CARE
Common Approach for REfugees
and other migrants' health

WP 8 National/Regional planning and the role of civil society organisations

Recommendations for strategic Public Health planning regarding migrant and refugee populations and the role of civil society organisations

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EXECUTIVE SUMMARY

The CARE project, coordinated by the Italian Institute for Health, Migration and Poverty (INMP), was launched in April 2016, with the participation of a consortium, consisting of fifteen partners from five EU Member States (Italy, Greece, Croatia, Malta, and Slovenia). The CARE project's general objective is to promote and sustain the good health of migrants and refugees populations in Member States experiencing strong migration pressure. The project worked towards achieving this objective through eight different Work Packages (WP).

The basic objective of WP 8, led by the National School of Public Health (ESDY – NSPH) in Athens, Greece, has been to support the development of integrated Public Health plans, relevant to migrant and refugee populations, based on a) synergies and complementarities between the public sector and civil society organisations, b) good practices and evidence-based interventions. As part of the activities undertaken for the purposes of WP 8, one report on the State of the Art concerning public health aspects of "people on the move" in Greece, Italy, and Slovenia was produced in September 2016, and a Good Practices report about civil society organisations and their role on preventive health assessment and preventive measures, produced in December 2016.

The present report is the final Deliverable of the WP 8 and presents recommendations for strategic public health planning regarding migrants and refugees at a national level for Greece, Italy, and Slovenia, while general concluding comments are made as well for other European countries who are faced with migration-related crises. Particular emphasis is given to the role of civil society organisations.

The report begins with an overview of the current volatile situation in Europe regarding migration and health is provided. A brief section follows where an important point is made about the differences between the three participating countries: Greece, Italy, and Slovenia represent very different realities and experiences when it comes to migration flows, thus in healthcare planning and provision.

Then in the next section the report draws on some of the material presented already in the aforementioned State of the Art report, circulated among the CARE partners in September 2016 (M8.1 "State of the art report concerning the public health aspects of the 'people on the move' in Greece, Italy and Slovenia"). In particular, it briefly reviews the literature on health assistance to these populations through civil society organisations in Greece, Italy, and Slovenia.

A brief critical appraisal follows regarding the integrated public health plans and actions put in place by Greece, Italy, and Slovenia, with a particular emphasis on the role that civil society organisations have played in each of these countries in providing health assistance to migrants and refugees. In this critical appraisal-section both the challenges experienced, and the ways in which these countries often successfully adapted their approaches and activities are noted.

In the next section, material is drawn from the Good Practices report, circulated among the CARE partners in December 2016 (M8.2 "Good practices report about civil society organisations and their role on health assessment and preventive measures"). The report on Good Practices captured a range of suggested good practices of civil society organisations in Greece and Italy who - in collaboration with public authorities and other bodies - worked on health assessment and preventive measures for migrants and refugees. The report briefly comments on those practices which emerged as fulfilling the 'goodness' criteria as well as the remaining challenges.

In its final section, recommendations are presented at a national level for Greece, Italy, and Slovenia separately for strategic Public Health planning regarding migrant and refugee populations with an emphasis on the role of civil society organisations. The recommendations for Greece, Italy and Slovenia concern a variety of issues respectively and this was expected since each country has had different experiences regarding migration and healthcare. Nevertheless, the recommendation about specialised mental healthcare for vulnerable migrants and refugees apply to both Greece and Italy, while the recommendation about provision of cultural mediators in sites and central healthcare units apply to both Greece and Slovenia. In the Conclusions section, general recommendations are made which could apply to other European countries that are also faced with migration-related crises.

AIMS

The aim of this report is to present a set of recommendations for strategic public health planning for migrants and refugees, at the national level for Greece, Italy, and Slovenia. Particular emphasis is placed on the role that civil society organisations-in collaboration with the governmental and public health sector- play at public health planning and delivery of services.

According to the definition by the World Health Organisation (WHO, 1952: 5) for the term 'public health' as modified by the Acheson Report (1988: 1): 'Public health is the science and art of preventing disease, prolonging life and promoting health through organized efforts of

society'. This means that strategic public health planning is referring not only to healthcare services but also to securing a good quality of life. This point is particularly pertinent to migrants and refugees that have recently arrived and are currently resettling in Europe, as they are often faced with challenges related not only to accessing and receiving healthcare but also to the quality of their actual living conditions.

The ultimate aim is to provide clear recommendations that will help improve healthcare planning and provision for migrants and refugees currently resettling in the EU and more specifically in Greece, Italy, and Slovenia, but also secure good living conditions for these populations. The recommendations for each country emerge by taking into consideration previous literature on healthcare policies (e.g. MacFarlane et al., 2014) and the differences between countries regarding the experience of migration and healthcare and by synthesising the findings presented in the two previous CARE WP8 reports (M8.1 'State of the art report' and M8.2 'Good practices report').

MIGRATION AND HEALTH IN EUROPE: A VOLATILE SITUATION

Migration and health in Europe has been acknowledged for quite a few years now as an issue of utmost importance: this observation is derived firstly from the numerous publications covering the topic (Lindert et al., 2008; Rechel et al., 2013; Watters, 2010) but also from various projects, set-up specifically for addressing and managing the health needs of migrant and refugee populations (e.g. MIGHEALTHNET (Information network on good practice in health care for migrants and minorities) whose goal has been to further the development of good practices concerned with the health of migrants and minorities in 19 European countries (Kotsioni & Hatziprokopiou, 2009); PHAME (Public Health Aspects of Migration in Europe) set up by WHO Europe which- in collaboration with the Italian Ministry of Health- has been providing since 2012 support to Ministries of Health through health-system assessments, provision of technical assistance and policy advice (Jakab et al., 2015).

In 2015 there was an evident increase in global forced displacement with record-high numbers of people being driven from their homes. By the end of the year, 65.3 million individuals were forcibly displaced worldwide because of persecution, conflict, generalized violence, or human rights violations. It is worth noting that this was a 5.8 million more when compared to 12 months earlier, that is the end of 2014 (UNHCR, 2015).

As far as Europe is concerned, in 2015 1 million migrants, refugees and asylum seekers made the dangerous journey across the Mediterranean into Europe. The majority – or 850,000 – crossed from Turkey to Greece through the Aegean and Dodecanese seas. This

movement constitutes one of the largest movements of forcibly displaced people through European borders since World War II (UNHCR, 2016a).

With regards to migrants' demographic profile in 2015: The main 5 nationalities of these Mediterranean Sea arrivals in Greece were Syrians (56%), Afghanis, Iraqis, Pakistanis, and Somalis. In Italy, the main 5 nationalities arriving were Eritreans (25%), Nigerians, Somalis, Sudanese and Gambians. It is worth noting the heterogeneity of arriving migrants and refugees who, much more than in previous migration crises, are very diverse in terms of profile and move motivation, with more women and educated individuals deciding to cross the Mediterranean (Kassar & Dourgnon, 2014). An increase in vulnerable populations is also important to note, as there are more unaccompanied minors arriving now than previously (OECD, 2015; UNHCR, 2016b).

The sheer numbers of migrants and refugees arriving in and moving through Europe, the rise in vulnerable populations, the increasing diversity of incoming populations, and the recently increased anti-immigration sentiment across Europe, with the resurgence of far-right political parties (Mladovsky et al., 2012) have rendered even more urgent the need for European countries not only to respond quickly and efficiently to these populations' increasing health needs, but also to provide continued and coordinated assistance. Recent literature highlights indeed an increased involvement of European countries and intensification of efforts in areas such as: organization of additional health-system assessment missions (WHO, 2012), delivery of medical supplies (ECHO, 2016), emergency immunization programmes (Hives-Wood, 2013) provision of training on migrant and refugee health issues for health professionals (Arnold et al., 2015), continuous training of expatriate health professionals who may return to offer their services to their torn home countries and people (Taleb et al., 2015) and development of information products to dissipate misconceptions about public health and migration, for example the fears that refugees arriving in Europe may bring infectious diseases (Gulland, 2015). A lot has been achieved, especially in schemes where civil society organisations and governmental and/or public authorities have collaborated efficiently for the well-being of migrants and refugees but still a lot needs to be done.

There is a clear message to respond to the migration-and-health crisis with 'humanity and solidarity' (Jakab et al, 2015) therefore constant involvement and coordinated intervention- despite the resource constraints and the lack of homogeneity in approaches- for the well-being of incoming populations and host societies is expected from European countries and the agents they work with.

DIFFERENCES BETWEEN PARTICIPATING COUNTRIES

The massive inflows of migrants, refugees, and asylum seekers in 2015-16 have undoubtedly affected all European countries. Before discussing the integrated public health plans and actions put in place in Greece, Italy, and Slovenia for migrants and refugees in 2015-16 and the emerging good practices regarding healthcare planning and provision, we should keep in mind that Greece, Italy, and Slovenia represent very different realities and experiences when it comes to migration and healthcare:

- They have different entry points: Italy has 2 main ways, by sea and by land. When migrants and refugees arrive by the sea-route, there are 16 main ports they may arrive at after the search and rescue operations have taken place. Greece has numerous entry points from the islands and 1 from the mainland, while Slovenia has its various borders with neighbouring countries which closed down in spring 2016.

- Healthcare services to migrants and refugees in Italy are not provided homogenously in all regions and this is because health services in Italy are decentralised. The Ministry of Health gives the guidelines and principles, but each region has the ability and capacity to manage and provide healthcare services, while adhering to national laws and principles. In Greece healthcare services are in principle provided by health professionals from the National Health Service, but often the role of Non-Governmental Associations (NGOs) is crucial in reaching this population. In Slovenia, state-appointed health professionals along with NGOs have been undertaking this task

- The right to health is a basic social right. The Charter of Fundamental Rights of the EU enshrines the right to healthcare in Article 35, stating that *'everyone has the right of access to preventive healthcare and the right to benefit from medical treatment under the conditions established by national laws and practices'*. The Charter's application is limited to those matters that fall within the scope of EU law. It does not distinguish on the grounds of nationality, but it does make the exercise of the right to healthcare subject to national laws and practices. This means that there are inevitably differences in healthcare practices performed in each country, e.g. in Greece and Italy health screenings of new arrivals are used for several purposes at once (identify cases of communicable diseases but also identify vulnerable persons) while in Slovenia the health screening is not part of the procedure for identifying vulnerable persons

- Moreover, the different socio-economic contexts should also be highlighted: Greece is still undergoing a severe economic crisis, which has resulted in a downsizing of all public service staff, including the healthcare sector, police, and coast guard as well as the staff employed at entry points, that is, the small islands that did not have the

capacity to accommodate such large numbers of incoming populations. Indeed, on many Greek islands the numbers of daily arrivals in 2015 exceeded by far the local population. The situation has become more critical when the Balkan route closed in spring 2016, stranding thousands of people and causing utter frustration. Slovenia had certainly fewer incoming populations than Greece and Italy, yet was still faced with financial constraints, e.g. for treating non-urgent medical conditions. In Italy, there has been a greater distribution of migrants and refugees throughout the country, and the fact that the provision of healthcare is decentralised, thus there are regional differences, creates a very particular socio-economic context.

STATE OF THE ART ON PUBLIC HEALTH ASPECTS OF THE 'PEOPLE ON THE MOVE' IN GREECE, ITALY AND SLOVENIA

The previous CARE WP8 report (M8.1 "State of the art report concerning the public health aspects of the 'people on the move' in Greece, Italy and Slovenia") examined the state of the art on public health aspects of 'people on the move' in Greece, Italy, and Slovenia, with a particular emphasis on the role that civil organisations play in each of these countries in providing health assistance to 'people on the move'. Before presenting the main findings emerging from this work, it is important to provide definitions of the populations under study.

DEFINITIONS

'Migrants', 'refugees', 'asylum seekers'

A fundamental conceptual problem is the lack of a universally agreed definition of who constitutes a migrant. Although the UN aimed to establish a set of common definitions of migratory movements, data collection still guided by national legislative, administrative and policy needs. Therefore, countries define migrants in many different ways, for instance, based on country of birth, citizenship, residency, the duration of stay etc. This makes it very challenging to measure international migration, not to speak of monitoring migrants' health (Rechel et al., 2012: 11) and public health aspects in this population.

In the case of refugees and asylum seekers, reference to their legal definition is common: asylum seekers are a type of migrant defined as those exercising their right to claim asylum, as defined by the Universal Declaration of Human Rights. Similarly, refugee status, as defined by the United Nations Convention relating to the Status of Refugees is regularly noted (Bradby et al., 2015: 29). However, few studies in the field of public health

acknowledge that asylum seekers and refugees are a heterogeneous group with differing experiences, backgrounds, health needs and health behaviours (Redman et al., 2011 in Bradby et al., 2015).

'People on the move'

Given the diversity of definitions on who is a migrant, a refugee, or an asylum-seeker and the often-blurred lines between refugees and asylum seekers, it is no surprise that the term 'people on the move' is also difficult to define. Zimmerman et al (2011) in their article on migration and health provide a comprehensive table with definitions for mobile groups (that is, not only international migrants, refugees and asylum seekers, but also internal migrants, irregular migrants, trafficked persons, international labor migrants, internally displaced persons etc.). It is clear then that the group of 'people on the move' comprises many other subgroups. Nevertheless, it was a pertinent term to use throughout the State of the Art report, since in 2015-2016 Greece, Italy, and Slovenia were 'transit- countries' through which thousands of groups passed by on their way to other Northern and Western European countries.

The term migrants and refugees was used in the Good Practices report and is also used in the present Recommendations report, as the emphasis is on the populations who are resettling in host societies either for a short while or for longer.

METHODOLOGY

The following methods were employed for composing the State of the Art report:

- *Desktop literature review and analysis* of material relevant to the theme of health assistance to migrants, refugees, and asylum seekers through civil society organisations in Greece, Italy, and Slovenia and also for the theme of national integrated public health plans in each of these countries. The material for this section was identified in journal articles, book chapters, reports, and policy documents ranging from 2006 to the present date.

- *Interviews* with representatives of civil society organisations and public authorities in Greece, Italy, and Slovenia, as well as focus groups with representatives of general hospitals who were dealing with large migrant/refugee/asylum seeking populations. The material collected through the interviews and the focus groups was thematically analysed. A synthesis of these findings along with some material from the desktop review informed the part of the State of the Art report, which presents and discusses the views of key persons regarding the national integrated public health plans and

actions that Greece, Italy, and Slovenia materialised in 2015-2016 for people on the move.

The interview themes that Greece, Italy, and Slovenia used when interviewing the different stakeholders were the following:

- Structures for the newly arrived populations (basic facilities, hot water, toilets etc)

- Health services to meet emergency and health needs for vulnerable populations (children, pregnant women etc) from the moment they arrived and thereafter

- Main actors (hospitals, NGOs, etc)

- Identification of main synergies and complementarities between public services and NGO's

The above-mentioned themes were further specified on the following questions

1. How many hot spots and different centres (describe them e.g. pre-removal centres, reception centres, hot spots, open camps etc.) for migrants/refugees/asylum seekers were set up and where?

2. Describe the conditions: availability of hot water, toilets, health services, psychological support etc.

3. Who is responsible for the health services at these centres? (Public or civil society?). Describe them.

4. Emergencies: who is responsible and what is the procedure to follow?

5. Vulnerable populations: pregnant women, children, older people, unaccompanied asylum seeking children, chronic illness. Who is responsible, what is the procedure to follow.

6. Psychosocial support: Who is responsible for mental health issues and procedures followed?

7. Describe the main NGO's who provided health services and the main public bodies involved in different areas.

8. What were the main synergies established between public and civil society organizations in order to cover the needs of the migrants/refugees/asylum seekers?

9. In which areas the complementarities between public services and NGO's were considered effective? Describe them.

10. Were there any difficult collaborations identified through all this period? What were the reasons?

11. Which were the most effective synergies established? What were the reasons?

12. What were the gaps in public health issues concerning migrants/refugees/asylum seekers?

LITERATURE REVIEW ON RECEPTION AND HEALTH ASSISTANCE TO MIGRANTS, REFUGEES AND ASYLUM SEEKERS

Before reviewing the relevant literature for Greece, Italy and Slovenia respectively, we should note that in recent international literature we can see an increasing number of publications acknowledging the importance of the services that civil society organizations offer: "*civil society and volunteer groups, better able to work around administrative, institutional and political blockages, have emerged as key to providing refugees and migrants with essential services throughout their journey*" (MSF, 2015: 4).

There is also an increase in reports of integrated services provided to migrants, refugees, and asylum seekers. Reference is made to these partnerships (between NGOs and also between NGOs and governmental agencies and/or public institutions) in the following pages where national integrated public health plans are discussed.

GREECE

Before the 1990s, Greek civil society was underdeveloped when compared to political parties and the state (Sotiropoulos & Bourikos, 2014). One of the key factors that boosted the development of civil society organizations in Greece - along with the increased sensitivity about environmental degradation and the fight against corruption - was the unprecedented rise of migration: first with the big waves of migrants coming to Greece in the early 1990s after the collapse of state Socialism in eastern Europe and second, in the 2000s where large populations fled parts of South Asia, the Middle East, and Sub-Saharan Africa because of war and deprivation. Finally, when the socio-economic and political crisis started unfolding in 2009, civil society mobilization for many migrants, refugees and asylum seekers, who were often experiencing worse living conditions than Greeks, became even more evident (Sotiropoulos, 2014).

Assistance to the thousands of incoming populations soon became a key task for many civil society organizations operating in Greece. The First Reception Service (FRS) was established in 2011 by Law 3907/2011, with the objective to register and refer migrants and refugees to competent authorities. In 2015, with the massive inflows in the country there was one

reception centre in Eleonas, in the Attica region close to Athens. The lack of first-line reception capacity led to thousands of new arrivals sleeping rough on the islands and in Athens in the first months of the emergency (that is the beginning of 2015). The identification of suitable reception sites was challenging and lengthy. Eventually the Greek authorities made sites available on the islands of Lesvos, Chios, Kos, Leros, and Samos to accommodate migrants and refugees, pending their registration (UNHCR, 2016a).

The need for the presence and assistance of civil society organizations in health-related matters was well known from the very first day of the migration crisis, as all services were provided via the civil society sector and the referral path to further support by the NHS was undergoing many problems-mainly the lack of human and other resources. At that point, the hospitals in the main entry had not received any additional staff and support to be able to fulfill this situation. It should be pointed out that both parties, civil society and local public hospitals, were facing many problems but were managing even in this conflict-burdened situation to cooperate and work further. The need for civil society organisations became even more evident and quite pressing when it was soon clear that these first reception sites lacked sufficient capacity, did not meet basic assistance and protection standards, and availability of services such as wash and healthcare was limited. People with specific needs, and also children and women, were often caught in insecure and inappropriate conditions for a considerable amount of time (UNHCR, 2016a: 35).

Reception sites have multiplied all over the country in the past 2 years and even though important services are provided to populations passing by or staying there, there are still many unmet challenges.

Civil society organizations are clearly playing an important role in the current migration crisis in Greece. Therefore when reviewing the literature on health assistance to migrants, refugees and asylum seekers through civil society organizations in Greece, we clearly see this move from sporadic interest in the topic to more intense, systematic, and evidence-based coverage of it.

ITALY

The following paragraphs offer an overview of the migration phenomenon in Italy, and of the reception system, which directly links to the issue of healthcare services for migrants, refugees, and asylum seekers. This section has been composed essentially by analysing official data (from Ministries and international organizations) and the laws concerning this field.

The first legislative act on the treatment of foreign people was the 1931 "Consolidation Act of Public Safety" and its implementation rules in 1940. 20 articles in all regulated the treatment of foreign people who had committed crimes. The law did not provide for any restriction for entering the country and these laws remained in force for many years. For several years, the phenomenon of migration was regulated directly by the local authorities through circulars from the Ministry of Internal Affairs, Ministry of Labour, and Ministry of Foreign Affairs. Only in 1986, with the law No. 943 of 30 December "Rules of Law for the Employment and Treatment of the Non-EEC Immigrant Workers and Against Illegal Immigration", the Government intervened in order to regulate some aspects of the migration phenomenon for employment-related reasons.

In 1989, with the law by decree No. 416 of 30 December, later modified with amendments into the Law of 28 February 1990 (known as "Martelli law"), there was a wider intervention with rules and regulations called "Urgent Rules on Political Asylum, Entry and Residence of Non-EEC Citizens, and Regularization of Non-EEC Citizens Already Resettled in the State Territory"). This law represents the first attempt to provide a wide-ranging regulation on the migration phenomenon, but it did not offer organic rules yet.

The emergency logic was overcome in 1998 with the Turco-Napolitano law (law No. 40 of 6 March 1998,), which programmes regular entries and offers integration paths for migrants and refugees. This law was integrated with the Decree No. 286 of 25 July 1998, the so-called *Testo Unico* on migration, which includes -apart from the general principles- the following topics: disposition upon entry, residence and expulsion from Italian territory; labour rules and regulations; right to family unit and to protection of minors; rules and regulations on health care, education, and social integration. The Consolidation Act on Immigration (*Testo Unico*), still in force, has been modified several times.

In recent years, the obligation to adopt and implement the European rules has modified the Italian laws on migration. In the 30th of October 2014 the provisions of the Law No. 161 on the detention and expulsion were revised, including alternative forms of detention and extending the period of residence in the Identification and Expulsion Centres (*Centri di Identificazione ed Espulsione* – CIE) from 180 days up to a maximum of 18 months. Also through the Decree 142 of 2015 (which implements the provisions of the European directives 013/33/EC and 2013/32/EC), new rules were established regarding international protection and identification, and the annulment of the status of international protection.

The Italian Reception System

The Italian reception system for migrants, refugees, and asylum seekers is divided into three main steps: first aid; first reception; second reception.

The step of first aid, first reception, and identification of the incoming persons conducted in the First Aid and Reception Centres (*Centri di Primo Soccorso e Assistenza - CPSA*), was established according to the law No. 563/1995 mainly for those places most affected by the massive inflow of incoming populations.

At first reception step, which is guaranteed to be provided in the government reception centres for asylum seekers according to the article 9 of the Decree 142/2015, a range of necessary operations are carried out: identification and definition of the juridical position of a migrant/refugee/asylum seeker; recording of an examination of his/her petition; checking of his/her health condition. The management of the first reception centres is given to local institutions, as well associations, unions or groups of municipalities, but also to civil society organisations or private institutions who work in the welfare service area in general or in particular, in assisting migrants, refugees and asylum seekers.

At the step of second reception, the identified asylum seeker, who has formalized his/her request and has no livelihood, is received in one of the structures working in the territorial reception system. This system- Protection System for Asylum Seekers and Refugees (*Sistema di Protezione per Richiedenti Asilo e Rifugiati - SPRAR*)- was established by local institutions and financed by the Ministry of Internal Affairs according to the article 14 of the Decree 142/2015.

The appointed reception structures for migrant/refugee/asylum seeking populations are:

- Reception Centres for Asylum Seekers (*Centri di Accoglienza per Richiedenti Asilo - CARA*), which were already established when the Decree 142/2015 came into force. In the *CARA*, as in every reception structure, basic rights are secured (e.g. the respect of privacy, health protection, family unity, and support for vulnerable people). Moreover, there is the ability to communicate with the UNHCR, as well as with other refugee-protection- institutions, with lawyers and ministers of religion and with relatives. Asylum seekers are allowed to leave at daytime with the obligation to return in the night hours, but they can ask the Prefect for a temporary leave permit for a different or longer period. It should be noted that due to the reception system congestion and the general lack of space, people with different status may stay in CARE centres and if needed their stay there can last for months.

- The Protection System for Asylum Seekers and Refugees (*SPRAR*) where a person can stay in while his/her request is being processed and, in case of jurisdictional appeal, until his/her residence on Italian territory is authorised.

The Ministry of Internal Affairs requires that an integrated set of services are offered for ensuring a proper quality of living-conditions. These services include: suitable lodging, meals that respect the different cultural traditions linguistic-cultural mediation; guidance to local services; Italian language courses and support for education and professional retraining paths; guidance and assistance for work, living and social integration programmes; legal guidance and protection.

- If there are no available places in the government first reception centres or in the SPRAR system centres, the Prefect of Police, under the orders of the Ministry of Internal Affairs, can decide that the reception will be carried out in temporary and expressly established structures called Extraordinary Reception Centres (*Centri di accoglienza Straordinari - CAS*). CAS may take a very mixed population of newcomers. Before entering these centres, peoples' health conditions have to be checked, in order to verify possible special reception needs, while their residence in the centre will be limited only at the necessary time before their transfer to a first or secondary reception structure.

The National Reception Plan as well as the programmes established by the National Table coordinate the implementation and management of these territorial reception centres (according to the article 14 Decree 142/2015) carried out by Municipalities, alone or collectively, because these functions are administrative tasks deputized by article 118 of the Italian Constitution.

The same law by decree, in article 17, specifies the need to take into account the asylum seekers' reception requirements, especially regarding particularly vulnerable people (e.g. disabled people, elderly, victims of trafficking etc.). Special reception services are provided for such groups, both in the government first reception centres and within the territorial reception system. The existence of special needs is also communicated to the Prefect of Police where the Territorial Commission is sited, so that additional resources are provided, e.g. support staff during the hearing with the Commission.

In this way, the system of these little centres called SPRAR, directly managed by the local institutions, lives together with CARA and several other structures. In addition to these centres, there are others giving shelter to most of the asylum seekers, called temporary structures or CAS, established by the Prefects on behalf of the Ministry of Internal Affairs.

In this very particular reception context, which naturally affects and shapes the health services provided, civil society organisations have been clearly playing an important role. More detail on how these organisations have provided health assistance to incoming

populations, is included in the next section where the national public health planning for each region is briefly presented.

SLOVENIA

Slovenia was formerly part of the USSR and became one of the post-communist countries that joined the EU in 2004 and 'sent off' economic migrant populations to other more affluent European countries such as the UK, Sweden, France, and Germany (McDowell, 2008).

In the recent literature, we find some scattered references which include Slovenia in discussions about migration and health care: such as use of health services by economic migrants in Slovenia (Rotar-Pavlič et al., 2007), national policy regarding the right of access to healthcare for undocumented migrants (Cuadra, 2012), or data collection practices for monitoring migrant health (Rechel et al., 2012).

But currently, Slovenia, as well as several other countries on the Balkan route, has been experiencing for the first time in its modern history the reception of massive waves of incoming migrants, refugees, and asylum seekers from other continents (in the early 1990s Slovenia saw a large inflow of forced migrants but those came from the neighbouring countries of former Yugoslavia (Vrecer, 2010)). Since the beginning of 2015, when almost over half a million people on the move have crossed the country, we see in the literature intense discussion about health assistance to migrants, refugees, and asylum seekers in Slovenia (SHA, 2015) and in particular through civil society organisations (EESC, 2016).

When the first large migration waves unfolded, most people entered the country through the green border from Croatia, unorganized and with a desire to reach Austria as soon as possible. Incoming populations would pass by reception centres and then within the timeframe of 24 hours, would continue their journey with different means of transport until reaching the border with Austria. This first period admittedly contained great organizational, health and security risks particularly because there were no train that is fast, connections yet set up between bordering countries (and in particular Croatia to Slovenia). When an agreement was made to set up such train connections migrants, refugees, and asylum seekers were quickly brought to the Croatian-Slovenian border, where they were registered and then supplied with food, clothing, and medical care as they continued on their journey to Austria. The above steps ensured that incoming populations would not be retained in Slovenia longer than five hours.

At the sites of the reception centres there were medical teams operating, with staff from Hungary, Austria, and Slovakia and there were also teams from Doctors Without Borders (MSF). These teams regularly collaborated with the Slovenian health services, which were available at the sites' health stations. Most people on the move did not want to make use of any health services nor psychological support services, as they wanted to reach Austria as soon as possible and then proceed to Germany. In those few exceptional cases where there was a medical emergency, health services were offered at the reception cases, and if needed at regular medical institutions or hospitals, where appropriate specialists were available.

Yet the situation changed rapidly with the closure of the Balkan route in March 2016. From the 17 reception centres which had been set up all over the country for people on the move and almost half of them operating, one 1 centre close to the capital Ljubljana with its 3 branches remained active. The focus shifted more towards asylum seekers who were placed either in these centres or in other institutions such as youth crisis centres or in private accommodation. Medical care continued to be provided by emergency teams from the Red Cross, by medicine students as well as regular medical institutions or hospitals.

It is clear then that Slovenia, as well as the other countries on the Balkan route, experienced 2 stages with regards to the inflow of people on the move: the first stage in 2015, where thousands of people were passing by but would not stay for long and would continue their journey across the borders; and the second stage, after the closure of the Balkan route in March 2016 where a few hundreds of asylum seekers inevitably had to stay in the country.

Civil society organisations have been playing an important role in terms of health assistance at both of these stages of the inflow of migrants, refugees, and asylum seekers.

NATIONAL INTEGRATED PUBLIC HEALTH PLANS AND ACTIONS: A BRIEF CRITICAL APPRAISAL

The State of the Art report discussed in detail the integrated public health plans and actions put in place by Greece, Italy, and Slovenia for the incoming migrant, refugee, and asylum seeking populations in 2015-16. Particular emphasis was given on the structures created and constantly reshaped for the newly arrived populations; health services provided-especially for vulnerable groups; and the synergies/complementarities and challenges that emerged between different stakeholders (e.g. governmental and civil society organizations). As already noted, this material emerged from interviews held with representatives of civil

society organisations and public authorities in Greece, Italy, and Slovenia, as well as focus groups with representatives of general hospitals who were dealing with large migrant and refugee populations.

Several cases of excellent collaborations between different stakeholders emerged and some examples were the following:

In Greece: The collaboration between the Hellenic Centre for Disease Control and Prevention and various NGOs in collecting epidemiological data and monitoring morbidity indicators in points of care in sites all over the country; also, the excellent collaboration between the MoH and certified NGOs in carrying out vaccinations in reception centres and providing primary health care services.

In Slovenia: medical teams from other countries and from MSF regularly working with the Slovenian healthcare services, and with emergency teams from the Slovenian Red Cross; also, a group consisting of representatives of the Civil Protection, the Police, the Ministry of the Interior, all participating NGOs, the MoH, and the National Institute of Public Health, met regularly for coordinating various tasks and addressing these populations' pressing needs such as clothing, food, medical care and health protection. Finally, once the need for a so-called 'corridor' was identified, governmental departments, and civil society all collaborated for creating a temporary railway station within 48 hours for leading migrants directly from Croatia to Austria.

In Italy: In the region of Friuli Venezia Giulia, the Prevention and Public Health Department of Udine and the Italian Red Cross run together the Cavarzerani Hub, a first reception centre for asylum seekers. Also in the region of Latium, a health service that mainly cares for refugees and asylum seekers called SAMIFO, works efficiently due to the cooperation between ASL Roma A (regional health system) and Centro Astalli (the Italian branch of the Jesuit Refugee Service, that is, a civil society organisation serving refugees and displaced persons). (As already noted, in Italy health services are decentralized-the MoH gives the guidelines and principles, but each region manages and provides healthcare services, while adhering to national laws and principles. This is why examples of good collaborations in Italy have been identified at regional level).

However, despite the above examples of excellent synergies, many ongoing problems and challenges emerged, as each country has been trying to find efficient and fair ways to design and provide healthcare to migrants and refugees. Some examples of these challenges were the following:

- Staff shortage especially on islands, lack of interpreters in emergency departments, and lack of suitable accommodation places for vulnerable populations in Greece

- Not enough training courses offered to health and social care professionals in Italy with regards to cultural competence, as well as specific infectious diseases, specific health needs, and the consequences of adverse experiences such as trauma, violence, and trafficking

- Lack of funding for treating chronic non-communicable diseases in Slovenia

- In Greece and Slovenia lack of coordination between participating organisations, for example with regards to supplying with food and clothing at the reception and accommodation centres, which often led to an imbalance between demand and supply between the different centres.

Based on the above, a mixed picture emerged, at times optimistic and at other times rather bleak, regarding the public health care plans and actions for migrants and refugees. An important finding was that in all three countries there was lack of coordination in several of the services set up and provided for migrants and refugees, yet at the same time there were very good synergies unfolding between various stakeholders from the governmental, civil society, and public sector. This finding highlighted the possibilities for improving the effectiveness of healthcare provision in ways that will ensure the health and well-being of both incoming populations and the host societies.

GOOD PRACTICES OF CIVIL SOCIETY ORGANISATIONS AND THEIR ROLE ON HEALTH ASSESSMENT AND PREVENTIVE MEASURES

Good practices in healthcare for migrants have been presented before (e.g. Priebe et al., 2011), but the particularity of the current socio-economic and political context in Europe (massive population inflows, diverse profiles, vulnerability of certain groups, and increased hostile social climate towards migrants and refugees) renders it imperative to identify the good practices unfolding at the present moment.

DEFINING GOOD PRACTICES

The *United Nations Population Fund* (UNFPA) describes best practices as 'planned or operational practices that have been proven successful in particular circumstances and are used to demonstrate what works and what does not, with evidence on how and why they work in different situations and contexts'. The *Global Health Council* (GHC) states that

practices are best practices if they are 'community-based, sustainable, replicable and have measurable outcomes to show the success of the programme'. There is no universally accepted definition of good or best practice- which continues debate over terminology and definitions can even create a roadblock to action (EN-HERA!, 2009).

Since there is no universal definition of 'good practice' and it varies greatly according to time and context, partners in the framework of CARE agreed that the notion of "*a practice that is effective, transferable and applicable in different contexts on the preventive health assessment and preventive measures' could be used as an indicator / guide for defining a good practice*".

Portugal et al. (2007) who wrote on good practices on health and migration in the EU and adopted the UNESCO model developed for best practices in immigration planning, described good/best practices as having the following characteristics:

- Innovation (creating new and creative solutions to problems);

- Making a difference (having a positive and tangible impact on the beneficiaries' quality of life);

- Having a sustainable effect (contribute to sustained eradication of health and related problems, especially by the involvement of the participants);

- Having the potential for replication (serving as a model for generating policies and initiatives elsewhere).

By taking into account then the definitions of good/best practices by the UNFPA and the GHC and the above characteristics listed in Portugal et al (2007:7) it is evident that a practice in order to be considered as good/best practice has to be effective, sustainable, replicable, and innovative.

METHODOLOGY

WP8 leader, the National School of Public Health (ESDY – NSPH) in Athens, Greece, in close collaboration with all involved partners set up and agreed on the criteria upon which "good practices" that were selected. In particular, 11 broad areas (services) which were anticipated to be provided within the hotspots and camps for migrants and refugees were suggested and researchers tried to identify good synergies between public bodies and civil society organizations with an emphasis on preventive health assessment and preventive measures. These areas (services) were: Health assessment at reception centres; Coverage of medical health issues; Monitoring / surveillance of communicable diseases; Vaccinations;

Handling of emergency situations; Follow up of medical cases (e.g. chronic diseases); Mental Health issues–diagnosis; Mental Health issues – referrals; Care of vulnerable populations (pregnant women, unaccompanied minors etc.); Training of healthcare staff; Support of healthcare staff.

The identification of civil society organisation's examples of initiatives could be indicators of good practices for the public health needs of migrants and refugees conducted through desktop research of available national data and literature review on the theme of NGOs' health assistance to migrants and refugees.

The documentation of the examples identified as good practices was carried out by Greek and Italian researchers through site visits and interviews with health and social care staff employed in NGOs and representatives of public authorities and bodies who offer their services to people in reception centres while dealing with the recent migration crisis.

GOOD PRACTICES IN GREECE AND ITALY

What emerged was a range of suggested good practices of civil society organisations in Greece and Italy who - in collaboration with public authorities and other bodies - work for migrants and refugees on issues such as: the initial health assessment and preventive measures to the newcomers (with a specific focus on minors), prevention and addressing of possible communicable diseases and cross-border health threats in reception areas and hosting sites.

All selected good practices were discussed along the aforementioned criteria of effectiveness, innovation, replicability, and sustainability. In Greece, two good practices (1) vaccination of migrant / refugee children by the Ministry of Health in collaboration with NGOs (MSF, MDM, Red Cross and PRAKSIS) and Regional Health Authorities and 2) the mental health assessment and psychosocial support and care services provided to migrants and refugees by Day Centre Babel in Athens) fulfilled to a satisfactory level all the above four criteria. In Italy, two good practices (1) the SAMIFO Centre in Rome protecting and providing healthcare to forced migrants for a period not exceeding 24 months and 2) the provision of psychosocial support to asylum seekers in Trapani by the MSF and the training of local staff and the setting up of a clinic of transcultural psychotherapy) emerged as fulfilling the four criteria.

All other suggested good practices have undoubtedly contributed to meeting specific and pressing needs, yet they often face with problems related to sustainability, as quite often, at

least in Greece, synergies between public bodies and civil society organizations unfold in an ad hoc manner. The lack of systematic synergies often couples with limited resources (e.g. staff shortage and lack of suitable accommodation places for vulnerable populations), therefore a sustained elimination or eradication of problems is hard to attain. Replicability also often emerged as problematic since several good practices were effective at a specific place and time, yet could not serve as a model for generating initiatives elsewhere. In Italy, findings show that synergies usually create in a less ad hoc manner in comparison to Greece, yet the uncertain availability of continuous resources is a constant threat. In addition - concerning replicability - the localised practices emerged at times as difficult to be transferred to other regions. Of course, since practices usual tailor to local realities, the limited replicability is not always a problem as it could indicate that specific needs are adequately met. Finally, the need for continuous training in cultural competence for healthcare professionals also emerged as influencing the sustainability of good practices.

RECOMMENDATIONS FOR STRATEGIC PUBLIC HEALTH PLANNING FOR MIGRANTS AND REFUGEES AND THE ROLE OF CIVIL SOCIETY ORGANISATIONS

It is clear that a lot of progress has been made about health assessment, healthcare provision and preventive measures for migrants and refugees in European countries, which may act either as destinations or as transitory contexts. At the particular national level for Greece, Italy, and Slovenia, the below are the following suggestions regarding public health planning for migrants and refugees (with a particular emphasis on the role of civil society):

RECOMMENDATIONS AT THE NATIONAL LEVEL:

GREECE

- As a significant number of migrants and refugees will stay for long in hotspots, camps and urban settings in Greece, it is clear that vaccination of children will continue to be a public health priority. In order for this practice to be sustainable, it is recommended that the EU provides the vaccines and health authorities in collaboration with NGOs deliver the vaccinations when and where needed

- It is recommended that NGOs and physicians operating in primary healthcare facilities in collaboration with the relevant health authorities keep continuously up-to-date the already developed epidemiological surveillance system for communicable diseases and adjust it when deemed necessary- for example when new syndromes/health conditions arise

- It is important to improve the system of recording public health data - not only epidemiological but also other health indicators too- so that the follow- up of cases and communication between different agents involved are facilitated, thus continuity of care is attainable. Civil society can provide useful insights and take part in improving this system of recording

- Healthcare professionals in public hospitals, administrative staff of local authorities and police and coast guard staff who encounter and often work with migrants and refugees should be systematically informed and supported regarding these

populations' mental health issues. Civil society organisations with expertise in this area can play an important role in information campaigns and support services. Also, it is recommended that better integration of mental healthcare with other health and social care services is secured

- There is need for more cultural mediators- or at least interpreters- to offer their services in sites where migrants and refugees reside and in public hospitals, especially in urban areas. In addition, continuous training should be provided to these professionals. Civil society organisations can play an important role both in terms of recruiting the staff needed but also in planning and providing the training for them

- Vulnerable migrants and refugees such as unaccompanied minors and victims of trafficking are on the rise, therefore it is recommended to plan specialised services, for addressing these particular healthcare needs. Civil society organisations with expertise in this field can play an important role in these planning initiatives

- As migrants and refugees are anticipated to stay in the country for a long period, a long term policy planning on housing (i.e. moving from the camps), schooling (i.e. addressing negative reactions), and employment should be established.

ITALY

- It is important that collaborations between the public and the civil society sectors carry on in order for effective and tailored healthcare to be secured for migrants and refugees. The public sector has a central role related to giving guidelines, liaising the relevant stakeholders and coordinating activities. And the civil society sector brings added value in terms of innovation and ability to reach the most marginalized and vulnerable populations

- The key element for the sustainability and effectiveness of the aforementioned best practices in healthcare for migrants and refugees is the formalization of a collaboration protocol between the public and the civil society sectors in order to clarify roles, tasks, and responsibilities and engage all the interested stakeholders in long term involvement

- It is recommended that each region adopts homogenous regional health planning in order to avoid fragmentation in healthcare provision. At the same time the implementation of the regional planning at local level has to be strictly monitored and healthcare staff have to be trained in order to provide the services and implement the protocols decided at regional level

- It is recommended that mental health services improve their commitment to respond effectively to the needs of vulnerable migrants and refugees and this can be attained by providing specific training to psychiatrics and psychologists and also by integrating the ethno-psychiatric approach in the planning and delivery of mental healthcare. Civil society organisation with expertise in migrant mental healthcare can play an important role in both these initiatives.

SLOVENIA

- It is recommended to appoint public relations authorities, as during the migration crisis there was a lot of media-generated tension in the general population who often perceived migrants and refugees as threatening and even resisted accommodating the newly arrived populations. Civil society can play an additional important role in dissipating such negative stereotypes

- At the peak of the migration crisis there was good coordination between governmental stakeholders and civil society, and volunteers from the general population contributed significantly to the success of the unfolding operations. It is recommended however that civil society organisations urge volunteers to get involved in the field more frequently (that is, more than a day or two per week) and engage on a longer-term perspective

- As there is an ongoing need for cultural mediators, it is recommended to maintain those cultural mediators-who may often come from a civil society background-already employed in all major healthcare centres in the capital, where the majority of migrants and refugees are treated.

CONCLUSIONS

The aforementioned recommendations apply specifically to Greece, Italy, and Slovenia. Yet from these recommendations, some general principles can be derived and applied to other European countries who are faced with migration-related crises. In particular, there is need for: sufficient but at the same time - flexible funding for healthcare planning and provision to migrants and refugees especially for civil society organisations who are often called to address emergency situations; less bureaucracy when it comes to setting up synergies between different stakeholders from the governmental, public and civil society sectors and launching collaborative initiatives; coordinated planning and action between the different stakeholders involved such as ministries, regional health authorities and national and

international civil society organisations; continuous quality training for volunteers in civil society organisations and also staff involved in the delivery of healthcare to migrants and refugees with an emphasis on considering cultural sensitivity in health care services; and last but not least, positive attitude-building at the community level, that is, challenging stereotypes embedded in many host societies regarding migrants and refugees being a 'potential public health danger' and tackling prejudiced attitudes, so that migrants' and refugees' healthcare rights are respected and their needs promptly addressed, while harmony at the community level is ensured.

When it comes to strategic public health planning regarding migrants and refugees in Europe, we are beyond the stage where countries are adopting or not 'migrant-friendly' approaches (Mladovsky et al., 2012). It is now clearly acknowledged that healthcare systems need to adapt-if they have not already- for ensuring appropriate healthcare for these populations (MacFarlane et al., 2014). Public bodies, in order to respond effectively to the ongoing pressures regarding appropriate healthcare for incoming migrant and refugee populations, must support the importance of collaborating with civil society and embrace the relevant expertise and long-term experience non-governmental associations have in managing large migration crises, such as the one Europe has been lately experiencing.

As we saw in the cases of Greece, Italy and Slovenia there is no lack of ongoing problems and challenges yet there are already important synergies between stakeholders from the governmental, public and civil society sectors that convey optimism regarding public healthcare plans for migrants and refugees.

REFERENCES

Acheson Report (1988). Public health in England. Report of the Committee of Inquiry into the future development of the public health function. London: HMSO.

Arnold, F., Katona, C., Cohen, J., Jones, L., & McCoy, D. (2015). Responding to the needs of refugees. British Medical Journal, 351:h6731.

Bradby, H., Humphris, R., Newall, D. & Phillimore, J. (2015). Public health aspects of migrant health: a review of the evidence on health status for refugees and asylum seekers in the European Union. Copenhagen: WHO Regional Office for Europe (Health Evidence Network synthesis report 44).

Cuadra, C.B. (2012). Right of access to healthcare for undocumented migrants in the EU: a comparative study of national policies. The European Journal of Public Health, 22(2): 267-271.

ECHO-European Commission- Humanitarian Aid and Civil Protection. (2016). Refugee crisis in Europe. Available at: http://ec.europa.eu/echo/refugee-crisis_en

EESC- European Economic and Social Committee. (2016). EESC fact-finding missions, on the situation of refugees, as seen by civil society organisations. Mission report-Slovenia, 13 and 14 January 2016. Available at:
http://www.eesc.europa.eu/resources/docs/slovenia_migration-mission-report_en.pdf

EN-HERA! (2009). Sexual and reproductive health and rights of refugees, asylum seekers and undocumented migrants: A framework for the identification of good practices. EN-HERA! Network, Ghent, Belgium.

Gulland, A. (2015). Refugees pose little health risk, says WHO. British Medical Journal, 351: h4808.

Hives-Wood, S. (2013). Syrian refugees could bring polio to Europe, experts warn. British Medical Journal, 347: f6778

Jakab, Z., Severoni, S., Ostlin, P., Verschuuren, M., & Stein, C.E. (2015). Refugee and migrant health: a priority in the WHO European Region. The Lancet, 386, December 19/26:2477-8.

Kassar, H. & Dourgnon, P. (2014). The big crossing: illegal boat migrants in the Mediterranean. European Journal of Public Health, 24 Suppl 1: 11-5.

Kotsioni, I. & Hatziprokopiou, P. (2009). MIGHEALTHNET: State of the art report on the Greek case. Available at: www.mighealth.net

Lindert, J., Schouler-Ocak, M., Heinz, A. & Priebe, S. (2008). Mental health, healthcare utilisation of migrants in Europe. European Psychiatry, 23, S14-S20.

MacFarlane, A. et al. (2014). Healthcare for migrants, participatory health research and implementation science- better health policy and practice through inclusion. The RESTORE project. European Journal of General Practice, 20(2): 148-152.

McDowell, L. (2008). Old and new European economic migrants: Whiteness and managed migration policies. Journal of Ethnic and Migration Studies, 35(1): 19-36.

Mladovsky, P., Ingleby, D., & Rechel, B. (2012). Good practices in migrant health: The European experience. Clinical Medicine, 12(3): 248-252.

MSF-Medecins Sans Frontieres. (2015). Obstacle course to Europe: A policy-made humanitarian crisis at EU borders. Brussels: MSF.

OECD- Organisation for Economic Co-operation and Development. (2015). Is this humanitarian migration crisis different? Migration Policy Debates, No 7, September.

Portugal, R., Padilla, B., Ingleby, D., de Freitas, C., Lebas, J. & Pereira Miguel, J. (2007). Good practices on health and migration in the E.U. Report prepared for the Conference on "Health and Migration in the EU: Better health for all in an inclusive society", Lisbon, September 2007.

Priebe, S. et al. (2011). Good practice in health care for migrants: views and experiences of care professionals in 16 European countries. BMC Public Health, 11: 187 doi:10.1186/1471-2458-11-187

Rechel, B., Mladovsky, P. & Devillé, W. (2012). Monitoring migrant health in Europe: A narrative review of data collection practices. Health Policy, 105: 10-16.

Rechel, B., Mladovsky, P., Ingleby, D., Mackenbach, J.P. & McKee, M. (2013). Migration and health in an increasingly diverse Europe. The Lancet, 381, April 6, 1235-1245.

Redman, E.A., Reay, H.J., Jones, L. & Roberts, R.J. (2011). Self-reported health problems of asylum seekers and their understanding of the national health service: a pilot study. Public Health, 125(3): 142-4.

Rotar-Pavlič, D., Brovč, M., I Švab, I., J Ahčin, J. & M Šlajpah, M. (2007). Attitudes to illness and use of health services by economic immigrants in Slovenia. Croatian Medical Journal, 48: 675-83.

SHA-Swiss Humanitarian Aid. (2015). Support for Slovenia and Croatia. Available at: www.eda.admin.ch

Sotiropoulos, D. (2014). Civil Society in Greece in the wake of the economic crisis. A report submitted to the Konrad Adenauer Stiftung Office in Athens and written with research assistance by ELIAMEP.

Sotiropoulos, D. & Bourikos, D. (2014). Economic crisis, social solidarity and the voluntary sector in Greece. Journal of Power, Politics and Governance, 2(2): 33-53.

Taleb, B., Bahelah, R., Fouad, F.M., Coutts, A., Wilcox, M., & Maziak, W. (2015). Syria: Health in a country undergoing tragic transition. International Journal of Public Health, 60 (Suppl 1): S63-72.

UNHCR- United Nations High Commissioner for Refugees. (2015). Global trends - Forced Displacement in 2015. Geneva: UNHCR.

UNHCR- United Nations High Commissioner for Refugees. (2016a). RRMRP-Regional Refugee and Migrant Response Plan for Europe. Eastern Mediterranean and Western Balkans Route, January-December 2016. Geneva: UNHCR.

UNHCR- United Nations High Commissioner for Refugees. (2016b). Briefing note-Unaccompanied and Separated Children in Europe. Geneva: UNHCR.

Vrecer, N. (2010). Living in limbo: Integration of forced migrants from Bosnia and Herzegovina in Slovenia. Journal of Refugee Studies, 23(4): 484-502.

Watters, C. (2010). Migrants, refugees and mental health care in Europe. Hellenic Journal of Psychology, 7: 21-37.

WHO-World Health Organisation. (1952). Expert Committee on Public Health Administration. Technical Report Series No. 55. Geneva: WHO.

WHO-World Health Organisation. (2012). Toolkit for assessing health-system capacity for crisis management. Copenhagen: WHO Regional Office for Europe.

Zimmerman, C., Kiss, L. & Hossain, M. (2011). Migration and health: A framework for 21st century policy-making. PLoS Medicine, 8(5): e1001034.