of the ministry of health. These meetings are usually short, lasting approximately 30 minutes, and should be arranged with one or two key informants each time in order to facilitate the exchange of information and to save time. The choice of individuals to be interviewed should be based on their expertise and responsibility within the ministry of health.

Previous assessments have shown that meetings to assess financing of response efforts can be challenging. In order to ensure adequate assessment of this important aspect of the response mechanism, a specific individual should be identified for interview about the financing aspects of preparedness and response.

Ensure adequate time and opportunity during the interviews for the participants to discuss specific areas of concern, strengths and needs in relation to each topic.

Legal framework

54. Describe the administrative structure of the country of arrival. LG
55. Is the administrative structure of the health system aligned and consistent with the administrative structure of the State? LG
    - If not, are there clear mandates for national and regional government and/or private-sector responsibility for different services within the health sector?
56. Does national and regional legislation recognize legally binding international agreements and conventions to which the country is party and/or which have been ratified? LG SD HF
    - Is national and regional legislation consistent with these international agreements and conventions?
    - Does current national and regional legislation grant migrants access to basic health services regardless of their legal status?
        - Describe possible barriers, limitations, restrictions and modalities of access to services, including those applying to nationals of the country.
        - Who covers the cost of migrant health services (i.e. State social system, health insurance, pooled health funds, etc.)?
    - Are any non-binding international agreements and/or treaties relating to migration and health incorporated into national and/or regional legislation? If so, which ones?
57. Does current legislation address the need for contingency plans in case of large influxes of migrants? If yes, please describe. LG
58. How is the health sector represented in contingency plans for sudden influxes of migrants? LG
    - Describe health sector responsibilities.
    - What resources are available to the health sector in this scenario?

Human resources

59. What is the total number and ratio-to-population of physicians, nurses and emergency medical technicians: HW
    - nationally
    - locally at potential reception sites for large groups of migrants?
60. Is there a regularly maintained database or emergency roster of health staff trained in emergency management and cultural competence? LG HW
61. Does a mechanism exist to deploy emergency health staff as needed? LG HW
62. Are competencies identified for medical personnel involved in the care of migrants? HW
63. Are the health workers involved in the care of migrants trained in mediation, cultural diversity, mental health and the prevalent diseases of the countries of origin and transit? LG HW
64. Do national occupational health guidelines exist for staff involved in large refugee and migrant influxes (infection control, vaccination of health workers, stress management)? LG
65. Do procedures exist to integrate national and international volunteers, nongovernmental organizations and other entities into the response mechanism for large refugee and migrant influxes, if necessary? LG HW
    - How is the integration of volunteer and nongovernmental organization staff coordinated?
    - How is accountability maintained?

Immunization

66. Is there a national policy to assess vaccination status and administer vaccines as necessary in the case of a large influx of migrants? LG MPVI

- If yes, what is the protocol for implementing this policy?

67. Is a stock of vaccines maintained to cover sudden, additional requests? MPVT
68. Is a system in place for the rapid procurement and distribution of vaccines? MPVT
69. Is there a system in place to ensure an appropriate cold chain during storage and distribution? MPVT
70. Are multilingual leaflets on immunization available for migrants? MPVT HI
71. How are vaccination status, frequency, and dosing monitored? MPVT HI
    - Is there an electronic or paper medical record?
    - How is this information shared with patients and across the health system as the migrant moves between reception, temporary accommodation and the health services?
    - Are migrants given personal vaccination cards?

Laboratories

72. Describe the protocol for the rapid procurement and distribution of laboratory supplies. LG MPVT
73. Is there a recommended laboratory screening protocol in place for migrants? LG
74. Is there a protocol for mandatory screening of migrants? (e.g. HIV, tuberculosis) LG
    - If so, please describe the method of screening for each health condition.
75. Is there a designated central laboratory to validate the screening investigations? LG MPVT
76. Is there a protocol for collection, handling and transport of specimens for laboratory analysis? LG MPVT

Pharmaceuticals

77. In case of a sudden large influx of migrants, has the stock of essential pharmaceutical supplies, including vaccines, been determined on the basis of a risk analysis? LG MPVT
78. Is a system in place for the rapid procurement and distribution of pharmaceutical supplies? LG MPVT
    - Is this compatible with different service providers (Red Cross, SAR, ministry of health, nongovernmental organizations)?
79. Have therapeutic algorithms been developed and distributed for specific syndromic illnesses or diseases that migrants arriving in large groups may suffer? LG
    - Have these been developed on the basis of a risk analysis?

Hospitals

80. What is the hospital bed density at: SD
    - the national level?
    - the local point of entry of large groups of migrants?
81. Describe the hospital networking mechanism, including any system of referral and transport for complex cases or overload of patients in need of hospital care. LG SD
82. Do hospitals have contingency plans in place for arrivals of large groups of migrants, including the management of mass casualties? LG SD
83. Are cultural mediators and interpreters included in the hospital staff? HW SD
    - Give total number, number of males, number of females.
    - State relation to the nationalities of potential migrants.
84. What is the role of the emergency services in case of major emergency events (police, fire brigade, ambulance service, etc.)? LG SD

Health information, surveillance, communication

85. How are individual health records managed from reception to accommodation? HI
86. Is an emergency surveillance system (EWARN or similar) defined and in use? LG HI
87. Are migrant health variables such as country of birth, country of origin, length and type of journey, reason(s) for migrating included in the emergency surveillance system? HI
88. How is confidentiality ensured for the information collected? HI
89. Are medical personnel working on emergency surveillance briefed on priority diseases, case definitions, data reporting and communication of findings, including alert verification, alert thresholds and outbreak control methods? LG
90. Have health personnel been trained in the emergency surveillance system? LG HW HI
91. Are information channels in place for sharing information with origin, transit, neighbouring and destination countries? LG HI
92. Is there a communications plan in place to share relevant health information with the media and the resident population? HI
93. Are a policy and a protocol in place for communicating to the general public the health risks associated with a large influx of migrants? LG HI
    - Does this include coordination with other actors (ministries, ground-level teams and staff in the reception and accommodation centres)?

Health financing

94. In case of a sudden, large influx of migrants, are funds available for a multisectoral response at both the national and subnational levels? HF
95. Have funds been designated for health sector emergency preparedness and response? HF
96. Do mechanisms exist for rapid mobilization of funds for emergency operations? HF
97. Are financing procedures available for the request, acceptance and use of international financial assistance? LG HF
98. How are monitoring and control of funds arranged? HF

Section 3. Meetings with other institutions

Introduction

Individual meetings with institutions and organizations involved in the overall management, coordination and implementation of the response is important to establish a clear picture of the role and capacity of each organization as well as the mechanism in place to coordinate these different actors and its effectiveness. The institutions concerned include civil protection, SAR institutions, UNHCR, IOM, Red Cross and nongovernmental organizations.

The interview guides in this section are divided into three parts. The civil protection authority and the institution responsible for SAR operations have mandates that require tailored assessment. The civil protection authority refers to the state organization that is responsible for preparation and response to emergencies. Civil protection authorities operate under a specific mandate known as a civil protection plan.

Institutions involved in formal SAR operations include the coastguard, the navy and the army. The International Convention for the Safety of Life at Sea and United Nations refugee conventions regulate the legal obligation to assist in SAR, the right of the ship to disembark rescued people in a safe port, and restrictions regarding the return of refugees to unsafe shores/ports.

Organizations such as UNHCR, IOM and the International Federation of Red Cross and Red Crescent Societies (IFRC) may assist in the response to large influxes of migrants, as may national and international nongovernmental organizations. A single interview guide has been developed for these groups, which is intended for use during separate interviews with each organization.

Meetings with civil protection and SAR authorities, UNHCR, IOM and nongovernmental organizations may last up to one hour, and should be arranged with one or two key informants familiar with the organization's activities and coordination with other institutions involved in preparedness and response to sudden arrivals of large groups of migrants.

Interview guide: civil protection

Responsible authority	
Total permanent staff	
Volunteers	
Medical personnel	
Cultural mediators	
Location of offices	
Emergency vehicles (type, number, location)	

Questions

99. What is the main institution involved in civil protection in the country? LG
100. What is the role of civil protection authorities during large influxes of migrants? LG
101. Who activates the civil protection plan? LG
102. Is there a contingency plan in case of a large influx of migrants? LG
103. Are the civil protection authorities managing migrant centres or camps in the country? LG
104. What services are provided for migrants? SD
105. Are relief items prepositioned for civil protection operations in case of need? MPVT
106. Where does the civil protection plan obtain staff during an emergency? LG HW
107. During the past 12 months, how many simulation exercises were performed? LG
    - Was a large influx of migrants included in the exercise scenario?
108. Is there a civil protection situation room? How is it coordinated with other situation rooms? LG
109. How does civil protection coordinate with: LG
    - SAR operations
    - IOM
    - UNHCR
    - other organizations?
110. Who is in charge of coordination? LG

Allow time for discussion of context-specific issues and concerns raised by participants.

Interview guide: SAR institutions

Responsible authority	
Contributing institutions	
Total permanent staff	
Volunteers	
Medical personnel	
Cultural mediators	
Location of offices	
Boats and other SAR vehicles (type, number, location)	

Questions

111. What is the main institution involved in SAR in the country? LG
112. How many SAR operations have been conducted during the last 12 months? LG
113. How many of them were related to refugee and migrant influxes? LG
114. Is there specialized training for staff working with migrants? LG
115. Describe the flow of information and command from the detection of an influx of migrants to the activation of a SAR operation. LG
116. Are medical personnel present during SAR operations? HW
    - If yes, how many, and what are their competencies?
    - When medical personnel are not present, are there SAR staff trained in first aid?
117. Are relief items prepositioned for SAR operations in case of need? MPVT
118. Is there a contingency plan in case of a large influx of migrants? LG
119. During the past 12 months, how many simulation exercises were performed? Was a large influx of migrants included in the exercise scenario? LG
120. Is there an SAR situation room? How it is coordinated with other situation rooms? LG
121. How does SAR coordinate with: LG
    - civil protection
    - IOM
    - UNHCR
    - other organizations?

122. Who is in charge of coordination? LG

Allow time for discussion of context-specific issues and concerns raised by participants.

Interview guide: UNHCR, IOM, IFRC and other nongovernmental organizations

Total permanent staff	
Volunteers	
Medical personnel	
Cultural mediators	
Location of offices	
Emergency vehicles (type, number, location)	

Questions

123. Is (IOM, UNHCR, Red Cross, or other organization) managing refugee and migrant centres or camps in the country? LG
124. What services are provided for migrants? SD
125. Is there a contingency plan in case of a large influx of migrants? LG
126. Do mechanisms exist for rapid mobilization of funds for emergency operations? HF
127. Do IOM, UNHCR, Red Cross, or other organizations have relief items prepositioned in case of need? MPVT
128. How does (IOM, UNHCR, Red Cross or other organization) coordinate with: LG
    - government authorities and line ministries
    - civil protection
    - SAR operations
    - other organizations?
129. Who is in charge of coordination? Are health data from nongovernmental organizations shared with the ministry of health? LG
130. Do IOM, UNHCR, Red Cross or nongovernmental organizations monitor mobility patterns? HI

Allow time for discussion of context-specific issues and concerns raised by participants.

Section 4. Site assessments

Local health system, referral hospitals and migrant centres

After arrival and reception, migrants are usually moved to their first accommodation. The first accommodation of migrants does not usually take into account the legal status of the person (asylum-seeker, unaccompanied minor, undocumented migrant, etc.). Depending on the specific circumstances, individuals may be taken to a temporary camp, open centre, closed centre, detention centre, the houses of local residents, centre for unaccompanied minors, or another site.

The interview guides included in this section are intended for the local health system in the vicinity of migrants' landing/crossing and transit points (regional, provincial, or district, as appropriate), referral hospitals and migrant centres. Additionally, a topic guide is included for interviews and/or focus group discussions with migrants currently in the accommodation.

This part of the assessment is important, as it provides an opportunity to verify the existence of minimum standards for living conditions and service provision in the existing migrant centres and the opportunity to expand them further in case of need. This section thus focuses on the system capacity to meet the basic human rights of current and potential migrants.

The assessment is conducted by a series of interviews and through direct observation during site visits. The assessment team should take notes and, where possible, photographs to document the findings during site visits. Consent should be obtained before taking photographs of people which could identify them.

Migrants are included in the interviews. From an assessment perspective, interviews with migrants can

serve as an important source of information regarding health risks, current states of health and health beliefs – all of which affect the kind of care provided and the ultimate outcome. Involvement of migrants or their representatives is also an important way to realize their rights, in particular the right to participate in their own health care.

The questions covered during site assessments explore topics that were also assessed at the central level. This is done intentionally in order to validate externally the findings from other parts of the assessment, to assess the effectiveness of activity coordination and to evaluate the coherence in the flow of information across levels of the preparation and response mechanisms.

Interview guide: local health system

Location	
Title of the person(s) interviewed	
Total population of the area (district/province/region)	
Number and type of health institutions	
Total number of staff (physicians, nurses, cultural mediators)	

Questions for local health authorities

131. Describe the subregional health contingency plan, if there is one, to manage large influxes of migrants. LG
132. Describe the registration of migrants. LG
133. Are there any subnational laws, directives or protocols complementing and/or adapting national legislation in case of a sudden large influx of migrants? LG
134. Are there discrepancies between the national and the subnational/regional legislations? LG
135. Does the present subnational legislation grant migrants access to basic health-care services regardless of their legal status? LG
136. Describe the existing mechanism for the rapid mobilization of additional health staff as needed. LG HW
137. Do procedures exist for integrating national and international volunteers, as well as personnel from nongovernmental organizations and other entities, into service delivery in the event of a large influx of migrants? LG
138. Describe the system in place for the rapid procurement and distribution of pharmaceutical supplies, vaccines and medical equipment. LG MPVT
139. What is the immunization protocol for migrants? LG MPVT
140. Is there a health information system for migrants that would allow sharing of information with other parts of the health system both within the country and across borders? HI
141. Describe the health promotion activities targeted at the migrant population. HI SD
142. Are health workers trained in cultural competence and health issues associated with migration? HW
143. Are health workers aware of the entitlements of refugees and various categories of migrants in the country? HW

Allow time for discussion of context-specific issues and concerns raised by participants.

Interview guide: referral hospital

Number of beds	
Total staff	
Physicians	
Nurses	
Cultural mediators	
Wards (type, number of beds)	
Intensive care units	
Emergency vehicles (type, number, location)	

Questions for hospital managers

144. Is an emergency response plan in place, including management of mass casualties? LG
    - Is it regularly maintained?
    - Are the hospital staff trained to carry out the plan?
145. Is there a contingency fund? How is additional expenditure covered? HF
146. Is the hospital triage system consistent with the system used at the reception point? LG
147. Are there national standards or guidelines for performing triage? LG
    - If so, are the hospital staff trained in their use?
148. How are follow-up treatments and rehabilitation services organized? SD
149. Are emergency stocks of pharmaceutical and medical supplies in place? MPVT
    - Is there a mechanism for rapid mobilization of these supplies?
150. What is the hospital networking procedure? LG SD
151. Is there a contingency plan for sharing of resources (for example, allocation of beds)? LG
152. Regarding migrant health records: HI
    - How are migrant health records stored and do health records include a variable or indicator that explains that the individual is "foreign-born" or "migrant" or indicates his/her "nationality"?
    - How is patient health information shared with other parts of the health system, both inside the country and across borders?
    - How is patient confidentiality maintained?
153. Are hospital staff trained in cultural competence? HW
154. Do cultural mediators work in the hospital? HW
155. Are hospital staff (in administration and/or health care) aware of the entitlements, such as insurance coverage, of refugees and various categories of migrant populations? HW

Allow time for discussion of context-specific issues and concerns raised by participants.

Interview guide: migrant centre

Centre (location, name, type)	
Total capacity (Total, men, women, children, families)	
Maximum capacity ever reached (Total, men, women, children, families)	
Demography of residents at present (Total, men, women, children, families)	
Type and size of building (m^2)	
Facilities (Number of rooms, beds, toilets, showers and sinks; ventilation; heating)	
Total staff	
Medical personnel at the centre	
Cultural mediators	

Questions for the migrant centre manager and staff

156. In emergency situations, how many people can be accommodated? SD
157. Is there a protocol in place to increase staff as needed for emergencies? LG SD
158. Describe the current water supply. SD
    - Are mechanisms planned to ensure provision of adequate amounts of safe water in case of increased need?
    - Are measures in place to ensure equitable access to water for all groups?
    - Are there adequate means to maintain and sustain a safe water supply?
159. Describe the current sanitation system. SD
    - How many functioning toilets/latrines are there? What is the ratio of latrines to persons?
    - Are mechanisms planned to ensure adequate sanitation facilities in case of an increased number of residents?
    - Are there facilities for sterilization of diapers or provision of disposable diapers?
    - Are adequate menstrual hygiene management measures in place (e.g. privacy, disposal of menstrual hygiene materials)?
160. Describe the hygiene measures in use. SD
    - Are facilities for handwashing with soap available in sufficient number?
    - Are mechanisms planned to ensure timely distribution of hygiene items to meet immediate needs?
    - Is there a sufficient number of adequate bathing and laundry facilities?
161. Describe the drainage system. SD
    - Are there proper drainage plans and/or facilities in place to prevent standing wastewater and contamination of water sources?
162. How is the food supply organized? SD
    - Are mechanisms planned to ensure nutritional needs are met, including those of infants and young children?
    - How is food safety and quality ensured?
163. Are multilingual health promotion messages on good hygiene practices in use? HI
164. How is medical waste managed? Do procedures and facilities exist for the safe collection, storage, treatment and disposal of increased amounts of medical waste? SD
165. How is non-medical waste managed? Do procedures and facilities exist for the safe collection, storage and disposal of increased amounts of non-medical waste? SD
166. Describe vector control plans and/or interventions and how vector-borne disease risk is defined (e.g. diseases caused by mosquitos, flies, lice)? SD
167. Which health services are provided within the centre and by whom (primary health care, psychological support, immunization, pharmacy, laboratory, minor surgery, referrals, etc.)? How are medical records managed? HW SD
168. Are these services linked with the local health system? How? LG SD

169. Are arrivals of migrants screened for unaccompanied minors? LG SD
170. Are arrivals of migrants screened for persons who have been trafficked? LG SD
171. Are arrivals of migrants screened for persons who have suffered sexual and gender-based violence? LG SD
172. How are communicable diseases reported and managed? HI
173. How many isolation rooms are available for migrants with communicable diseases? SD
    - Describe the size (including number of beds), ventilation and use (i.e. for which diseases). SD
174. How are the safety and maintenance of accommodation building(s) ensured? SD
    - To what regulations/standards are accommodation sites held?
    - How frequently are site safety and maintenance evaluated (personal safety, including adequate privacy to attend bathroom areas, breastfeeding areas, adequate lighting after dark, the ability to call for competent assistance and the ability to separate single women and children from adult males)?
    - Are other policies to avoid sexual and gender based violence in use in the centres?
175. Is a legal advice service available? SD
176. Is clothing provided for migrants? SD
177. What recreational activities are available for residents? SD
    - Are there specific activities for children?
178. Are residents limited in the amount of time they are allowed to spend outside? LG

Allow time for discussion of context-specific issues and concerns raised by participants.

Migrants

The following questions can be used as a topic guide for semistructured interviews and/or focus group discussions with migrants living in migrant accommodation. The inclusion of migrants in the assessment is a useful way to understand their health needs and risks, as they have expertise from their experiences and observations throughout their journey. Furthermore, incorporating the views of migrants allows the assessment team and the actors involved in preparedness and response to put human rights principles into practice, particularly in terms of health participation rights.

Questions

179. What is your nationality? SD
180. How old are you? SD
181. How did you arrive at the centre? Describe your journey from your point of origin until you reached the centre. HI SD
182. When did you arrive at the centre? SD
183. Do you know how long you have to stay in the centre? SD
184. How many people are accommodated in your room/tent? HI SD
185. Are you able to communicate effectively with the staff of the centre? HI SD
186. Do you have a way to communicate with your family and loved ones? If so, how? SD
187. What health care have you received in your home country and during your journey? SD
    - Have you received any immunizations during your life? If you know, which ones?
188. Do you feel safe in the accommodation centre? Can you tell me about this? SD
189. Did you experience any violence during your journey, or in your home country? Can you tell me about this?* HI SD
190. What are your health needs? HI SD
191. What are the major health needs of the people staying in the centre? HI SD
192. Are these needs addressed by the services provided here? SD
193. Are there any barriers to accessing essential health services? SD
194. Are you receiving legal advice? SD
195. What kinds of activities have you been involved in at the centre? SD
196. Describe a typical day at the centre. SD
197. Are there any gaps in the assistance, or are there needs that are not met? SD

* Interviews on gender-based violence should be undertaken by experts who are trained for this purpose, and dedicated support and treatment services should be provided for participants afterwards *(39)*.

Mapping of questions with health system functions

LEADERSHIP AND GOVERNANCE

Questions: 8, 14, 19, 21–27, 30–32, 34, 35, 41, 42, 44, 48–58, 60, 61, 63–66, 72–79, 81, 82, 84, 86, 89–91, 93, 97, 99–103, 106–115, 118–123, 125, 128, 129, 131–139, 144, 146, 147, 150, 151, 157, 168–171, 178

HEALTH INFORMATION

Questions: 1–7, 13, 16, 19, 20, 34, 36, 42, 43, 70, 71, 85–88, 90–93, 130, 140, 141, 152, 163, 172, 181, 184, 185, 189–191

HEALTH WORKFORCE

Questions: 9, 17, 26, 28, 29, 59–63, 65, 83, 90, 106, 116, 136, 142, 143, 153–155, 167

HEALTH FINANCING

Questions: 56, 94–98, 126, 145

MEDICAL PRODUCTS, VACCINES AND TECHNOLOGIES

Questions: 10, 11, 15, 26, 41, 66–72, 75–78, 105, 117, 127, 138, 139, 149

SERVICE DELIVERY

Questions: 12, 14, 18, 20, 21, 24, 25, 29, 31, 33, 37–40, 45–47, 56, 80–84, 104, 124, 141, 148, 150, 156–162, 164–171, 173–177, 179–197

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Annex I. Glossary

5+5 DIALOGUE – The Western Mediterranean Forum, also known as the 5+5 Dialogue, is an informal subregional forum with the aim of fostering relations between European countries and the Arab Maghreb Union. Countries involved in the 5+5 Dialogue include Algeria, France, Italy, Libya, Malta, Mauritania, Morocco, Portugal, Spain and Tunisia *(1)*.

ASYLUM-SEEKER – "An asylum-seeker is an individual who is seeking international protection. In countries with individualized procedures, an asylum-seeker is someone whose claim has not yet been finally decided on by the country in which he or she has submitted it. Not every asylum-seeker will ultimately be recognized as a refugee, but every refugee is initially an asylum-seeker" *(2)*.

CIVIL PROTECTION – The system of measures, usually run by a governmental agency, to protect the civilian population in wartime, to respond to disasters, and to prevent and mitigate the consequences of major emergencies in peacetime. The term "civil defence" is now used increasingly *(3)*.

CIVIL PROTECTION AUTHORITIES – The national, local and international authorities involved in civil protection planning and the coordination and response to emergency and disaster situations.

CONTINGENCY PLANNING – A management tool used to ensure that adequate arrangements are made in anticipation of a crisis. This is achieved primarily through engagement in a planning process leading to a plan of action, together with follow-up actions *(3)*.

EARLY WARNING SYSTEM – The set of capacities needed to generate and disseminate timely and meaningful warning information to enable individuals, communities and organizations threatened by a hazard to prepare for it and to act appropriately and in sufficient time to reduce the possibility of harm or loss *(4)*.

HAZARD – A dangerous phenomenon, substance, human activity or condition that may cause loss of life, injury or other health impacts, property damage, loss of livelihoods and services, social and economic disruption or environmental damage *(4)*.

HEALTH 2020 – Evidence-based, peer-reviewed framework which provides governmental and societal organizations with a vision, strategic path and priorities to improve health and well-being. The health of migrants is explicitly addressed, particularly in the context of vulnerability, marginalization, health inequities, and human rights *(5)*.

HEALTH GOVERNANCE/GOVERNANCE FOR HEALTH – The governance of the health system and the strengthening of health systems *(6)*.

INTERNATIONAL CONVENTION FOR THE SAFETY OF LIFE AT SEA (SOLAS) – Convention that regulates the legal obligations to assist in SAR, the right of the ship to disembark those rescued in a safe port, and restrictions regarding the return of refugees to unsafe shore/ports *(7)*.

LARGE INFLUX OF MIGRANTS – For the purposes of this paper, a large influx of migrants refers to an influx of migrants of significant magnitude such as to challenge and overwhelm the response capacity of the receiving territory and requiring the mobilization of national and, in the case of major events, international resources.

MIGRANT – At the international level, no universally accepted definition of a "migrant" exists. For the purposes of this toolkit, the definition of "migrant" includes economic migrants, internal and international migrants, refugees and asylum-seekers, family members of previously settled migrants, victims of human trafficking, internally displaced persons, returnees and undocumented migrants. Migrants may remain in the home country or host country ("settlers"), move on to another country ("transit migrants"), or move back and forth between countries ("circular migrants", such as seasonal workers) *(8)*.

MIGRATION – The movement of "a person or a group of persons from one geographical unit to another for temporary or permanent settlement" *(9)*. "A process of moving, either across an international border, or within a State. It is a population movement, encompassing any kind of movement of people, whatever its length, composition and causes" *(10)*.

Note: "Temporary travel abroad for purposes of recreation, holiday, business, medical treatment or religious pilgrimage" does not entail an act of migration because there is no change in the "country of usual residence" *(11, 12)*.

PHAME – WHO Public Health Aspects of Migration in Europe project. The PHAME project is a project of the WHO Regional Office for Europe which seeks to help Member States to strengthen health sector preparedness and the public health capacity to better address emergency-related migration *(13)*.

PREPAREDNESS – The knowledge and capacities developed by governments, professional response and recovery organizations, communities and individuals to effectively anticipate, respond to and recover from the impacts of likely, imminent or current hazard events or conditions *(4)*.

PREVENTION – The outright avoidance of adverse impacts of hazards and related disasters *(4)*.

REFUGEE – A person, who "owing to well-founded fear of persecution for reasons of race, religion, nationality, membership of a particular social group or political opinions, is outside the country of his nationality and is unable or, owing to such fear, is unwilling to avail himself of the protection of that country" *(10)*.

RESPONSE – The provision of emergency services and public assistance during or immediately after a disaster in order to save lives, reduce negative health impact, ensure public safety and meet the basic subsistence needs of the people affected *(4)*.

RISK – The combination of the probability of an event and its negative consequences *(4)*.

RISK ASSESSMENT – A methodology to determine the nature and extent of risk by analysing potential hazards and evaluating existing conditions of vulnerability that together could potentially harm exposed people, property, services, livelihoods and the environment on which they depend *(4)*.

RISK COMMUNICATION – The range of communication principles, activities and exchange of information required through the preparedness, response and recovery phases of a serious public health event between responsible authorities, partner organizations and communities at risk to encourage informed decision-making, positive behaviour change and the maintenance of trust *(14)*.

SITUATION ROOM – A situation room is a single point of coordination for response to public health crises, such as disease outbreaks, natural disasters and chemical emergencies. The situation room is equipped with information and communications technologies to support field operations and facilitate collaboration between response actors both nationally and internationally *(15)*.

UNACCOMPANIED MINOR – A minor who arrives on the territory of the Member States unaccompanied by an adult responsible for him or her, whether by law or by the practice of the Member State concerned, and for as long as he or she is not effectively taken into the care of such an adult; it includes a minor who is left unaccompanied after he or she has entered the territory of Member States *(16)*.

UNDOCUMENTED MIGRANT – A migrant whose current residence status is characterized by non-conformity with the immigration laws of the receiving country, regardless of their mode of entry. Undocumented migrants constitute a particularly vulnerable group due to their limited access to health-care and/or other public services available to legally recognized international migrants.

Note: the terms "undocumented" and "irregular" migrant are synonymous.

VULNERABILITY – The characteristics and circumstances of a community, system or asset that make it susceptible to the damaging effects of a hazard *(4)*.

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16. Regulation (EU) No 604/2013 of the European Parliament and of the Council of 26 June 2013 establishing the criteria and mechanisms for determining the Member State responsible for examining an application for international protection lodged in one of the Member States by a third-country national or a stateless person. Brussels: European Parliament/European Council; 2013 (http://eur-lex.europa.eu/legal-content/en/TXT/?uri=celex:32013R0604, accessed 3 July 2016).

Annex II. Declarations, agreements and key papers relating to migrant health

Declarations, agreements, and key papers	Notes
Health 2020 European health policy framework (2012)	Evidence-based, peer-reviewed framework which provides governmental and societal organizations with a vision, strategic path and priorities to improve health and well-being. The health of migrants is explicitly addressed, particularly in the context of vulnerability, marginalization, health inequities, and human rights.
Recommendation CM/REC(2011)13 of the Committee of Ministers to Member States on mobility, migration and access to health care. Strasbourg, Council of Europe (2011)	Provides recommendations for Member States on intersectoral collaboration for preparedness and response to the health needs of migrants, including irregular migrants.
Health of migrants: report by WHO Secretariat to the Sixty-first World Health Assembly (April 2008)	Report to the World Health Assembly leading to the adoption of resolution WHA61.17 on the health of migrants.
Resolution WHA61.17 on the health of migrants (May 2008)	Calls for migrant-sensitive health policies, equitable access to services, information systems to assess migrant health, best practices, capacity-building of health service providers and professionals and intersectoral action to promote the health of migrants.
Progress report on resolution WHA61.17 on the health of migrants to the Sixty-third World Health Assembly (May 2010)	Report on migration trends and WHO activities in accordance with resolution WHA61.17.
Health of migrants: the way forward. Report of a global consultation. Madrid, Spain (March 2010)	Examines actions by Member States and other stakeholders, articulates a consensus on priority areas and strategies to address migrant health needs and presents an operational framework to address these needs.
How health systems can address health inequities linked to migration and ethnicity. Copenhagen: WHO Regional Office for Europe; 2010	Briefing on policy issues for the WHO/European Commission joint project on equity in health (2006WHO03).
Poverty and social exclusion in the WHO European Region: health systems respond. Copenhagen: WHO Regional Office for Europe; 2010	Provides an overview and analysis of migration and health in the WHO European Region, with particular attention given to the nature of marginalization, the health risks of migrants and relevant international and regional policies and legal instruments.
Overcoming migrants' barriers to health. Bulletin of the World Health Organization. 86;8:577-656	Report on health issues relating to migration, migrant health needs and barriers in access to health care.
Bratislava Declaration on health, human rights and migration. Strasbourg: Council of Europe; 2007	Declaration by a conference of European Ministers of Health recognizing the health needs and rights of migrants and calling for interstate and intersectoral collaboration to protect and promote migrant health.
International Health Regulations (2005)	Came into force as international law in 2007, following approval by the World Health Assembly. The Regulations specifically target the need to respond to "public health emergencies of international concern", calling for the strengthening of health systems by improving national core capacity and mobilizing collective global action to deal with public health crises of international concern.

Declarations, agreements, and key papers	Notes
European Commission communication on strengthening coordination on generic preparedness planning for public health emergencies at European Union level and European Union technical guidance on generic preparedness planning (2005, updated 2011)	Provides guidance on preparedness and intersectoral collaboration. The recommendations are being implemented at the political and technical levels in WHO European Member States with the support of the European Centre for Disease Prevention and Control (ECDC), which provides scientific advice, technical assistance and training.
International migration, health and human rights	Examines migration and health from a human rights perspective. The document addresses health and rights during the period before departure, during arrival in the host country, detention, and while resident in the host country.
International Convention on the Protection of the Rights of All Migrant Workers and Members of their Families (1990)	Focus on migrant workers and their families, providing a framework for the universal human right to health without discrimination.
5+5 Dialogue on Migration in the Western Mediterranean (1990)	Relaunched in Portugal in 2001. Migration, in particular irregular migration, is a prominent focus of activity.

Annex III. Resources

Desk review

Annex II provides an overview of relevant WHO and international documents and treaties relating to migrant health and the responsibilities of health systems. This is not an exhaustive list. Further resources can be found in the WHO, European Union and United Nations web archives:

- WHO country health profiles [website]. Geneva: World Health Organization; 2016 (http://www.who.int/countries/en/, accessed 26 October 2016);
- FRONTEX trends and migratory routes [website]. Warsaw: European Border and Coast Guard Agency; 2016 (http://frontex.europa.eu/trends-and-routes/migratory-routes-map/, accessed 26 October 2016);
- WHO disease fact sheets [website]. Geneva: World Health Organization; 2016 (http://www.who.int/mediacentre/factsheets/en/, accessed 26 October 2016).

Health statistics and health information systems:

- Country measurement and evaluation [website]. Geneva: World Health Organization; 2016 (http://www.who.int/healthinfo/systems/en/, accessed 26 October 2016);
- United States Centers for Disease Control and Prevention country profiles [website]. Atlanta, GE: Centers for Disease Control and Prevention (http://www.cdc.gov/, accessed 26 October 2016);
- Health. In: Migrant integration policy index 2015 (MIPEX) [website]. Barcelona: Barcelona Centre for International Affairs; 2015 (www.mipex.eu/health, accessed 26 October 2016).

Embassies of the relevant country are important resources for updated information on migration trends, sociopolitical and economic conditions and health risks.

Conducting interviews

1. Berry RSY. Collecting data by in-depth interviewing [paper presented at the British Educational Research Association Annual Conference, University of Sussex at Brighton, United Kingdom, 2–5 September 1999] (http://www.leeds.ac.uk/educol/documents/000001172.htm, accessed 26 October 2016).
2. Boyce C, Neale P. Conducting in-depth interviews (Pathfinder International Tool Series). Watertown, MA: Pathfinder International; 2006 (http://www2.pathfinder.org/site/DocServer/m_e_tool_series_indepth_interviews.pdf, accessed 26 October 2016).
3. Vilela M. Conducting interviews (Community Toolbox series). Lawrence, KS: Work Group for Community Health and Development, University of Kansas; 2016 (http://ctb.ku.edu/en/table-of-contents/assessment/assessing-community-needs-and-resources/conduct-interviews/main, accessed 26 October 2016).

Sample reports

Reports from previous assessments provide examples of the information obtained during the desk review and how this information is integrated into the assessment itself and ultimately presented in the final report. For access to previous reports, see http://www.euro.who.int/en/health-topics/health-determinants/migration-and-health/publications.

Documents and guidelines on special topics

1. Community emergency preparedness: a manual for managers and policymakers. Geneva: World Health Organization; 1999 (http://apps.who.int/iris/bitstream/10665/42083/1/9241545194.pdf, accessed 26 October 2016).
2. Guidelines for medico-legal care for victims of sexual violence. Geneva: World Health Organization; 2003 (http://www.who.int/violence_injury_prevention/publications/violence/med_leg_guidelines/en/ accessed 26 October 2016).
3. Responding to intimate partner violence and sexual violence against women: WHO clinical and policy guidelines. Geneva: World Health Organization; 2013 (http://www.who.int/reproductivehealth/publications/violence/9789241548595/en/, accessed 26 October 2016).
4. Understanding and addressing violence against women (WHO series, including information on human trafficking and sexual violence). Geneva: World Health Organization (http://www.who.int/reproductivehealth/topics/violence/vaw_series/en/, accessed 26 October 2016).

The WHO Regional Office for Europe

The World Health Organization (WHO) is a specialized agency of the United Nations created in 1948 with the primary responsibility for international health matters and public health. The WHO Regional Office for Europe is one of six regional offices throughout the world, each with its own programme geared to the particular health conditions of the countries it serves.

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This toolkit is a good example of the application of Health 2020 policies to an existing and devastating scenario. The toolkit provides a basis for the preparation of migrant-sensitive health systems and makes a strong case for investment and action through whole-of-government and whole-of-society approaches. It gives national ministries of health the opportunity to lead a multisectoral collaboration to optimize their health system preparedness and capacity. The area of migration and health is a highly complex and multifaceted one, in which many different stakeholders interact. In due course, it will also be essential to adopt an intersectoral approach of jointly identifying and addressing health system gaps in collaboration with other actors, including ministries of the interior, education, social affairs and employment, and with civil society, in order to address the social determinants of health of refugees, asylum-seekers and migrants.

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