SUMMARY OF SITUATIONAL ASSESSMENT REPORTS
Health Situation at EU’s Southern Borders - Migrant, Occupational, and Public Health

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Acknowledgements

This document represents a summary based on findings from six situational assessments undertaken between 2013 and 2015 by the International Organization for Migration (IOM), within the framework of the project “Fostering health provision for migrants, the Roma and other vulnerable groups” (Equi-Health), co-financed under the 2012 work plan of the second programme of Community action in the field of health (2008-2013), by a direct grant awarded to IOM from the European Commission’s Directorate General for Health and Food Safety (DG SANTE), through the Consumers, Health, Agriculture and Food Executive Agency (CHAFEA). The Equi-Health project was launched in February 2013 and ended in January 2017. It was divided into three sub-actions: (1) Migrant health at Southern EU borders, (2) Roma health, and (3) Migrant Health. The situational assessments were conducted in six countries: Italy, Greece, Malta, Croatia, Bulgaria, and Spain (http://equi-health.eea.iom.int/), as part of the first sub-action. Findings from the original Situational Assessment Reports (SARs) are supplemented by updated information for each of the six countries in the present document, based on information provided by national experts, a Regional Consultation held in Athens in March 2016, and work undertaken as part of the Equi-Health project. This information can in no way be considered to be comprehensive.

The Equi-Health project was designed and implemented by the Migration Health Division (MHD) of IOM’s Regional Office (RO) in Brussels. The methodology for the fieldwork and analysis undertaken as part of the SARs was based on the prior IOM project “Increasing Public Health Safety alongside the New Eastern Border Line” (PHBLM), co-funded under the European Commission’s Public Health Programme 2006, and was further developed by IOM with the support of the Andalusian School of Public Health (EASP).

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### Acronyms

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<th>Acronym</th>
<th>Description</th>
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<tbody>
<tr>
<td>AFM</td>
<td>Armed Force of Malta</td>
</tr>
<tr>
<td>ASP</td>
<td>Local Health Authority</td>
</tr>
<tr>
<td>AWAS</td>
<td>Agency for the Welfare of Asylum Seekers</td>
</tr>
<tr>
<td>BRC</td>
<td>Bulgarian Red Cross</td>
</tr>
<tr>
<td>CAR</td>
<td>Refugee Assistance Centres (Centro de Ayuda al Refugiado)</td>
</tr>
<tr>
<td>CARA</td>
<td>Reception Centres for Asylum-Seekers</td>
</tr>
<tr>
<td>CDA</td>
<td>Reception Centre</td>
</tr>
<tr>
<td>CETI</td>
<td>Centres for Temporary Stay of Migrants (Centros de Estancia Temporal de Inmigrantes)</td>
</tr>
<tr>
<td>CIE</td>
<td>Migrant Detention Centres (Centros de Internamiento de Extranjeros)</td>
</tr>
<tr>
<td>CIE</td>
<td>Identification and Expulsion Centres</td>
</tr>
<tr>
<td>CSO</td>
<td>Civil Society Organization</td>
</tr>
<tr>
<td>CSPA</td>
<td>First Aid and Reception Centres</td>
</tr>
<tr>
<td>DC</td>
<td>Detention Centre</td>
</tr>
<tr>
<td>DG SANCO</td>
<td>European Commission’s Directorate General for Health and Consumers</td>
</tr>
<tr>
<td>DG</td>
<td>Directorate General</td>
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<tr>
<td>EC</td>
<td>European Commission</td>
</tr>
<tr>
<td>ECDC</td>
<td>European Centre for Disease Prevention and Control</td>
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<tr>
<td>EEA</td>
<td>European Economic Area</td>
</tr>
<tr>
<td>EU</td>
<td>European Union</td>
</tr>
<tr>
<td>FRC</td>
<td>First Reception Centre</td>
</tr>
<tr>
<td>FRONTEX</td>
<td>European Agency for the Management of Operational Cooperation at the External Borders of the Member States of the European Union</td>
</tr>
<tr>
<td>HCDCP</td>
<td>Hellenic Centre for Diseases Control and Prevention</td>
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<tr>
<td>HIV</td>
<td>Human Immunodeficiency Virus</td>
</tr>
<tr>
<td>HP</td>
<td>Health Personnel</td>
</tr>
<tr>
<td>HRW</td>
<td>Human Rights Watch</td>
</tr>
<tr>
<td>HSP</td>
<td>Health/Social-care Providers</td>
</tr>
<tr>
<td>IBM</td>
<td>Integrated Border Management</td>
</tr>
<tr>
<td>ICT</td>
<td>Information and Communications Technology</td>
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<tr>
<td>IOM</td>
<td>International Organization for Migration</td>
</tr>
</tbody>
</table>
LCHIHF Law on compulsory health insurance and health care of foreigners in Republic of Croatia

LEO Law Enforcement Officers

MDM Médecins Du Monde (Doctors of the World)

MFSS Ministry of Family and Social Solidarity

MH SEUB Equi-Health Project’s Southern EU Border component

MHAS Ministry of Home Affairs and National Security (previously MJHA)

MJHA Ministry for Justice and Home Affairs (now MHAS)

MoH Ministry of Health

MoI Ministry of Internal Affairs

MSF Médecins sans Frontières (Doctors without Borders)

NCC National Consultative Committee

NGOs Non-Governmental Organizations

PHS Public Health System

RAO Regional Asylum Offices

RC Red Cross

RCAS Reception centre for asylum-seekers

SAR Situational Assessment Report

SAR State Agency for Refugees

SAR Rescue at Sea

SIRIA Integrated and Collection Capacity Information System (Sistema Integrado y Recolección de Información de Aforos)

SPRAR Protection System for Asylum Seekers and Refugees

SSN National Health System

STP Temporary Present Foreigner

TB Tuberculosis

TCN Third-Country National

UAM Unaccompanied minors

UNHCR United Nations High Commissioner for Refugees

USMAF Office of Maritime and Border Health

WHO United Nations World Health Organization
Introduction

This document is a summary based on the findings of six situational assessments undertaken by the International Organization for Migration (IOM) in Italy, Greece, Malta, Croatia, Bulgaria, and Spain within the framework of the project “Fostering Health Provision for Migrants, the Roma, and Other Vulnerable Groups” (Equi-Health). Findings from the original Situational Assessment Reports (SARs) are supplemented by some updated information for each of the six countries in the present document.

The Equi-Health assessments aimed to address: 1) migrants’ health; 2) occupational health; and 3) public health under the overall lens of equity and efficient management of migration during the different stages of the reception process of complex migration flows,\(^1\) from rescue at sea onward, including in detention and reception centres.

Health is an essential element of effective migration management. Moreover, the concept of health goes beyond physical diseases, and comprises the psychological and social wellbeing of mobile populations and communities affected by migration. Migration health addresses the needs of individual migrants as well as the public health needs of receiving communities through policies and practices corresponding to the emerging challenges facing mobile populations today.

Therefore, the approach used in the assessments attempted to be as comprehensive as possible, covering communicable and non-communicable diseases, emergency interventions, chronic diseases, mental health, the understanding of culture and health beliefs, human rights protection, migration health management and other factors that impact on the health of migrants and the communities along.

The desk review and field work findings are presented following the IOM/WHO/Spanish Presidency of the EU “1st Global Consultation on Migrant Health” conceptual framework (Madrid, 2010),\(^2\) according to the following four pillars:

I. **Policy and Legal Framework**: the assessments examined both European and National legal frameworks in all six countries.

II. **Partnerships, Networks and Multi-Country Frameworks**: the assessments covered all phases of the reception process, identified as the following segments: rescue, first reception, transfer, housing at a centre, and eventually release/integration.

III. **Monitoring Migrant Health**: during the assessments, an increasing number of vulnerable groups was observed to have been registered, while the health

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\(^1\) IOM identifies complex flows as comprising, in addition to asylum-seekers: victims of trafficking, smuggled and stranded migrants, unaccompanied (and separated) migrant children, those with specific health needs or subject to sexual, physical, and psychological violence (including gender-based) during the migration process and family members seeking to re-unite with their families. In addition, these flows may include migrant workers and migrants moving for environmental reasons (IOM, *Addressing complex migration flows and upholding the rights of migrants along the central Mediterranean route*, Discussion paper, 21 October 2013, Brussels).

\(^2\) [https://publications.iom.int/books/health-migrants-way-forward-report-global-consultation](https://publications.iom.int/books/health-migrants-way-forward-report-global-consultation)
condition of migrants arriving by sea deteriorated, indicating worse travelling conditions. At the time of the assessments there was a lack of standardized screening protocols nationally and internationally, as well as information exchange between actors.

IV. **Migrant-sensitive Health System:** access to health and living conditions varied between countries and between different types of centres. In most cases, the centres were overcrowded and lacked basic amenities.

**Methodology**

The same assessment methodology was followed by IOM expert teams in all six countries, including desk review, regional, national and local consultative committees, and field work.

The first phase of the assessment process comprised a desk review on the relevant situation in eight Southern EU Border Member States (SEUB MS) to provide the contextual framework for the field visits in the participating countries. The desk reviews covered literature and other relevant documents that were published in the period between 2009 and 2013. Five countries were selected initially – Croatia, Greece, Italy, Malta and Spain; in 2014, it was decided to include Bulgaria as well as it witnessed an unprecedented migration influx during the period 2013-2014.

Following the desk review, a Regional Consultative Committee and Expert Working Group meeting “Priorities and Methodology for the assessment of migrant, occupational and public health at Southern EU Borders” was held on 17-18 June 2013 in Granada, Spain, aimed at sharing plans and approaches with partners, collecting ideas on gaps and priorities including identifying the appropriate methodological approach for the planned field assessment. The meeting included the participation of government and international organizations’ representatives.

National Consultative Committees (NCCs) were held in all countries prior to the field work in order to present the project to national partners and discuss forthcoming field visits, including the selection of sites/centers. Local Consultative Committees (LCC) or local stakeholder meetings were held prior to each site study. NCCs were also organized following the assessments in order to validate the findings and recommendations with a view to finalizing the SARs. A Regional Consultation was organized in Athens in March 2016 by IOM and the Hellenic Ministry of Health to further discuss the findings from the SARs and identify key common priorities and actions taken since.
Table 1: Locations and dates of NCCs & LCCs

<table>
<thead>
<tr>
<th>Location</th>
<th>Dates</th>
<th>Location</th>
<th>Dates</th>
<th>Location</th>
<th>Dates</th>
<th>Location</th>
<th>Dates</th>
<th>Location</th>
<th>Dates</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>NCC</strong></td>
<td></td>
<td><strong>Greece</strong></td>
<td></td>
<td><strong>Malta</strong></td>
<td></td>
<td><strong>Croatia</strong></td>
<td></td>
<td><strong>Bulgaria</strong></td>
<td></td>
</tr>
<tr>
<td>Palermo</td>
<td>July 2014</td>
<td></td>
<td>November 2014</td>
<td>Malta</td>
<td>September 2014</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Siracusa</td>
<td>July 2014</td>
<td></td>
<td></td>
<td>Lesvos</td>
<td>November 2014</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Catania</td>
<td>July 2014</td>
<td></td>
<td></td>
<td>Alexandroupolis</td>
<td>November 2014</td>
<td></td>
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</tr>
</tbody>
</table>

Extensive field work took place in the six countries: the selection of sites and centres were driven by data and information collected during the desk review prior to field and after consultation with national stakeholders, partners and IOM missions in respective countries, based on the following criteria:

1. Migration flows: to cover the route of different migration flows and nationalities in the country of destination.
2. Management type: to cover different types of management and types of facilities for migrants’ reception.

Table 2: Dates and locations of the field visits

<table>
<thead>
<tr>
<th>Location</th>
<th>Dates</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bulgaria</td>
<td>10-12 February &amp; 11-14 March 2014</td>
</tr>
<tr>
<td>Croatia</td>
<td>07-14 April 2014</td>
</tr>
<tr>
<td>Greece</td>
<td>06-12 November 2013</td>
</tr>
<tr>
<td>Italy</td>
<td>04-18 September 2013</td>
</tr>
<tr>
<td>Malta</td>
<td>11-15 November 2013</td>
</tr>
<tr>
<td>Spain</td>
<td>18-27 November 2013</td>
</tr>
</tbody>
</table>

The objective of the field work was to gather information and perceptions from key informants belonging to four profiles and involved in the entire reception process - health professionals (HPs), law enforcement officers (LEOs), civil society organizations (CSOs), and migrants.

The field visit at each site started with a local stakeholders meeting that gathered the four profiles covered by the assessment. After the stakeholders’ meetings, the assessment teams continued with visits to various sites and collected data. A mixed research method was used during the assessments, including in depth-interviews, focus-group/stakeholder discussions and observational analysis.
Prior to each interview/focus group, information regarding the Equi-Health project was provided to the participants. Informed consents were secured and interviews were audio recorded, whenever possible.

Overall **428 interviews** were held (table 1).

**Graph 1: Total Interviews Equi-Health field research in 6 SEUB countries**

During the assessments, the following limitations were identified:

- There are different types of reception and detention centres within and between countries.
- As per the methodological criteria presented above, not all operating centres were visited in each country.
- Not all visited centres provided information and forms about data collection.

The findings from the original SARs were broadly updated (mostly up to end of 2016) for the present report for each of the six countries, based on information provided by national experts and other available resources.

**Chapter 1: Bulgaria³**

In 2013–2014, Bulgaria saw an unprecedented migration influx in as a consequence of military conflicts and sociopolitical instability. The expanding war in the Syrian Arab

Republic and Iraq had forced more than 1.6 million refugees to escape to neighbouring Turkey, many of them seeking to continue their journey westward. As the road passes through either Greece or Bulgaria, the construction of a new fence along the Greek – Turkish border diverted an increasing number of undocumented and afflicted migrants towards Bulgaria.

**Table 3: Sites visited during the EH field research (February – March 2015)**

<table>
<thead>
<tr>
<th>Type of site</th>
<th>Location</th>
</tr>
</thead>
<tbody>
<tr>
<td>State Agency for Refugees (SAR) Headquarters</td>
<td>Sofia</td>
</tr>
<tr>
<td>Open Reception Centre - Ovcha Kupel (SAR)</td>
<td>Sofia</td>
</tr>
<tr>
<td>Open Reception Centre – Voenna Rampa (SAR)</td>
<td>Sofia</td>
</tr>
<tr>
<td>Open Reception Centre – Vrazhdebnia (SAR)</td>
<td>Sofia</td>
</tr>
<tr>
<td>Detention centre – Busmantsi (Mol)</td>
<td>Sofia</td>
</tr>
<tr>
<td>Medical Institute of the Ministry of Interior</td>
<td>Sofia</td>
</tr>
<tr>
<td>MSF Emergency Mission Headquarters</td>
<td>Sofia</td>
</tr>
<tr>
<td>Council of Refugee Women NGO</td>
<td>Sofia</td>
</tr>
<tr>
<td>ACET NGO (mental health-care provider)</td>
<td>Sofia</td>
</tr>
<tr>
<td>Open Reception Centre – Kovatchevtsi (SAR)</td>
<td>Kovatchevtsi, Pernik region</td>
</tr>
<tr>
<td>Open Reception Centre – Harmanli (SAR)</td>
<td>Harmanli</td>
</tr>
<tr>
<td>MSF Medical Office – Harmanli (within centre)</td>
<td>Harmanli</td>
</tr>
<tr>
<td>Municipal Hospital</td>
<td>Harmanli</td>
</tr>
<tr>
<td>Open Reception Centre – Pastrogor (SAR)</td>
<td>Pastrogor, Svilengrad</td>
</tr>
<tr>
<td>Detention Centre – Lyubimets (Mol)</td>
<td>Lyubimets, Svilengrad</td>
</tr>
<tr>
<td>Emergency Unit, Municipal Hospital</td>
<td>Yambol</td>
</tr>
<tr>
<td>Emergency Unit, Municipal Hospital</td>
<td>Haskovo</td>
</tr>
<tr>
<td>First Reception Centre (Mol)</td>
<td>Elkhovo</td>
</tr>
</tbody>
</table>

*Source: IOM Equi-Health project*

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4 See UNHCR data base. Available at [www.unhcr.org/pages/49e48e0fa7f.html](http://www.unhcr.org/pages/49e48e0fa7f.html)
The Ministry of Interior Act (2006) exempts asylum seekers from punishment for irregular border crossing and charges the Border Police with protecting and controlling national borders. The Foreigners Act (1998, amended in 2011) defines the conditions for entry, residence, and work of foreigners in Bulgaria. It specifies that persons who constitute a threat to public health may not be admitted to the country (art.10). Foreigners who are subject to removal are to be placed in special detention facilities for a maximum of 18 months. These are under the supervision of the Ministry of Interior (MoI), which also supervises the medical staff charged with performing the obligatory medical screening. The State Agency for Refugees (SAR) manages open centres where migrants can officially submit their asylum application as specified by the Asylum and Refugees Act (2002), and where an initial assessment of their health is done, following a standard medical form. Although the relevant EU directives have been adopted, certain parts of Bulgarian legislation still need to be harmonised with them while, crucially, implementation is often hindered by limited capacity, lack of resources and administrative barriers. On the other hand, certain proposed changes to the legal framework limiting the freedom of movement of asylum-seekers and UAMs would constitute violations of International Law.

A major deficiency in the legislation covering the reception process was the lack of protocols for the identification of vulnerable persons and performing age assessment tests for UAMs. The latter are entitled to health insurance, accessible medical care and free health care and mental health support (Asylum and Refugees Act art.29) as well as education and professional training (art.26) similar to all Bulgarian citizens. In line with the Health Act of 2005, asylum-seekers are also entitled to free and accessible health services. According to the Health Insurance Act, SAR is obligated to insure them by paying their contribution to the National Health Insurance Fund (NHIF). They may then receive their health insurance card, register with a medical general practice and...
access such medical care as is justified by their inclusion in the NHIF. The administrative procedure is quite long and poses practical problems in asylum seekers’ access to health care. Foreigners with long or short-term residence are expected to pay for medical care, either directly or through their insurance. The same applies to recognised refugees who, because of the lack of job opportunities, are often unable to pay the monthly insurance premium and are therefore excluded from health care other than basic emergency assistance. Undocumented migrants outside detention centres are also entitled only to free emergency care, while those inside are entitled to primary health care, preventive measures, rehabilitation, and hygienic services in support of overall physical and mental health, all provided by medical personnel from the MoI which are also responsible for the referral to specialized medical aid and/or hospital treatment6.

II. PARTNERSHIPS, NETWORKS AND MULTI-COUNTRY FRAMEWORKS

Figure 1:

Source: IOM Equi-Health project

The Border Police Units and Migration Directorate of the MoI manage migrant reception and processing. The Border Police transports people intercepted at the border to the First Reception Centre (FRC) in Elkhovo. After 3 to 5 days, asylum seekers are transferred to open reception centres run by the State Agency for Refugees (SAR) while other irregular migrants are transported to one of the two pre-removal detention centres (Busmatsi or Lyubimets). Once accommodated at SAR centers,

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asylum seekers should undergo a medical check-up. The health assessment is followed by an evaluation of the foreigner’s family situation by SAR interviewers, who decide on future accommodation possibilities. The FRC and closed centres are serviced by health professionals of the MoI, initially intended for the care of MoI personnel only, and not sufficient for the needs at hand. Although funding has been secured by the European Refuge Funds/Emergency Funds, MoI health staff and budget are stretched thin, as most of the EU funds went into the building, renovation of infrastructure and supplies, as well as the purchase of two ambulances for the needs of the open reception centres. On occasion migrants may also be referred to the emergency units of nearby hospitals, while Doctors without Borders (MSF) also greatly helped by covering the three then newly-opened reception centres in an intervention that was concluded in June 2014. The initial chaos due to the poor coordination of state agencies was brought under control thanks to the efforts of the SAR, BRC, UNHCR, and the Refugees Friends activist group.

III. MONITORING MIGRANT HEALTH

Initial deficiencies of the Bulgarian reception system were connected to the lack of appropriate facilities and staff. The lack of adequate health care provision was mitigated by the intervention of MSF (November 2013–April 2014), but following their departure the situation relapsed due to the lack of funding and personnel. The Bulgarian Red Cross (BRC) and other CSOs and volunteers currently support migrants with the provision of essential medicine or by providing links to the public health system, but this solution is neither sustainable nor efficient. The need persists to ensure a long-term sustainable provision of health care services, with well-defined roles and responsibilities of the different institutions involved in the reception process in Bulgaria, taking into consideration migrant, occupational, and public health needs. All the entities involved in the reception process maintain registries of services rendered and patients’ medical histories, but this data is rarely shared, aggregated, or analysed. The MoH does collect data on the epidemiological situation from the reception centres, monitors developments and provides recommendations. There is however no way to control the implementation of such recommendations and no medical data sharing system to monitor migrants’ health and provide information for timely follow-ups and treatment. A web-based system such as the E-PHR could prevent the duplication of efforts, medical tests, etc., increase the efficiency of medical staff, facilitate communication and medical information exchange, and improve the overall quality of health-care services for migrants, while guaranteeing the confidentiality of sensitive information.

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7 http://re-health.eea.iom.int/
Box 1: Promising practice

**MSF stepped in and established an emergency mission in Bulgaria from November 2013 until April 2014 in the newly opened centres in Sofia “Voenna rampa” and “Vrazhdebna”, and in the largest centre in Harmanli. The MSF team provided medical care to an average of 65-70 people daily in the beginning of their mission.**

MSF assisted migrants for registration with GPs and covered incurred medical expenses for hospital and/or any other specialized treatment incl. child birth, etc. They also covered medications as often these are covered partially or not at all by the standard medical package of insured people in Bulgaria.

Unfortunately, after the end of MSF’s emergency mission, these good examples were not continued. The organization officially handed over the facilities constructed by them to state authorities. Unfortunately, insufficient funding and/or lack of proper organization impeded proper continuation of the services. The medications supply relies solely on the Bulgarian Red Cross and campaigns occasionally organized via social media by the Refugees Friends Group.

IV. MIGRANT-SENSITIVE HEALTH SYSTEM

Bulgaria has a First Reception Centre (FRC) in Elkhovo with a capacity of 240 persons and two detention centres with a capacity of 700 persons both under the MoI, and six open reception centres managed by SAR. As of February 2015 SAR capacity should have reached 6,000; however, at the time of the field visit they were only 61% full. Despite the SAR having received €5.6 million from the European Refugee Fund to renovate facilities, buildings are deteriorating, while migrants reported problems with the availability of hot water and quality and quantity of food provided. Large families (with three or more children) stated they had not been provided with enough living space for their families’ needs. Law enforcement officers involved in the first reception process were overwhelmed and exhausted, while detention staff experience high level of stress and are worried about contracting a contagious disease. Vaccination programmes (e.g. for Hepatitis A and B) are limited, and those who wish to be vaccinated have to cover the expenses from their own meagre salary.

Neither SAR, nor the MoI have so far provided trainings on health topics and intercultural competences for employees, whose command of foreign languages is often limited. SAR is compelled to hire interpreters for the so-called “asylum interview” but translators, and even more cultural mediators, at the medical office are unknown. There are urgent needs for training at all levels - basic health knowledge for law enforcement officers and general staff, human rights and intercultural communication for all categories of employees, early identification of vulnerable groups and [basic] provision of psychological support prior to handing cases over to specialized NGOs.
UPDATE

The closing of the Balkan route had detrimental effects in Bulgaria too, altering migration routes and sending thousands more through the country. A monitoring visit during September 2016 found severely overcrowded detention centres working at 188% of their capacity and poor hygiene in the bathrooms and common areas, while the spaces designated for medical use were inappropriate, lacking in privacy and necessary equipment. Likewise, SAR capacity in Bulgaria has risen from 61% (February 2015) to 95% (September 2016) creating overcrowded conditions. The asylum seekers complain of food, medicine and hygienic supplies shortages, while the buildings and infrastructure are not maintained and hygiene is substandard. Management and residents blame each other for the condition of the infrastructure, while EU funds directed at fixing this problem are misspent because of the initial bad planning and low quality of original materials used. Access to health for both asylum seekers and detained migrants is very limited, with chronic shortages in health personnel and social support staff, including interpreters and mediators.

Some training activities on migration, human rights, vulnerable groups and intercultural competences did take place in 2015, organized by the MoI and international organizations; however, further training and psychosocial support of existing personnel and the recruitment of new specialised staff are urgently needed. Medical facilities should be established, well equipped and well staffed. Facilities in general need to be reconstructed as per international standards in order to remain functionable in the long run, while pest control has also emerged as an immediate necessity.

Chapter 2: Croatia

Given Croatia’s political stabilization and economic growth leading up to its accession to the European Union in July 2013, the country attracts increasing numbers of immigrants, especially from neighbouring countries (Bosnia and Herzegovina, former Yugoslav Republic of Macedonia, UNSC resolution 1244-administered Kosovo). Additionally, its close proximity to the Western Balkan migration route and its location at the periphery of the European Union bring with them a number of unique challenges with respect to migration policy.

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8 IOM Bulgaria monitoring visit to SAR and Mol centers, September 2016.
9 Information provided by a representative of the Bulgarian MoH during EQUI-HEALTH Regional Consultation co-organized by IOM and Hellenic Ministry of Health in March 2016, in Athens. Also, information provided during discussions with Mol staff and international organizations.
Table 4: Sites visited during the EH field research April 2014

<table>
<thead>
<tr>
<th>Type of site</th>
<th>Location</th>
</tr>
</thead>
<tbody>
<tr>
<td>Detention Centre for Foreigners administration</td>
<td>Zagreb</td>
</tr>
<tr>
<td>Reception Centre for Asylum Seekers in Zagreb</td>
<td>Zagreb</td>
</tr>
<tr>
<td>Institution for Education of Children and Juveniles</td>
<td>Zagreb</td>
</tr>
<tr>
<td>Bajakovo border crossing point (with Serbia)</td>
<td>Vinkovci</td>
</tr>
<tr>
<td>Vukovar river Border Crossing point (with Serbia):</td>
<td>Vinkovci</td>
</tr>
<tr>
<td>the HQ of Customs Directorate</td>
<td></td>
</tr>
<tr>
<td>Karasovići Border Crossing point (with Montenegro)</td>
<td>Dubrovnik</td>
</tr>
<tr>
<td>Port Gruž Authority in Dubrovnik</td>
<td>Dubrovnik</td>
</tr>
</tbody>
</table>

Source: IOM Equi-Health project

Graph 3: Interviews in Croatia – Total 41

I. POLICY AND LEGAL FRAMEWORK

The current Asylum Act (NN 79/07, 88/10, 143/13) regulates the principles, conditions, and procedures for asylum status application and approval. Migrants’ and asylum seekers’ rights to health are foreseen by the Law on compulsory health insurance and health care of foreigners (LCHIHF, NN 80/13). In accordance with it, migrant workers are to be insured by their employers, while the unemployed and self-employed are required to pay a monthly fee to the Croatian Health Insurance Fund (CHIF) in order to make use of the public health system. Asylum seekers now have the right to emergency care only, when previously they were also entitled to “necessary treatment of illness”. Emergency care is also available to the following categories of irregular migrants: Those in detention centres, those whose removal from Croatia is pending, and those before the deadline for voluntary departure. A large number of acts were passed prior to joining the EU in 2013 in order to align Croatian legislation to the EU Acquis, but this was not necessarily done in the best possible manner. Also, while great care is taken to ensure effective coordination among the various ministries
and agencies involved in migrant health, there is still need for more clearly defined procedures. For example, the Asylum Act specifies that “the required health care shall be granted based on individual assessment of the needs of vulnerable asylum-seekers” but not who and how it will be assessed whether one person belongs to a specific category. Also, the Minister of Health was obliged to issue Ordinances on Specific Health Needs (for vulnerable groups) and Medical Screenings but those were yet to be proclaimed at the time of the assessment. Mental health is another issue that is not properly addressed within the current legislative framework. Although there is mention of it in the context of asylum-seekers, there are other migrant groups, such as undocumented migrants and UAMs, who have comparable needs that are not addressed.12

II. PARTNERSHIPS, NETWORKS AND MULTI-COUNTRY FRAMEWORKS

Source: IOM Equi-Health project

National partnership networks among relevant actors in the migration management process are defined in an Integrated Border Management (IBM) framework, based on the Strategy for IBM and the Croatian government’s Action Plan. The strategy defines specific goals for improved interagency and international collaboration in the area of legal and regulatory frameworks (Ministries of Interior, Finance, Agriculture, and

Health). Most irregular entries into Croatia are recorded at the land border. Migrants are usually intercepted by border police or customs officers at border checkpoints or during patrol of the green border and during regular inspection of the vehicles by custom officers. Croatia has 26 bilateral readmission agreements signed with countries in the region and within the EU. Persons arriving from (or through) these countries are subject to return, and transported by police to the Detention Centre for Foreigners in Ježevo. At first reception, medical screening and assistance is provided by the public health system (MoH). The Croatian Red Cross (CRC) provides information on the location and working hours of health facilities. In addition to this, the CRC distributes hygiene items. If a migrant seeks asylum at the border, he/she is given a document confirming the intention to apply for asylum, and is directed to the reception centre for asylum-seekers (RCAS) in Zagreb. Once at the centre, they need to fill out an official application. Migrants recognized as being in a vulnerable situation are given transport, while the rest have 48 hours to reach the centre on their own. At the time of the visit of the RCAS, a doctor was present, albeit only for a few hours per day; emergencies were directed to the local hospitals for treatment. The Croatian Institute for Public Health (CIPH) is tasked with the provision of information on epidemic threats to the institutions working at the border and/or the centres accommodating migrants, as well as of collecting information on the health-care situation in Croatia. For the border police and other staff, such information is insufficient as it lacks practical instructions on how to apply certain measures or deal with specific situations. No epidemics were ever reported at the border region or linked to migrants but, despite that fact, there is a widespread misconception that migrants pose a public health risk.

Some resistance among local populations against the opening of reception centres in their communities was noted as they did not feel they had been consulted by the MoI on this and there was also some worry regarding possible health risks, resulting in the deterrence of plans to set up new RCAS in two cases, Trstenik and Stubička Slatina. The Croatian Strategic plan of 2014 contained provisions for the building of new transit centres and premises for the detention of irregular migrants, mostly near the Serbian border, to be completed by the end of 2015.

**Box 2: Promising practice**

| The Croatian Coast Guard is part of the Central Coordinating Committee for Surveillance and Protection of Croatian Interests and Rights at Sea, which is in turn considered a good practice of coordination of intergovernmental bodies. |

**III. MONITORING MIGRANT HEALTH**

Medical services in the Detention Centre of Jezevo were not available at the time of the assessment due to an expiration of the contract with the National Insurance Fund. As reported above, a doctor was available at the RCAS Zagreb but only for a few hours per day. Furthermore, migrants mentioned that the long process of awaiting decisions on their status severely affected their mental state. Psycho-social support is left to civil society organizations (CSOs) and volunteers. A Red Cross phone line for psychological
support in detention has been discontinued due to financial reasons, while some psychosocial activities organised by CSOs are only available to asylum-seekers, and not irregular migrants.

**Box 3: Promising practice**

| The CSOs’ initiative in providing such support on mental health for migration populations is a good practice but it needs to be stressed that they often lack resources to provide any kind of sustainable psychological provision. |

In terms of data collection on irregular migrants\(^{13}\), the Border Police is responsible for the collection of administrative data on persons subject to border control, persons that have been refused entry into or exit from the country, and those attempting to commit or committing criminal acts related to the safety of the state border.

The collection of health-related data in open and closed centres is regulated by existing health laws (ordinances); however the lack of medical staff at the borders and lack of or limited presence in facilities poses difficulties as to the medical screening of migrants, collection of health data and syndromic surveillance.

**IV. MIGRANTS-SENSITIVE HEALTH SYSTEM**

The reception system in Croatia is smaller in scale than Greece or Italy, as the migrant inflows are comparatively lower. Still, some reception conditions could be improved, such as housing sanitation, and food and social and health-care services. Asylum-seekers are entitled to emergency medical care, but at the time of the visit a doctor was employed at the RCAS only for two hours per day and a system of immediate referral was not in place. Dental care was also non-existent.

Integration activities are being provided to persons granted international protection status in Croatia, while asylum seekers receive some early integration activities predominantly from the non-Governmental sector. However, integration of persons granted international protection into the Croatian society is still lagging behind. For instance, they don’t systematically receive language courses in spite of two attempts to regulate this area. Some informal language classes have been delivered by NGOs/IOs to asylum seeking population.

Neither are they provided with housing or jobs after their release from the centres. Asylum seekers have the rights to reside in the RCAS until the completion of the sylum process unless they would like to use private accommodation. Following a period of nine months after the submission of the asylum application, they are allowed to work. Beneficiaries of international protection are entitled to a free-of-charge government provided accommodation for a period of two years. They may participate in the labour market as any other Coratian citizen. Local communities are sometimes suspicious of

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asylum seekers and refugees, and the need to properly educate the general public on migration issues has often been mentioned. Detention staff cited elevated job stress and fear of being infected by a contagious disease from the detainees. They also complained about the linguistic and cultural communication barriers and uncertainty over the legal processes. Border Police officers mentioned the lack of health safety equipment. The staff are in need of psychosocial support as well as training in intercultural communication, migration and public health, and health-protective measures. This will also have a spillover effect on migrants’ health and well-being.

Further interventions needed include the improvement of sanitation in the centres, including hygienic supplies and laundry service, appropriate food according to their age, religion and health condition, and leisure activities which can be organised in cooperation with CSOs. Detained migrants should be given opportunity to use their own electronic devices in order to stay in touch with their families.

**UPDATE**

During the period from April 2014, when the field work took place, and the completion of the SAR report, several changes took place in Croatia with respect to migrant health protection. Specifically, the MoH entered into four separate agreements to provide health services to migrants at the reception and detention centres. Outpatient clinics from the City of Zagreb, Zagreb County and Kutina provide the services of a general practitioner and emergency dental care, while a psychiatrist from the Dr. Ivan Barbot Neuropsychiatric Hospital provides psychosocial support to vulnerable asylum seekers in the Kutina reception centre. The initial duration of these agreements was one year, from 1 January to 31 December 2015

Furthermore, training of trainers and roll-out sessions on migrant, occupational and public health, as well as intercultural competence and communication skills were organized by IOM, in partnership with public health and safety at work specialists, as part of the EQUI-HEALTH project for health professionals, law enforcement officers, the CRC, the institution for UAMs and an NGO working with migrants in 2014. Trainings were co-funded by the Swiss Embassy in Croatia.

As regards the national legal framework, Croatia adopted a new Act on International and Temporary protection (Official Gazette, No. 70/15), replacing the above Asylum Act. The Act came into force on 2 July 2015 and specifies healthcare for three categories, including:

- Health care of applicants for international protection (asylum) seekers, including emergency medical assistance, and necessary treatment of illnesses and serious mental disorders. For those in need of special reception and/or procedural guarantees, especially victims of torture, rape or other serious forms of psychological, physical or sexual violence, such persons are to be provided with the appropriate health care related to their specific condition or the consequences of those offences;

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• Asylees and foreigners under subsidiary protection shall exercise the right to health care pursuant to the regulations governing health insurance and health care of foreigners in the Republic of Croatia; and
• Health care for foreigners under temporary protection includes emergency medical assistance and, for vulnerable groups, appropriate medical and other assistance.

The Act prescribes that the costs of providing health care in all three instances shall be paid from the State Budget of the Republic of Croatia, and fall under the responsibility of the ministry competent for health care.

However, the findings of SAR in terms of the initial medical examination of international protection seekers, their healthcare beyond emergency medical services, healthcare of persons granted international protection and the level of awareness of all system stakeholders as to the rights and duties of both healthcare providers and recipients persist.

In terms of improving the reception system, the Tovarnik Transit Centre was completed in August 2016. However, the centre is not yet operational due to human resource issues, since the employment ban for the Croatian civil service, introduced at the beginning of the global financial crisis in 2008/2009, is still in place. In October 2016 piloting of the IOM/EC Electronic personal health record (E-PHR) was initiated\(^\text{15}\) in Kutina and Jazevo.

**Chapter 3: Greece\(^\text{16}\)**

Because of its relatively underdeveloped economy, Greece received very few migrants until the end of the 1980s. This changed abruptly in the early 1990s, with extensive arrivals of irregular migrants from Eastern Europe and especially neighbouring Albania. Irregular migration to Greece increased rapidly in the late 2000s, to which the country responded with legal and administrative reforms circa 2011, including the opening of a number of detention centres. Lately the flows have escalated, with thousands of migrants (mostly from war-torn countries like Syria, Afghanistan and Iraq) attempting the short but dangerous sea crossing between Turkey and the Greek Aegean islands.

**Table 5: Sites visited during the EH field research (November 2013)**

<table>
<thead>
<tr>
<th>Type of site</th>
<th>Location</th>
</tr>
</thead>
<tbody>
<tr>
<td>Amygdaleza Pre-removal Detention Centre in Menidi</td>
<td>Athens</td>
</tr>
<tr>
<td>Sotiria hospital for chest diseases, TBC department</td>
<td>Athens</td>
</tr>
<tr>
<td>Children’s hospital Agia Sofia</td>
<td>Athens</td>
</tr>
<tr>
<td>Unaccompanied minors’ shelter of SMA, Exarchia</td>
<td>Athens</td>
</tr>
</tbody>
</table>

\(^{15}\) [http://re-health.eea.iom.int/](http://re-health.eea.iom.int/)
I. POLICY AND LEGAL FRAMEWORK


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transferred jurisdiction for the operation of a new Asylum Service (based on the development of First Reception Service, pre-removal/detention service, and specific measures for vulnerable migrants) from the MoI to the Ministry of Public Order and Citizen Protection (MPOCP). There are 5 Regional Asylum Offices (RAOs) situated in Attica/Athens, Komotini, Orestiada, Lesbos and Rodos, financed by the State Budget (€8.9 m) and EU funds (€1.5 m). Detention centres in Greece have been reported (by UNHCR, Council of Europe and others) as falling short of international and European standards, while the European Court of Human Rights ruled on many occasions that Greek centres were violated Article 3 of the European Convention on Human Rights (inhumane and degrading treatment). Furthermore, it was documented that irregular migrants were mixed in with criminal detainees in violation of article 31 of the Asylum Law and that detention may last for months in police holding cells and border guard stations designed for a maximum stay of 24 hours.

Greece’s health care system provides universal coverage for all insured persons, including legally residing migrants. Due to the financial crisis and sharp rise of unemployment, however, many of them, together with many Greek nationals, have lost their national health insurance and are now excluded from the health system, with the exception of a few NGO-run clinics in Athens. Public servants are prohibited by Law 4251/2014 from providing health care services to undocumented persons, except in cases of emergency and/or for minors. Asylum seekers have the same nominal rights of access as insured persons but are hindered by obstacles in accessing asylum procedures and the duration of their asylum seeker ID-cards (ranging from 45 days for Albanians and Pakistanis, to 6 months for Syrians). Health care services in FRCs and pre-removal/detention centres are under the responsibility of the MPOCP, and range from insufficient to non-existent.

The Asylum Law (art.11) and Presidential Decree 220/2007 (art. 17, 20) charge asylum authorities and local administrations with providing special treatment for asylum applicants belonging to vulnerable groups such as persons with disabilities, elderly persons, pregnant women, single parents with minor children and victims of torture, rape or other serious forms of psychological, physical or sexual violence. The latter are to be referred to a specialized units run by NGOs META-DRASI, GCR/BABEL joint action Prometheus, and MSF. Interviews with stakeholders, however, suggest that very few cases are dealt with properly, due to the scarcity of resources. Despite the establishment of an age assessment procedure in 2013, many children do not undergo the process and get treated as adults, either because they lie about their age or because they are registered as such. Recent protocols regarding age and vulnerability assessment, health screening models and other procedures, are often not carried through due to limited financial and/or human resources, making the proper implementation of national and European legal frameworks the biggest challenge of the new asylum and migration management system in Greece.
II. PARTNERSHIPS, NETWORKS AND MULTI-COUNTRY FRAMEWORKS

Figure 3:

Several national and local stakeholders are engaged in the reception process in Greece. The Hellenic Coast Guard and the Hellenic Police are the main actors at first reception, while the police are also responsible for the administrative procedure. Medical first aid is administered by local health authorities, NGOs, and/or volunteers, depending on their availability. Migrants are then transferred to the First Reception Centre (FRC), where health care is mainly provided by medical NGOs. Many of them are dependent on irregular donations or EU funding and have difficulty sustaining their operations. NGO respondents in FRCs have voiced their frustration in having to replace the Greek state in its duties, with such limited resources available. In the absence of medical staff, the law enforcement officers on duty often have to decide whether a migrant needs to be referred to a hospital for treatment. Transportation to hospitals or between centres is problematic due to limited funding and staff shortages. It is supposed to be carried out with a police vehicle, but on occasion private cars have been used. Neither driver nor escort are aware of any personal protective measures or protocols. The large inflows and lack of available places in the Greek reception system create accommodation problems, especially for vulnerable groups. Migrants out of FRC and/or detention centres have limited access to health care, especially if they are uninsured and/or undocumented, in which case they have to rely on a few NGO clinics, mainly located in Athens. Despite the scare campaign by certain media,
no infectious disease outbreaks have been recorded among the migrant population or in border areas. According to health personnel in those areas, it is not migration itself that poses a danger to public health, but the effects of the financial crisis which has resulted in a shortage of personnel and medical supplies.

Besides the lack of funding, which severely limits the functioning of all service providers involved, problems include the lack of proper coordination between authorities, as well as lack of a clear description of roles and responsibilities of each entity as to the registration of migrants. At initial reception, the burden falls mostly on the border police, who are ill-equipped to provide first aid assistance, as they have no relevant training.

III. MONITORING MIGRANT HEALTH

Upholding migrant health is challenging, given the increased number of unaccompanied minors, pregnant women, babies, elderly, and disabled migrants arriving by sea. The long trip and the trying migration conditions, even before embarking on the final transit of the Greek-Turkish sea border, have a significant impact on both the mental and physical health of migrants arriving in Greece. At arrival, migrants are checked by doctors from NGOs or the public health system for any urgent medical conditions needing immediate treatment. There is no systematic screening for infectious diseases at this point. Law 2745 – 29/10/2013 does specify a common procedure for medical screening, psychosocial diagnosis, support, and referral of undocumented migrants to be followed in FRCs, but its implementation is seriously lacking. The visiting team did not find any system of epidemiologic surveillance in any of the centres. At various facilities, medical staff collects data locally using a variety of templates, but this is not uploaded on any web-based database or constitute a comprehensive medical file that can follow the patient throughout the system or outside of it. Systematic screening in Greece is further obstructed by the lack of cooperation between public health and law enforcement authorities and the unclear distribution of relevant responsibilities among them.

Under the auspices of the Greek Presidency of the EU, the Hellenic Centre for Disease Control and Prevention (KEEPLNO) in collaboration with the European Centre for Disease Control (ECDC) hosted a technical expert workshop on “Public Health Benefits of Screening for Infectious Diseases among Newly Arrived Migrants to the EU/EEA” in Athens in March 2014, bringing together experts in the area of public health from EU member states, international organisations and the USA. Participants in the workshop strongly advocated evidence-based, non-discriminatory screening of new arrivals, which should not be restricted to infectious diseases and always be connected to a treatment option that will benefit the individual. It was stressed that there is insufficient evidence to settle into a definitive migrant-appropriate screening method.

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and there was a call for continuous evaluation of the existing programmes and sharing of information. The following year, in November 2015, the ECDC organized the first meeting of the advisory group for evidence-based guidance for the prevention of infectious diseases among newly arrived migrants in the EU/EEA.

Hospital staff reported difficulties obtaining accurate and timely medical information on migrants from NGOs and other previous care providers. They also indicated that all of the migrants’ health problems are referred to the hospitals when they could be more efficiently and economically treated by primary health-care providers. Unfortunately there isn’t any primary care service for migrants except from the fragmentary care provided by NGO’s in and outside centres. Lack of interpreters and health mediators further limits irregular migrants’ access to free health care, again with the exception of a few NGO clinics.

Box 4: Promising practice

| With five open polyclinics in Greece and presence in the detention and first reception centres, Medecins du Monde provides health care and psychosocial support. Their services include medical screening, information on HIV, hepatitis, pregnancy and vaccinations. |

IV. MIGRANTS-SENSITIVE HEALTH SYSTEM

Most of the detention centres visited had problems with heating and hot water, and detainees complained about the quantity and quality of food, lack of soap and other hygiene products, as well as insufficient clothing, shoes, and blankets. The previous situation of severe overcrowding had improved in most centres at the time of the visit, but living conditions were far from acceptable. Prolonged detention in unsuitable places such as police stations, and the lack of appropriate accommodation for children and families, constituted other serious problems. Health services are not regularly provided, as often there are neither medical practitioners present nor an immediate referral system. Dental services are unavailable, except in a few cases where there’s voluntary contribution from local dental associations.

Staff in both detention centres and public hospitals complained of elevated job stress, psychosomatic symptoms and burnout. Law enforcement officers were worried about sustaining injuries or contracting a contagious disease from detainees. Interviewees were unaware of any vaccination programmes for them (e.g. for Hepatitis B) despite the fact that FRC interlocutors and HCDCP claimed that such programmes exist and are available for free. NGO staff mostly voiced their disappointment by the overall situation and anxiety for the security of their jobs and sustainability of their work, which is largely dependable on irregular EU funding. None of those interviewed reported ever receiving specific training on migration health and/or intercultural


26
mediation, although FRC managers informed us they had trained their staff on intercultural issues and edited an educational booklet on the subject.

Psychological support is urgently needed, for migrants as well as the staff working with them. The HPs and LEOs working in this field are usually skilled professionals but feel the need for specialised training on topics such as intercultural competencies, foreign languages, first aid and protection from infectious diseases, migration and human rights, and working with vulnerable groups such as victims of human trafficking and unaccompanied minors.

**Box 5: Promising practice**

The PIKPA open centre in Lesvos was run by a consortium of volunteers and NGOs called The Village of All Together. After negotiations with the municipality, the group was granted permission to run a migrant reception centre at the disused PIKPA (Patriotic Institution of Social Protection and Restoration) camp. The area was leased for free by the municipality and the camp was run exclusively by volunteers. Lesvos’ civil society had thus created a strong alternative proven to work – an open reception centre for migrants in an environment which respects human life and dignity. Unfortunately, in April 2013 the project had to be discontinued due to lack of funding. Nevertheless, it remains a good practice to follow as an alternative to prison style detention of undocumented migrants.

**UPDATE**

Since the beginning of 2015, a number of positive steps were taken to improve the management of the migrant situation. These include the termination of detention centres in early 2015 and opening of the first temporary open hospitality centre (Elaionas) in Athens in August. In 2015 alone, 1 million migrants arrived in Europe through its sea border, more than 800,000 of them to Greece. For the registration of these migrants, “hot spots” were created on the Greek islands and northern mainland. Stay in these temporary centres would supposedly last for a maximum of 25 days, while medical screening was irregularly provided by NGOs such as MSF. In reality, at that stage migrants stayed even less, as they were very keen to continue their journey to Central and Western Europe through the so-called Balkan route. As borders along the route closed progressively late 2015 and early 2016, tens of thousands of migrants became stranded in Greece, a number that the country’s reception system was ill-equipped to handle. According to UNHCR, the number of migrants registered at these centres reached 62,580 in November 2016. Hot spots

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23 [https://missingmigrants.iom.int/mediterranean](https://missingmigrants.iom.int/mediterranean)


were converted into long-term facilities overnight and new ad-hoc centres (open and closed) were hastily established throughout the country\textsuperscript{26}.

The living conditions in the Hot Spots are reported as inhumane, lacking in infrastructure and safety precautions, causing a number of accidental deaths in recent months\textsuperscript{27}. The situation is swiftly deteriorating despite the efforts of state and CSOs, partly because of the haphazard way these centres were put up and partly because of the perennial budget deficits due to the country’s enforced austerity policy. The worsening of living standards and deepening of desperation among migrants as regards reaching their final destination has led to violence inside and around the centres, including riots and the destruction of infrastructure\textsuperscript{28}, thus reversing the public’s stance from one of sympathy and solidarity to hostility and fear. For example, in a few cases parents have attempted to block migrant children’s access to public schools, citing public health and security reasons\textsuperscript{29}. Furthermore, the failure of “traditional” parties to both tackle the financial crisis and manage migrant accommodation has led to far-right “activists” posing as concerned citizens taking unhindered aggressive action against refugee camps\textsuperscript{30}.

On a positive note, there have been some constructive legal and administrative reforms: the Greek MoH has set up an Operational Working Group on Migration and Health chaired by the Hellenic Ministry of Health with the participation of local authorities, CSOs and international organizations, while a joint decision of the MoH and deputy minister for migration policy has aligned Greek procedures for the age assessment of UAM asylum seekers to European Directives. Regarding access to health care, Law 4368/2016 was enacted in February 2016, with the aim of providing universal health care coverage, free access to the Public Health System and easier access to medical care, treatment and hospitalization. It expands the categories of migrants who have access to health care, improving access for uninsured individuals and their family members, pregnant women, chronically ill, disabled persons, minors and other vulnerable groups. Unfortunately, in the context of the Greek financial crisis such provisions are quickly rendered irrelevant. The overburdened public health system is on the verge of collapse due to severe cutbacks, and is unable to deliver the services specified by the law. Migrants, who are facing additional obstacles to access (for e.g. lack of information, communication problems), are therefore practically excluded from even basic health provisions.

Furthermore, in 2015 and 2016, IOM organized training of trainers and roll-out sessions on migrantion and health, occupational health and intercultural competence, in partnership with the Department of Sociology at the National School of Public Health (NSPH), for health professionals and law enforcement officers working with

\textsuperscript{26} https://www.law.ox.ac.uk/research-subject-groups/centre-criminology/centreborder-criminologies/blog/2016/05/continuum
\textsuperscript{27} http://www.independent.co.uk/news/world/europe/refugee-crisis-woman-child-boy-killed-moria-camp-lesbos-centre-greek-island-cooking-gas-a7438171.html
\textsuperscript{28} https://www.hrw.org/news/2016/09/21/greece-refugee-camp-destroyed-fire
\textsuperscript{29} https://uk.news.yahoo.com/greek-police-escort-refugee-children-school-145215260.html
\textsuperscript{30} http://www.independent.co.uk/news/world/europe/refugee-crisis-latest-greek-islands-chios-camp-attack-far-right-firebombed-molotov-cocktails-rocks-a7425386.html
migrants and refugees in Athens, Thessaloniki, and on the Greek islands of Lesbos, Chios, Kos, Samos and Leros. Trainers included representatives from the NSPH, KEELPNO, MSF, and the NGO Almasar, a psychologist from the Greek Unit for the Psychological Health of Migrants (BABEL), a psychologist from the NGO Merimna and a member of IOM MHD RO Brussels.

An ambitious relocation program of asylum seekers from Greece and Italy to other EU MS has been put into action by the European Commission. Following the Commission proposal, the Council of Europe adopted decisions 1523/2015 and 1601/2015, which call for the relocation of 160,000 asylum seekers from Greece, Italy and other EU MS under particular migratory pressure to different EU MS by September 2017. As regards Greece, it is planned to relocate 66,400 asylum seekers. Until the end of 2016, however, only 6,212 persons had been relocated from Greece to other EU MS. The EC decision on relocation is facing fierce political opposition, with many MS displaying unwillingness or outspoken defiance to comply.

At the end of 2016 piloting of the IOM/EC Electronic personal health record (E-PHR) was initiated as additional surveillance related initiatives by the national health authorities.

Chapter 4: Italy

The number of irregular entries at sea varies greatly depending on both the presence of humanitarian crises and the existence of bilateral agreements. Between 2012 and 2013, there was a great surge in the arrival of migrants on the Italian coastline, including many unaccompanied minors (UAM). In the first nine months of 2013, Italy had already received 18,780 asylum applications, more than the number of requests for all of 2012 (Protection System for Asylum Seekers and Refugees - SPRAR, 2013).

Table 6: Sites Visited during the EH field work (September 2013)

<table>
<thead>
<tr>
<th>Type of site</th>
<th>Location</th>
</tr>
</thead>
<tbody>
<tr>
<td>CIE, Identification and Expulsion Centres (Centri di Identificazione ed espulsione)</td>
<td>Caltanisseta</td>
</tr>
<tr>
<td>CDA Reception Centre (Centro di accoglienza) /CARA Reception for Asylum Seekers (Centri di Accoglienza per R. Asilo)</td>
<td>Caltanisseta</td>
</tr>
<tr>
<td>S. Elia Hospital</td>
<td>Caltanisseta</td>
</tr>
<tr>
<td>CARA Mineo</td>
<td>Catania</td>
</tr>
</tbody>
</table>

32 https://ec.europa.eu/home-affairs/what-we-do/policies/european-agenda-migration/background-information_en
33 http://re-health.eea.iom.int/
I. POLICY AND LEGAL FRAMEWORK

Italy recognizes the right of asylum in the Constitution (art. 10), but does not have a comprehensive law on the subject, and refers mainly to European legislation, especially the Reception Conditions Directive 2003/9/EC (new 2013/33/EU), laying down the minimum standards for the reception of applicants for international protection, the Qualification Directive 2011/95/EU and Asylum Procedures Directive 2005/85/EC (new 2013/32/EU) and the Dublin Regulation, which significantly affects the lives of asylum seekers. During the field visit, it was observed that many of the persons having arrived since the beginning of 2013 (especially Syrians) refuse to be voluntarily identified in Italy in order to avoid the effect of the Dublin system and continue to other European countries where they have friends or relatives, and/or where they perceive better conditions for asylum seekers than those in Italy. The Dublin Regulation thus exacerbates vulnerabilities by creating a situation in which persons with valid asylum potential choose not to lodge their claims but rather continue their journey undocumented, thus running a high risk of exploitation.

The reception system consists of First aid and reception centres (CSPA), Reception centres (CDA), Reception centres for asylum seekers (CARA), Secondary reception centres (SPRAR)\(^{36}\) and Identification and expulsion centres (CIE). Imprisoned migrant offenders are sent to the CIEs after serving their sentence, adding more months to their internment. Some facilities fulfil double functions (e.g. CPSA/CIE in Pozzallo), making it difficult to assess whether all provisions of the law are followed for each category of resident. Temporary ad hoc centres can be activated by local authorities (Prefettura) under the so-called “Apulia law” if needed. The lack of regulations regarding the management of such centres results in very low living standards and provision of services, while their number, capacity and characteristics are unknown, even to officials.

The Consolidated Immigration Act, (l.94/2009, Art.34 and 35) regulates migrants’ access to health care. Regular migrants and asylum seekers can register in the National Health System (SSN) and access all its services, while irregular migrants are entitled to urgent and essential treatment as well as preventive services necessary for the public health. Because of the decentralised Italian health system, implementation of this law (and access to health care) varies according to region and provider. Access is further curtailed by the lack of knowledge on migrants’ health rights on the part of both migrants and staff, as well as the extensive length of stay which forces asylum seekers to renew their health cards two or three times in order to gain access to the SSN. Migrants in detention/reception centres are assigned a code (STP) that allows access to primary health and prevention services. Because of the unavailability of places, unaccompanied minors (UAM) often remain in CPSA or in ad hoc centres for a long time without adequate protection and access to health care. Italian legislation on UAM is generally deemed insufficient as it is designed for Italian nationals and does not take into account the specific needs of UAM migrants.

II. PARTNERSHIPS, NETWORKS AND MULTI-COUNTRY FRAMEWORKS

A broad range of partners are involved with migration management in Italy, making the co-ordination of their actions somewhat of a challenge. The MoI (Department for Civil Liberties and Immigration) is responsible for civil rights protection, immigration and asylum procedures; the Ministry of Foreign Affairs (Office for Migration and Asylum Policies) is responsible for the development of the relevant bilateral agreements and transposition of EU asylum law; the Ministry of Labour and Social Policies (General Directorate of Immigration and Integration Policies) is responsible for the protection of unaccompanied minors and integration of third country nationals into the labour force. Rescue operations at sea include stakeholders from the Ministries of Interior, Transport, and Defence. These are well regulated and coordinated by the Capitaneria di Porto, while the disembarkation phase is coordinated by the Prefettura (MoI) and involves law enforcement agencies, the Protezione Civile (Presidency of the Council of Ministers) and representatives of international organizations (IOM, UNHCR) and NGOs.

\(^{36}\) Protection System for Asylum-Seekers and Refugee
Medical first aid and screening at official points of entry is provided by ASP (hospitals), NGOs (Red Cross), and USMAF (Office of Maritime and Border Health, MoH) whose timely intervention, on occasion with doctors aboard rescue vessels, has often proven crucial. USMAF is also charged with informing the local authorities on possible public health risks on arrival. Although in some cases ad hoc protocols have been developed through practice, the lack of standardized operational procedures for rescue at sea has become apparent, resulting in confusion and waste of resources. Transportation to the centres is also problematic. Typically this should be provided by the MoI and/or the management of the centres but, on occasion, private cars have been used, out of necessity, without regard as to safety precautions, while on other occasions migrants have slipped through the system before they could be properly identified. Daily syndromic surveillance reports are filled out in official reception centres and any outbreaks have been quickly and efficiently dealt with by using mostly preventive measures. The field visit noted various degrees of integration of the public health care system in the different phases of the reception process, from continuity or full coverage of services in the centres (i.e. Pozzallo), to integration or partial coverage by the public health system and the rest of the services provided by a private entity (i.e. Mineo), to detachment or referral to hospitals in case of emergency (i.e. Caltanissetta).

A lack of available places in the reception system results in the creation of informal settlements on the outskirts of cities. Another problem is that centres are usually clustered near entry points, resulting in an uneven distribution of migrants across the
country which hinders their integration and diminishes their chances to enter the labour force.

Box 6: Promising practice

| The municipality of Pozzallo has created an internal department dedicated to migrants that arrive at the CPSA, especially for the situations of the unaccompanied minors. Two social operators work in this service. From the health and social assistance, the CPSA Pozzallo is therefore a good example of how the existing public services may be capitalized for welcoming migrants. |

III. MONITORING MIGRANT HEALTH

On arrival, migrants are often exhausted, dehydrated, severely sunburnt and suffering from various skin abrasions. Their overall health condition, however, is generally good. The assessment has shown that it is their long stay in the centres that causes their physical and mental health to deteriorate. Centres are overcrowded and understaffed, while services are tailored for shorter periods of stay. Urgent and basic medical assistance is provided, but mental health is inadequately addressed throughout the reception procedure. The health personnel is usually insufficient and the lack of cultural mediators exacerbates migrants’ perceived feeling of health professionals’ indifference for their personal/health situation, often a subject of their complaints.

The monitoring of migrants’ health data is impeded by the absence of standardized forms and procedures and the haphazard way of health data collection when this is done at all. Data collection does not include the large number of migrants living in ad hoc centres, while migrants transferred from prison or discharged from the CIE are not provided their medical files. The only regular health data collection consists of syndromic surveillance (as per MoH guidelines) and USMAF’s report after every disembarkation event with information from the initial health screening. Health professionals have repeatedly stressed the need for a standardised health-related discharge document and for an integrated data collection system that will guarantee continuity of care within and outside the reception system. The assessment also pointed out the need for better inter-institutional coordination and common Standard Operating Procedures, as well as for an improved information flow between health and other sectors, including the media.

IV. MIGRANT-SENSITIVE HEALTH SYSTEM

Conditions in the centres are suboptimal because of the excessive length of stay and overcrowding due to the unavailability of reception places and their uneven (national) distribution. Centres designed to host migrants for a few hours (CPSA) or up to 35 days (CARA) end up having to accommodate them for much longer – one or two years in the case of CARA. The length of stay at CIE was likewise extended by a 2011

amendment to the Consolidated Immigration Act, from 180 days (L.94/2009) to 18 months. The extension of stay leads to deteriorating living conditions and psychological distress, and to an increased demand for health services which the centres are not equipped to handle.

Although migrants’ access to health care is guaranteed by law, this is severely limited by the shortage and skill mix of health and support staff in the centres. Irregular migrants residing outside are also hindered by the lack of information, particularly regarding women’s health issues and child-care. Communication problems between migrants and staff arise from the difficulty in understanding the migrants’ language, even when they speak English, as well as from culturally divergent perceptions and expectations from health care. Cultural mediators could help with this problem but they are not readily available and not integrated in the health system. An interesting solution adopted in CARA Mineo was to elect representatives from various nationalities to act as intermediaries between the staff and migrants.

HPs admit to having communication problem, not only because of the language but also because of their difficulty to read correctly the signs, symptoms or perceptions of illnesses in their foreign patients, especially concerning mental health, which is why they ask the support of interpreters and cultural mediators as well as to be trained in a transcultural approach to health. Some LEOs have had training on first aid and occupational health, but not on migrant-related topics. Many of them expressed the need for further training related to health protection as well as inter-cultural competences.

**Box 7: Promising practice**

| At the SPRAR, living conditions of migrants are of higher quality: this is especially due to the number of residents (usually up to 20 or between 20 and 100), the assistance provided and the limited permanence in the centre (maximum six months). Vocational trainings provided by the centre in coordination with other local entities are particularly important for the well-being of the migrants and their future inclusion in the territory. A good practice detected is weekly meeting between the staff of the centre and the migrants with the assistance of a cultural mediator, to share any potential problems encountered during the week. |

**UPDATE**

Since the field research, steps have been taken to strengthen the legal framework on health rights and access to health assistance with the adoption of law 142/2015, which obliges asylum seekers to register with the National Health System (SSN). Action towards developing national guidelines for managing migrant health at arrival and standardizing procedures of health care provision is under way by the National Institute for Health, Migration and Poverty (NIHMP), in collaboration with the Regional network for migrants’ health, while a Sicily contingency plan as a response
to a potential surge of health care needs is under development with the support of WHO PHAME project.38

Trainings and roll-out training sessions for health professionals were organized in Italy between 2014 and 2016 as part of the Equi-Health project by IOM in partnership with the training institution Centro per la formazione permanente e l’aggiornamento del personale del servizio sanitario (CEFPAS) and the Italian Society of Migration Medicine (SIMM), with co-funding by the Italian MoH. The training units were focused on the legal framework of the right to health, psychosocial health and working with vulnerable groups, caring for individual and staff health, as well as intercultural competence and cross-cultural communication. The trainings are recognized with Continuing Medical Education (CME) credits.

Regarding the EU relocation program from Italy to other EU MS, Council decisions 1523/2015 and 1601/201539 call for the relocation of a total 39,600 asylum seekers from Italy by September 2017. In the two years of implementation, the results were very poor, with only 1,950 relocations taking place until December 201640.

At the end of 2016 piloting of the IOM/EC Electronic personal health record (E-PHR) was initiated41 as well as additional surveillance related initiatives by the national health authorities.

Chapter 5: Malta42

Malta has seen an increase in arrivals of irregular migrants onto its territory during the last decade, with numbers surging in 2014, much like in Italy, Spain, and Greece. Most new arrivals originate from sub-Saharan Africa and Syria. Malta has the highest number of asylum seekers per 100 inhabitants among the major destination countries and, given its small size and population, tackling irregular migration has become one of the country’s top policy priorities. In addition to the continuing influx of migrants from Africa, Malta has to manage an additional number of asylum seekers who are returned there by other EU member states in compliance with the Dublin Regulation.

Table 7: Sites visited during the EH field research (November 2013)

<table>
<thead>
<tr>
<th>Type of site</th>
<th>Location</th>
</tr>
</thead>
<tbody>
<tr>
<td>Marsa open centre</td>
<td>Marsa</td>
</tr>
<tr>
<td>Hangar open Centre</td>
<td>Hal-Far</td>
</tr>
</tbody>
</table>

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38 Information provided by a representative of the Italian MoH during Equi-Health Regional Consultation co-organized by IOM and Hellenic Ministry of Health in March 2016, in Athens.
40 https://ec.europa.eu/home-affairs/what-we-do/policies/european-agenda-migration/background-information_en
41 http://re-health.eea.iom.int/
I. POLICY AND LEGAL FRAMEWORK

The two main legislative acts forming the basis of the asylum system in Malta are the Immigration Act, Chapter 217 (1970) and the Refugees Act (2000). In order to transpose EU asylum directives, these have been amended and augmented by subsidiary legislations several times. A non-legally binding policy document from 2005 (MJHA and MFSS, 2005a) indicates various entitlements and services for migrants, but its implementation relies on the discretion of officials. Furthermore, in 2011, Malta transposed the EU Return Directive, which limits the scope of services provided to irregular migrants. Asylum claims are processed by the Office of the Refugee Commissioner, while the Agency for the Welfare of Asylum Seekers (AWAS) is concerned with the welfare of migrants in both open and detention centres as well as with the identification of persons in vulnerable situations. Despite the official policy that vulnerable individuals are not to be detained, almost everyone passes through...

detention, where there is an initial screening for vulnerabilities, including age. Age assessment in Malta is advanced but time-consuming, using a psychosocial approach in addition to the usual x-ray tests. People with psychological problems and victims of torture are not so readily recognised and often spend a lot of time in detention. While many physicians and NGO staff notice signs of torture or other vulnerabilities, they are not charged with the specific role of assessing these or reporting them to AWAS.

Article 13(2) of the Refugees Act grants refugees and asylum seekers access to health care services provided by the state, although those with enough resources and/or a job may be asked to contribute to the costs. There are no legal regulations granting access to health care for irregular migrants, whose entitlements are unclear as the 2005 policy document setting them out isn’t legally binding, as mentioned above.

Overall neither service providers nor migrants are well informed about health care entitlements and provisions available for migrants.

II. PARTNERSHIPS, NETWORKS AND MULTI-COUNTRY FRAMEWORKS

Figure 5:

Source: IOM Equi-Health project

Note: In 2016, the policy for automatically detaining migrants was modified. They are now accommodated in Immediate Reception Centres where they are held for seven days. In certain cases, the police may detain certain individuals after the initial interview.

The reception process usually starts when a boat carrying migrants is intercepted and rescued at sea by the navy of the Armed Forces of Malta (AFM). The crew members
engaged in the rescue operations are trained in first aid, but there are no dedicated medical personnel on board the vessels. Migrants are then brought to the military port at Hay Wharf, and processed by Immigration Police. Ministry of Health (MoH) personnel are present to administer basic health services, perform an initial screening for possible infectious diseases and arrange for the transfer of emergencies to the hospital. The main problem at this stage as reported by medical personnel and migrants is a lack of privacy during examination. From the port they are transferred to detention centres run by the AFM, where they can apply for asylum and where they remain for a period of up to 18 months. Effort is made to identify people in vulnerable situations and speed up the procedure for them. Medical assistance in these centres is outsourced to private entities, financed and supervised by the Ministry for Home Affairs and National Security (MHAS). Further assistance (including legal help and activities such as language lessons) is provided by NGOs and AWAS. Migrants released from detention may stay for a year in open centres, managed or supervised by AWAS. These do not have health personnel, meaning that migrants in need of medical assistance have to visit primary health centres or emergency departments.

According to NGO representatives, there is a general lack of information: those who should provide a service do not know the entitlements of different categories of migrants, staff of the centres or NGOs do not know to whom to refer migrants for specific services; and the migrants are not given clear information and, as a result, do not understand the procedure. The responsibilities of the actors involved in the reception of migrants (MHAS, private entities, public health system, AWAS, NGOs) are not clearly defined and coordination of activities needs to be improved. NGOs often provide essential services, but the sustainability of those is in danger due to the complicated procedures in acquiring EU funding and weak coordination between NGOs and governmental institutions.

III. MONITORING MIGRANT HEALTH

Although generally speaking health issues reported by the migrants were similar to those experienced by the Maltese population, the assessment team noticed a deterioration of the physical and mental health of migrants during the reception process. Open centres are often afflicted by unhygienic conditions and there are no proactive measures to screen for diseases or health prevention measures. Migrants are supposed to address their health problems to the public health system, but this is difficult because of the lack of transport and the insufficient number of cultural mediators working in the health system. Social workers from AWAS are charged with assessing mental health problems in the open centres and referring to the relevant hospitals, but language and cultural barriers may impede the timely discovery and treatment of such issues.

Medical services at detention centres are provided by a doctor and a nurse from a private medical provider. In the case when treatment outside of the centres is required, migrants reported that it might take some time before they were transported to the hospitals by centre personnel. The assessment team identified a major gap as regards mental health support as there are no formal measures
established to provide psychological support for migrants in detention centres. Volunteers from NGOs often try to provide support; however this not enough to satisfy all identified needs. If a detainee requires psychological help, the doctor will usually refer him/her to a hospital. Health professionals also stressed the need for a pharmacy in detention centres as the delivery of medicine to patients can sometimes take a couple of days.

Regarding the collection of health data, an initial screening is done at disembarkation for emergency cases, and dermatological or infectious diseases. At the detention centres migrants are screened for active tuberculosis and vaccinated. When leaving detention, they are usually accompanied by some kind of health records, in contrast to those who reside in open centres. Unfortunately, the use of different ID numbers by immigration and health authorities results in a fragmentation of data and the use of multiple and incompatible health records. Additionally, flow of information during movement from detention to open centres may be disrupted due to the lack of health personnel in the open centres and passage from private health care providers to the public health system.

IV. MIGRANT-SENSITIVE HEALTH SYSTEM

Both detention and open centres are understaffed and offer suboptimal living conditions. While the infrastructure and the physical conditions at Mater Dei Hospital and Floriana Health Centre were deemed to be satisfactory, the Asylum Seekers Unit at the Mount Carmel Hospital mental health services was also deemed inappropriate in terms of physical conditions and social activities. Migrants’ entitlements to health care vary according to their legal status, and regulations are unclear and confusing for both migrants and service providers, thus limiting their access to services they are entitled to. Other obstacles include difficulties regarding transport, lack of trust for doctors and perceived discrimination practices, as well the serious shortage of interpreters and cultural mediators. Acquaintances from the migrant community are used as unofficial interpreters, raising serious concerns regarding the accuracy of translation and confidentiality of sensitive information. Due to fear of being stigmatised or mistreated, migrants sometimes withhold information from doctors, who also face problems with certain tropical diseases they are unfamiliar with. Staff working in open centres feel overburdened and detention staff complain they find it difficult to carry out tasks for which they have not been sufficiently trained, especially those having to do with care provision to detainees. All staff expressed the need for cultural awareness training and health personnel underlined the need for training on communicable diseases common among migrants. Most of the state employees reported receiving psychological support, though this is lacking in certain institutions and should be prioritized.

UPDATE

Since the assessment, a number of actions have been undertaken, focusing on capacity building and awareness raising, including within the framework of the Equi-Health project. These consist of a training program for cultural mediators in health care (delivered by the Migrant Health Liaison Office of the MoH), training for health and social care professionals on issues like migration, cultural competence, female genital mutilation, cultural mediation and human trafficking, and health workshop sessions at the Islamic School. The training is aimed at sensitizing health professionals about cultural diversity and the situation of migrants. Evaluation reports of these training/workshops sessions illustrate that doctors, nurses, and other health professionals are becoming more aware about different cultures and cultural practices in health.45

Box 8: Promising practice

Since the beginning of the relocation program of asylum seekers from Italy and Greece who started to arrive in Malta in March 2016, the Migrant Health Liaison Office has been delivering a Health Orientation programme within the first weeks of arrival. The aim of this program is to orientate the asylum seekers on how to navigate the Maltese Health System: where the hospitals and health centres are located, what documents are needed, the importance of attending all health appointments, attending on time, how to postpone an appointment, and the importance of vaccinations. Moreover, migrants are informed on how to keep healthy, how to avoid accidents and how to avoid transmission of infectious diseases. This program is delivered with the assistance of cultural mediators working in Primary Health Care.

In 2016, the automatic detention policy of migrants at first arrival was modified. Two Initial Reception Centres (IRCs) have been opened and are run by AWAS. One of the IRCs is located in Halfar (previously this was an open centre for families) and the other is in Marsa. Newly arrived migrants are accommodated, medically screened and processed in these centres for 7 days; medical clearance needs to be established.46 They are also informed of their right to apply for international protection, and are screened for vulnerability. Migrants may be detained longer if they fulfil the criteria set out in the Reception Conditions Directive or if they have been issued a return decision. Vulnerable migrants may not be detained.47

45 Information provided by a representative of the Migrant Health Liaison Office.
46 Ibid.
Chapter 6: Spain

In the last few decades, Spain has become a destination country for immigrants, with foreign nationals comprising 10.45% of the population in 2013. At the same time, the recent financial crisis has created an outward wave, causing a negative migratory balance of -256,849 persons for 2013.

Table 8: Sites visited during the EH field research (November 2013)

<table>
<thead>
<tr>
<th>Type of site</th>
<th>Location</th>
</tr>
</thead>
<tbody>
<tr>
<td>CETI, Centre for the Temporary Stay of Migrants, Melilla</td>
<td>Melilla</td>
</tr>
<tr>
<td>Reception Centre managed by Red Cross, Algeciras</td>
<td>Andalusia</td>
</tr>
<tr>
<td>Reception Centre managed by Red Cross, Canillas</td>
<td>Madrid</td>
</tr>
<tr>
<td>Refugee Reception Centre (CAR), Vallecas</td>
<td>Madrid</td>
</tr>
<tr>
<td>Refugee Reception Centre (CAR), Sevilla</td>
<td>Andalusia</td>
</tr>
<tr>
<td>Refugee Reception Centre (CAR), Valencia</td>
<td>Valencia</td>
</tr>
<tr>
<td>Migrant Detention Centre (CIE), Algeciras (with an additional facility) in Tarifa</td>
<td>Andalusia</td>
</tr>
<tr>
<td>CIE, Migrant Detention Centre, Aluche</td>
<td>Madrid</td>
</tr>
<tr>
<td>Hospital of Melilla</td>
<td>Melilla</td>
</tr>
<tr>
<td>Punta Europa Hospital, Algeciras</td>
<td>Andalusia</td>
</tr>
<tr>
<td>Ramón y Cajal Hospital, Madrid</td>
<td>Madrid</td>
</tr>
<tr>
<td>Guardia Civil Headquarter, Huelva</td>
<td>Andalusia</td>
</tr>
<tr>
<td>Guardia Civil Headquarter, Algeciras</td>
<td>Andalusia</td>
</tr>
<tr>
<td>Guardia Civil Headquarter, Melilla</td>
<td>Melilla</td>
</tr>
<tr>
<td>Guardia Civil Headquarter, Ceuta</td>
<td>Ceuta</td>
</tr>
<tr>
<td>Port of Tarifa</td>
<td>Andalusia</td>
</tr>
<tr>
<td>Port of Algeciras</td>
<td>Andalusia</td>
</tr>
<tr>
<td>Port of Melilla</td>
<td>Melilla</td>
</tr>
<tr>
<td>Border crossing points in Melilla – including the fence</td>
<td>Melilla</td>
</tr>
</tbody>
</table>

Source: IOM Equi-Health project

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I. POLICY AND LEGAL FRAMEWORK

Residence entitlements and deportation norms for migrants are regulated by the Foreigners Act, or Organic Law (LO) 4/2000, modified several times over the last decade, including by LO 2/2009 and Royal Decree-Law 16/2012, to keep pace with the increase in migrant flows and to align national with EU legislation, especially the Dublin Regulation. Foreigners who are denied entry at the borders must return to their place of origin. If their return is delayed longer than 72 hours, a judge must determine the type of detention centre where they must remain until they leave the country. Foreigners who do not comply with the established requirements for entry into Spain and/or those who enter the country irregularly can be transferred to different centres, in accordance with the judge’s decision: those who are to be removed from Spain are sent to Migrant Detention Centres (CIEs), while asylum-seeker or refugees without resources are sent to Refugee Assistance Centres (CARs). Migrants about whom a judicial decision has not been made are sent to interim reception centres (CETIs – Centres for Temporary Residence, or centres managed by CSOs).

Until fairly recently, access to and provision of health care in Spain was free and universal. However, in April 2012, Royal Decree-Law (RDL) 16/2012 was adopted by the Spanish government, limiting access to the National Health System (SNS) to legal residents, those who are insured and other categories officially labelled as “beneficiaries.” Legally residing migrants are covered by the same system as nationals. If they are neither insured, nor beneficiaries of the Social Security System, undocumented migrants residing outside of centres can only access health services if they pay for them. Exceptions include emergency, maternity and child care, and assistance to victims of human trafficking. As emergency services do not offer

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treatments or follow-ups, however, such restrictions pose a danger to both the patient and the public health system. The application of RDL 16/2012 varies between the different autonomous regions due to the decentralized nature of the Spanish health care system: while the Andalusian PHS continues to uphold the universal coverage model, the autonomous regions of Ceuta and Melilla apply the restrictions introduced by this law, without exception. Despite the fact that LO 4/2000 modified by LO 2/2009 states that undocumented migrants residing in closed centres are entitled to health care and social assistance, the absence of healthcare cards poses an administrative obstacle when patients are transferred to hospitals. On the bright side, some good practices were identified: CSO platforms (e.g. “Somos Migrantes”) to inform migrants about their rights; the (now discontinued due to lack of funds) project “Migrant-Friendly Hospitals” in Punta Europa Hospital (Algeciras); and culturally sensitive reproductive health clinics in Andalusia and Catalonia.

II. PARTNERSHIPS, NETWORKS AND MULTI-COUNTRY FRAMEWORKS

Figure 6:

Source: IOM Equi-Health project

Irregular migrants attempting to reach Spain by land enter the border city of Melilla through the pedestrian border crossing Barrio Chino or Beni Enzar border checkpoints
or by jumping the border fences separating Melilla from Morocco\textsuperscript{51}. Entry by sea takes place in Melilla and Algeciras-Tarifa, where a clearly defined intervention protocol guides the actions of all actors involved (e.g. Maritime Rescue, Guardia Civil, etc). At this point, medical first aid is provided by the Spanish Red Cross and NGOs, while medical emergencies are referred to local hospitals. Migrants are transferred to the nearest Policía Nacional station and from there to different centres, depending on their administrative status. Irregular migrants whose deportation is hindered and failed asylum applicants are "freed" and abandoned to join the population of undocumented people.

The coordination of all stakeholders in the migrant reception process can be improved, with a deeper involvement of the Public Health System and upgrade of the role of the Maritime Rescue Service during sea rescue efforts. It may help to organise regular coordination meetings, establish common procedures, share resources, etc. Building networks and partnerships with the countries of origin in order to combat smuggling activities and organized crime is of equal importance.

III. MONITORING MIGRANT HEALTH

Migrants in receiving zones such as Melilla and Algeciras have had to climb over border fences or endure long and perilous sea journeys, and thus often present dire health and physical conditions upon arrival. Their health can be further negatively affected in reception and detention centres, especially in CIEs.

Migrants arriving in CETIs, undergo a compulsory set of tests known as “African Profile”, which includes a haemogram test and also screens for Hepatitis B/C, HIV, and Tuberculosis (TB). HIV testing in CETIs is free of charge and conducted on a voluntary basis.

Information transfer between centres, non-profit organizations and institutions is neither systematised nor always fluid - for example, migrants transferred from CETIs to CIEs are given a copy of their medical record instead of it being officially exchanged between centres. A welcome exception to this rule is the SIRIA system for the collection, management and transfer of data. Health-related data collection systems differ in the various regions, stressing the need to develop protocols adapted to the general mobility of migrants in order to facilitate the continuity and tracking of treatments as well as Health/Social care providers’ (HSPs’) access to medical records in case of transfers. Medical checks at reception centres should be strengthened and expanded, and special attention given to the early detection of outbreaks through closer cooperation between centres and the public health system. Additionally, the absence of standardised protocols\textsuperscript{52} makes it difficult to calculate the statistics needed

\textsuperscript{51} There are other entry points for irregular migrants attempting to reach Spain, mainly Ceuta and the Canary Islands. Although these are not included in this study, their characteristics are similar to those of Melilla and Algeciras-Tarifa, respectively.

\textsuperscript{52} More information at the Equi Health report on the mechanism of data collection \url{http://equi-health.eea.iom.int/images/Data_collection_report.pdf}
for a comprehensive evaluation of migrants’ health status in order to adapt health services to their needs.

Box 10. Promising practice

The SIRIA system: A data collection system that allows health-care providers to access, manage and transfer health-related or administrative information concerning migrants. This system is presently limited to the city of Melilla and remains unconnected to other data collection systems in the country.

IV. MIGRANT-SENSITIVE HEALTH SYSTEM

Public health challenges in border cities (Ceuta and Melilla) include the large number of people legally crossing the border to work or shop, and the deteriorating living conditions in the centres and settlements, causing the re-emergence of forgotten diseases. It is imperative that first-line staff – in particular the Guardia Civil -- receive training in self-protection from infectious diseases and detection of basic symptoms so that they can alert the proper authorities.

Infrastructure and living conditions vary from one centre to another. Open centres, including border area CETIs and MoL/CSO operated CARs, offer adequate services. Two main issues are the prolonged stay and overcrowding that can be attributed to the scarcity of positions, shortage of funds and personnel, protracted asylum application processing, and constant flow of migrants. Closed centres (CIEs) are usually located in former prisons and military buildings where living conditions are poor and pose physical and mental health risks for detained migrants. Long stays at CIEs have a negative effect on migrants’ physical and mental health, consequently increasing the demand for health care services. Although theoretically guaranteed by law, migrant access to health care and other social services inside detention centres is severely curtailed, mainly due to a shortage of HPs. Migrants in open centres supposedly have access to the public health system, but this is also diminished by the lack of information on their health care rights and on how the public health care system in Spain functions. Primary health care at CIEs and CETIs is subcontracted out to private health care services providers. CETIs offer additional tests and services for vulnerable groups, including minors. Living conditions in the centres need to be improved (e.g. by installing adequate heating systems, providing nutritious meals, and reallocating residents to alleviate overcrowding). The introduction of activities, such as training courses, internet access, and leisure activities could prove beneficial to the migrants’ physical condition as well as their mental health.

Many LEOs present characteristic signs of burnout syndrome, which has negative consequences for them and for centre residents. Their emotional exhaustion results in poor work performance and the depersonalization of residents, which partly explains instances of racist treatment in CIEs. The very atmosphere in detention centres (usually decommissioned, run-down old prisons) is inductive to such behaviour. In contrast, LEOs at the border areas display more empathy towards
newcomers because of the often poor physical conditions in which they arrive. They are able to derive some job satisfaction from the feeling that they are contributing to the common good but they are at times conflicted about following orders contrary to their personal principles, suffer from extreme stress and anxiety, and are often in need of mental health support. HPs’ cultural competencies vary according to their individual professional background but they generally report being highly motivated with respect to their work and aware of basic protection measures and migration-related issues, while also acknowledging how psychologically challenging working with migrants is. Many providers from CSOs or volunteers are especially sensitive to cultural differences but all are in need of training on cultural competencies. This may include topics like (a) critical awareness, which would enable providers to reflect upon their own cultural backgrounds and to empathize with migrants; (b) finding positive meaning in their work; (c) gaining capacity to take action in cultural diversity contexts – based on intercultural skills, social justice values, and organizational support which empower them; and (d) embedding community-based sustainability in cooperation with other professionals and institutions. Regarding CETI LEOs, special emphasis must be given on the values and principles of social justice, and coexistence with undocumented migrants. Besides training, necessary measures include the provision of universal and equitable access to health care services for all migrants with particular attention paid to vulnerable groups such as undocumented migrants, women, and minors, improvement of living conditions, and addressing deficiencies at centres by providing more HSPs, social assistance and intercultural mediation.

Box 11: Promising practice

Reproductive health clinics in Andalusia and Catalonia have shown to be culturally sensitive, i.e. by working with health professionals on how to address patients who have undergone female genital mutilation. A maternal care guide was drafted and translated into several languages, including Chinese and Arabic. Other basic documents, such as a list of patients’ rights and obligations, have also been translated and provided to HSPs to use in their daily practice.

UPDATE

Despite the introduction in 2014 of Royal Decree 162/2014 of 14 March, approving the operating regulation and internal regime of immigration detention centres, living conditions in CIEs have not seen any important improvements since the assessment was carried out. In 2015, three judgments by supervisory judges in Barcelona, Madrid and Las Palmas found that CIEs management arbitrarily deprived detainees of legal rights and guarantees including in relation to removal of private property, the use of mobile phones, time allocated for showers, access to health care, information prior to expulsion and legal assistance.53

Although the Ombudsman had urged the Spanish government to draft a referral protocol for transfers from CETIs to CIEs in order to ensure continuity of care, this

53 https://www.globaldetentionproject.org/countries/europe/spain
recommendation has not yet been taken into account. CETI staff manage the SIRIA system mentioned above as a good practice and, while, mainland NGOs and the Ministry of Employment and Social Affairs have access to the information entered into the system, the staff of CEIs and the Ministry of Interior do not have access to the information if someone is transferred from a CETI to a CEI.

On a positive note, in 2015, the Council of Europe’s Committee on the Prevention of Torture (CPT) noted in its report on an ad hoc visit to Spain to examine certain aspects of the treatment of foreign nationals in Melilla a new system at the Aluche CIE for the recording of traumatic injuries in accordance with the Istanbul Protocol and urged the Spanish authorities to establish similar practices in all CIEs. Following a number of allegations of physical ill treatment and verbal abuse perpetrated by law enforcement officers at some CIEs and while apprehending irregular migrants at the border, the CPT recommended that all law enforcement officers working at the border and at the CIEs receive training on intercultural communication, physical techniques of restraint and prevention of ill-treatment. Despite the approval of RDL 16/2012, as mentioned above, a number of Spanish regions continue to provide universal health care coverage to undocumented migrants, including Andalucia, Balearic Islands, Basque Country, and Galicia. The Spanish government has been reconsidering the effectiveness of RDL 16/2012, partially as regards to the lack of adequate medical treatment for undocumented migrants, and in September 2015 submitted a proposal to the Inter-Territorial Council of the Spanish Healthcare System to extend primary care to undocumented migrants with no economic resources and living in the country for more than six months (only for the region where they reside) but no decision has been taken in that respect to-date. The specifications of the proposal are as follows:

- The special healthcare card would have a validity of one year and only in the Spanish region where the migrant resides;
- Migrants would have to prove they do not have financial resources and/or medical insurance;
- Copayment of 40% of the cost of medicines (scale established for citizens having an annual income lower than 18,000 EUR);
- Aim: harmonize healthcare coverage for undocumented migrants in all the Spanish regions and avoid health tourism.

On the 14th of June 2017, the Catalan Parliament approved a new law on the universalization of public health care. The law is a step forward in respect to the restrictions introduced by the RDL 16/2012, as it expands the right to access health care services to several vulnerable groups excluded by the latest reform of the Spanish Healthcare System. The specifications of the law are as follows:

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54 https://www.globaldetentionproject.org/countries/europe/spain#_ftn65
55 https://rm.coe.int/168069d58c
56 ec.europa.eu/social/BlobServlet?docId=16003&langId=en
57 https://www.msssi.gob.es/gabinete/notasPrensa.do?id=3748
58 https://reder162012.org/
• The new law guarantees healthcare coverage to all citizens residing in Catalonia, independently of their legal status. This substitutes the previous requirement of having to prove a minimum of 3 months legal residence in the region, but residency in the region will still be a requirement;

• It also considers provision of emergency health care to all citizens, residents or not.

The new law, consolidates the “Instrucción 08/2015 de 22 de julio de 2015” (a normative legal resolution), adopted by the Catalan Government in 2015, in which the requirements and actions to be taken by health care providers towards non-nationals were established. This resolution stipulated that non-nationals legally residing in Catalonia and without healthcare coverage under the Spanish Healthcare System would have guaranteed access to emergency health care.

Other regions in Spain, such as Aragon (May 2017), have developed similar actions, also to circumvent the restrictions established by RDL 16/2012 and guarantee better healthcare coverage for those vulnerable groups excluded in the latest reform of the Spanish Healthcare System.59

Chapter 7: Conclusions and Recommendations

In recent years, the Southern EU Member States’ national policies and legislation on migration have been converging in order to align themselves to EU standards and directives such as the Dublin regulation. This specific regulation has proved to have an inadvertently adverse effect to migrants’ health, as many of them have declined to be identified in the countries of entry, in order to move onto other European countries of their choosing. By continuing their journey as undocumented persons, they run the risk of being exploited by criminal networks and may be deprived of health care provisions available to registered asylum seekers.

A multitude of actors is involved in the reception process and migration management, ranging from the central government (e.g. ministries of interior, health, defence) to local authorities, civil society organisations, the public health system, etc. The degree of collaboration between them varies from country to country, but in many cases interviewees stressed the need for better cooperation, information sharing, and use of shared protocols. Most countries recognise the need for the screening of people in vulnerable situations on arrival; implementation, however, varies much within and between countries, including the methods that are employed (for e.g. age assessment of unaccompanied minors).

Different types of centres were visited during the assessments, the prevalent models being closed detention centres for migrants who do not have documents or are to be deported and open centres for asylum seekers. These centres were of course very

59 https://reder162012.org/
diverse between the different countries. Serious deficiencies were noted in all the settings. Most of them are understaffed, with little or no provision of cultural mediation/interpretation and psycho-social support, much left to initiatives of CSOs and/or volunteers.

Generally, the duration of stay in the centres is very lengthy, often longer than is permitted by law, leading to overcrowding, and stretching resources and personnel. Findings from the assessments link the long stay in centres with deteriorating physical and mental health among migrants, and subsequently an increase in healthcare needs. Some centres employ health personnel while others refer patients to the public health care system. In most cases, health services provided in the centres are relatively basic while the transport and referral system to the hospitals is problematic. Regarding the monitoring of migrant health, most countries have systems of syndromic surveillance for notifiable conditions in place but no systematic health assessment (HA), including for screening of communicable diseases. Data, where some HA are done, is recorded but rarely further transmitted; every institution uses its own methods of data collection, usually paper based, making it difficult to share and compare findings, both at national and EU level.

Cultural mediation and intercultural competence seem to be almost absent from the reception facilities and public health system. In all the countries visited, interviewees from various sectors stressed the need for and interest in having more training on topics such as health protection and intercultural competences. While certain countries (e.g. Italy) offer some sporadic first aid and occupational health training, none of these focuses specifically on migrant issues, including migrant rights, intercultural communication, or trafficking.

**Recommendations**

The field work carried out as part of IOM’s Equi-Health project in the six Southern EU Border Member States highlighted some common needs and shortcomings that should be addressed. Taking into account good practices and suggestions by field workers, a number of recommendations were formulated and are presented below in accordance with the IOM/WHO four pillars action framework. Some of these recommendations are already being addressed.

**I. Political and Legal Framework**

Regarding EU policies on asylum and migration, the Dublin regulation has outlived its usefulness and tends to place an overwhelming burden on the budget and operational capabilities of border member states while putting potential asylum seekers in risk, as

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60 For more information on the country-specific recommendations please see the individual SARS: [http://equi-health.eea.iom.int/index.php/southern-eu/milestones-and-deliverables-eu](http://equi-health.eea.iom.int/index.php/southern-eu/milestones-and-deliverables-eu)

61 For more information, see at: [http://equi-health.eea.iom.int/](http://equi-health.eea.iom.int/)

62 [https://publications.iom.int/books/health-migrants-way-forward-report-global-consultation](https://publications.iom.int/books/health-migrants-way-forward-report-global-consultation)
many of them prefer to continue their journey in an irregular manner than register in one of the border countries with the risk of being "trapped" there.

Burden sharing within regions and among EU Member States would be advisable, both at the early stage of application processing and at a later stage (e.g. resettlement/relocation).

Guidelines for the border management, detention and reception centres should be promoted and implemented, with special reference to securing a public health perspective.

The opening of ad-hoc centres with unclear legal framework should be avoided, and administration procedures should be simplified in order to shorten migrants’ stay in reception/detention centres which has proved to be detrimental to their health. Other measures to the same effect could be the increase of territorial commissions, wider use of information and communications technology (ICT) and a centralized EU information system.

Alternatives to detention should be sought as a way to improve migrants’ well-being and reduce pressure on reception facilities, while incarcerated migrants should be identified and processed while serving their sentence rather than afterwards, something that unfairly prolongs their detention and adds strain on the detention facilities.

Detention of unaccompanied minors and other vulnerable groups, when otherwise unavoidable, should take place in dedicated and specially adapted facilities.

II. Partnerships, networks, and multi-country frameworks

Stakeholders involved in the assessments stressed the need to develop shared/horizontal protocols common to all actors involved in the reception process, to identify and assign tasks, and provide coordinated and standardised services throughout the reception process.

The exchange of practices and effective cooperation and solidarity at EU level, as well as regional and global levels, between countries and with international organizations should be urgently intensified, while the EU should set specific standards regarding health care provisions, including type and number of personnel in the detention/reception centres.

Some examples:
Communication must be improved among different levels involved (national/local), different institutions (ministries, municipalities, authorities and NGOs) and structures (hospitals, and reception and detention centres). Information and good practices should be shared between all structures and services involved.

The development of EU operational responses, in combination with the opening of institutionalised and safe migration procedures, would save lives and prevent more tragedies during the crossing of sea borders.

III. Monitoring Migrant Health

The need of a shared and standardised template for migrant health data collection was indicated as a priority action during the assessments. This could open the way for an online information system to be used for epidemiological surveillance, information sharing, and health data analysis which would help us assess treatment needs, plan for future services and, crucially, ensure the continuity of care. Besides the necessary screening for infectious diseases, more care should be given to the early diagnosis and treatment of mental health problems. Moreover, it would be useful to involve the public health system at local level in continuity of care throughout all stages of the reception process, i.e. first arrival, transfer, and detention/reception centres.

IV. Migrant-Sensitive Health Systems

Reception facilities should ensure humane and dignified conditions in line with international, CoE and EU standard, in terms of infrastructure, living conditions, and social and health assistance. The type of personnel and number of HPs should be flexible as to reflect the real number of persons that are accommodated in centres and therefore guarantee the capability to provide adequate levels of support for migrants and a sensible workload for the staff.

Of utmost importance is the creation of adequate health and social support systems, including interpretation, cultural mediation, psychosocial assistance and staff training, which need to be reinforced throughout the reception process (in the centres and also within the national health system). HPs request the availability of more interpreters and cultural mediators, as well as to be trained in a transcultural approach to health. Standardised procedures should ensure the presence of competent interpreters and cultural mediators throughout the reception system. A practical and more economical alternative, and that is already being employed in some places, could be interpretation via telephone or online applications.

Small (but perceived as significant) changes suggested by migrants to improve living conditions in the centres are: Wi-Fi (to communicate by internet with their families and to have access to news about their countries of origin), washing machines, sports facilities and the possibility to receive the pocket money in cash rather than via badge that allow limited choices. The provision of more possibilities for sports, cultural activities, training courses, media in multiple languages (TV, newspapers and internet)
and other activities could improve the well-being of migrants in detention/second reception centres and foster their subsequent integration into society.

Suggestions for a broad range of potential training topics for health professionals and law enforcement officers, as well as CSO staff, were collected during the assessments. These include intercultural competence, language competence, project management and fundraising, human trafficking, gender-based violence and violence against children, health-related courses on first aid, infectious diseases, and safety and security at the workplace. Specific subjects could include communication skills and how to handle prejudices and cultural gaps working with people from different cultural and risk backgrounds; understanding of global migration patterns, deeper understanding of the public health implications of migration; self-protection and occupational health issues; sensitizing to physical and mental health issues of vulnerable persons, including victims of trafficking, smuggled migrants, and minors.

Chapter 8: Current situation and impact of the SAR reports

Equi-Health findings and recommendations remain as pertinent as ever. Based on them, a number of actions have been planned and/or carried out.

Since 2013-2104 when the SAR field research took place, Europe was confronted by the highest number of displaced people by violence and conflict since World War II. The unstable situation that emerged after the Arabic Spring in North Africa and the continued war in Syria created millions of internally and externally displaced people and formed another reality, not only at the EU border areas but in Europe in general. Migrant and refugee flows to Europe escalated, prompting fierce political debate and sensationalist headlines. The previous main sea route through Libya to Italy was superseded by the much shorter, but still deadly, crossing from Turkey to the Greek islands. Nearly 7,500 people have lost their lives crossing the Mediterranean Sea in 2016 and the first half of 2017.

In 2015, the European Commission introduced the ‘hotspot approach’ to support Greece and Italy in coping with the sudden drastic increase in migrants arriving at the external borders of both of these EU Southern MS in 2015 and 2016. The first hotspot opened in Italy in September 2015 and in Greece in February 2016. The hotspots, with a total capacity in Italy of 1,600 and in Greece of 7,450, serve as first reception facilities to allow EU MS to quickly identify, register and fingerprint incoming migrants before transferring them to other facilities for the next phases of their asylum processes or to other EU MS as part of the EU relocation scheme (see below),

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64 IOM. 2014. Global Migration Trends: an Overview. [https://missingmigrants.iom.int/migrateme](https://missingmigrants.iom.int/migrateme)
65 [https://missingmigrants.iom.int/mediterranean](https://missingmigrants.iom.int/mediterranean)
or returning them to their countries of origin or transit. In April 2017, the EU Court of Auditors issued a report detailing a review conducted by the watchdog of the hotspots. The report concluded that while the hotspots helped improve migration management of new arrivals in both countries, at the end of 2016 these reception facilities in both countries were not yet adequate to properly receive (Italy) or accommodate (Greece) the number of migrants arriving, and there was a shortage of adequate facilities to accommodate and process unaccompanied minors in line with international standards, both in the hotspots and at the next level of reception.69

In order to help prevent migrants in need of international protection from resorting to criminal networks to reach Europe, in July 2015, the Council of the EU adopted the European Resettlement Scheme to provide legal and safe ways to enter the EU. Under the agreed 2-year scheme, over 22,000 persons will be resettled from non-EU to EU countries. Further to this, as part of the Turkey-EU Statement (see below) from March 2016, it was agreed that that for every Syrian national returned from the Greek islands another will be resettled to the EU directly from Turkey, aiming to replace the dangerous conditions of sea travel across the Aegean see with orderly and safe migration channels. Under both of these schemes, up until mid-June 2017, over 22,000 migrants had already been resettled to EU Member and Associated States.70

In September 2015, the Council of the EU, with a view to alleviate high migratory pressure on EU Southern MS, adopted the emergency relocation scheme under which asylum seekers with a high chance of having their applications successfully processed are relocated from Greece and Italy to other EU MS where their applications will be processed. Up until mid-June 2017, over 20,000 asylum seekers had benefited from the scheme, with 6,896 relocated from Italy and 13,973 relocated from Greece.71

The EU-Turkey Statement72 between the EU Heads of State and Governments and Turkey, which took effect on the 20th of March 2016, aimed at eliminating dangerous irregular migration flows from Turkey to the EU and instead replacing them with legal channels such as resettlement of those entitled to international protection, in line with EU and international law. This agreement did manage to reduce the number of people irregularly crossing the Aegean Sea, but created a lot of debate in terms of human rights issues such as detention conditions or the right to appeal, in addition to reactivating the Central Mediterranean route73. The agreement may have resulted in relatively reduced arrivals via the Eastern Mediterranean route – around 170,000 for all of 2016 compared to 850,000 in 2015 – but, as mentioned above, the human cost of reaching the EU has remained a heavy one and even increased in 2016 as compared to 2015.74 The EU-Turkey Statement has been criticized by some humanitarian

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73 https://www.hrw.org/news/2016/03/15/eu-turkey-mass-return-deal-threatens-rights
organizations who alllege that it outsources the EU’s responsibility to Turkey, exacerbates the vulnerabilities of highly traumatised people, and exposes them to further risks and abuse in Greece.\textsuperscript{75}

The gradual closing of the so-called Balkan route at the end of 2015 and beginning of 2016, led to a high number of stranded migrants and refugees. This resulted in a worsening of the stress and dangerous conditions for thousands of people on the move. As noted by MSF\textsuperscript{76}, border closure has a domino effect, abruptly halting thousands of people in no man’s lands with little to no humanitarian assistance, ultimately forcing them onto more dangerous routes or into the hands of smugglers.

In view of the unprecedented influx of migrants in clear need of international protection, the European Commission’s DG SANTE decided to amend the third Programme of the Union's action in the field of health (2014-2020) to provide support to organisations which take immediate actions and are able to quickly support Member States under particular migratory pressure to help address the health-related issues of arriving migrants while preventing and addressing possible communicable diseases and cross border health threats. It was deemed necessary to also support public health capacity building and develop appropriate tools, as well as increase access to medical expertise and information to support Member States to deliver the necessary health care\textsuperscript{77}.

Also in this context, the EU addressed the need for the harmonization of health assessment practices in accordance to the recommendations of the Equi-Health project, by launching the RE-Health IOM/EC action\textsuperscript{78}, including a standardized electronic health data collection tool, to contribute to the sharing and exchange of health-related data in a secure manner by protecting individual patient rights. This project is being piloted and its aim is to ensure continuity of health care provision, limit the duplication of efforts and respective financial implications of repeated medical interventions (i.e. vaccinations, X-ray, etc.) and optimise the efforts in provision of proper health services at national and EU level. During the negotiation and implementation phases of Re-Health, Member States, NGOs and civil society acknowledged the need for a tool to perform a standardised data collection. Lack of data on migrant health has also been recognised by different international organizations (i.e. IOM and WHO).

In addition, a recent Scoping Study on “Infectious disease health services for refugees and asylum seekers in Europe” carried out by ECDC and IOM came to emphasize the Equi-Health project findings and recommendations. Although the research included only 3 of the SEUB countries (Greece, Italy and Croatia) with the addition of 1 transit country (Slovenia) and countries of destination (Sweden and Austria), the similarity of the results were complementary rather than contradictory to the Equi-Health findings.

\textsuperscript{76} http://www.msf.org/en/article/eu-migration-crisis-update-february-2016
\textsuperscript{78} http://re-health.eea.iom.int/
In light of the new developments in EU border areas, the need for training on migrant health and occupational health is becoming even more relevant. Based on Equi-Health findings, as well as prior IOM work on health and border management (PHBLM project), a package of training materials was developed with the objective to strengthen the capacity of public health authorities, health care providers and law enforcement officers working in the field of migration and health at the EU’s Southern Borders.\(^79\) Trainings of Trainers (ToTs) and roll-out training sessions in Croatia, Greece, Italy, Malta and Portugal were implemented and 990 people were trained over the period March 2014 to June 2016, amongst who 133 trainers and 857 trainees. The latter includes more than 300 HPs who were trained on-site during 12 roll out sessions that were held at border entry points during the massive influx of people via the Greek sea borders at the end of 2015 and first half of 2016. In Greece Equi-Health training continues via the Hellenic National School of Public Health which incorporated it in its regular training activities for professionals at first reception. In Italy, in 2016, nearly 1,100 health professionals completed an online training course on intercultural competence in health services.

Finally, in line with the need for training on migration health identify in all assessed countries, the Annual work plan 2016 of the 3rd EU Health Program forsees provision for trainings on migrants' and refugees' health for health professionals, border guards and trainers.\(^80\)
