Health of refugees and migrants

Regional situation analysis, practices, experiences, lessons learned and ways forward

WHO European Region

2018

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Acronyms and abbreviations

EU	European Union
ILO	International Labour Organization
IOM	International Organization for Migration
MKD	The former Yugoslav Republic of Macedonia.
MIG	Migration and Health programme
NGO	Nongovernmental Organization
TB	Tuberculosis
UNHCR	Office of the United Nations High Commissioner for Refugees

WHO European Region

I. INTRODUCTION

Background

To achieve the vision of the 2030 Agenda and the Sustainable Development Goals, to leave no one behind *(1)*, it is imperative that the health needs of refugees and migrants be adequately addressed. In its 140th session in January 2017, the Executive Board requested that its Secretariat develop a framework of priorities and guiding principles to promote the health of refugees and migrants *(2)*. In May 2017, the World Health Assembly endorsed resolution 70.15 on Promoting the health of refugees and migrants *(3)*. This resolution urges Member States to strengthen international cooperation regarding the health of refugees and migrants in line with the New York Declaration for Refugees and Migrants. It urged Member States to consider providing the necessary health-related assistance through bilateral and international cooperation to those countries hosting and receiving large populations of refugees and migrants, as well as using the Framework of priorities and guiding principles at all levels. In addition, the resolution requested the Director-General to conduct a situation analysis and identify best practices, experiences and lessons learned in order to contribute to the development of a global action plan for the Seventy-second World Health Assembly in 2019.

In alignment with World Health Assembly resolution 70.15, WHO made an online call from August 2017 to January 2018 for contributions on evidence-based information, best practices, experiences and lessons learned in addressing the health needs of refugees and migrants. This generated 46 inputs covering practices in 28 Member States in the WHO European Region; these were received from 22 Member States as well as from partners such as the Office of the United Nations High Commissioner for Refugees (UNHCR), the International Organization for Migration (IOM) and the International Labour Organization (ILO). The submissions included valuable information on the current situation of refugees and migrants, health challenges associated with migration and forced displacement, past and ongoing practices and interventions in promoting the health of refugees and migrants, legal frameworks in place for addressing the health needs of this population, lessons learned and recommendations for the future.

Furthermore, at the High-level Meeting on Refugee and Migrant Health, held in Rome in November 2015, Member States of the WHO European Region agreed on the need for a common framework for collaborative action on refugee and migrant health, acting in a spirit of solidarity and mutual assistance to promote a common response and avoid uncoordinated single-country solutions.
In the context of the Sustainable Development Goals and the European policy framework Health 2020 *(4)*, the Strategy and Action Plan for Refugee and Migrant Health in the WHO European Region was developed and endorsed by the WHO European Regional Committee in 2016 *(5)*. The Strategy and Action Plan provides a coherent and consolidated national and international response to protect lives and provide for the health needs of refugee and migrant populations in the countries of transit and destination, and to respond to the health needs associated with the migration process.

Scope of the report and evidence synthesis

This report has examined the contributions from WHO regional and country offices, Member States and partners in responding to a global call for contributions, as well as from evidence available on current migration trends, legal frameworks, health challenges and outcomes, policies and public health interventions and good practices to improve the health of refugees and migrants in the Region. The report will contribute to the development of a draft global action plan to promote the health of refugees and migrants to be considered at the Seventy-second World Health Assembly.

The report also aims to provide information to Member States and partners in the Region regarding current public health intervention, and good practices in promoting refugee and migrant health, including access to and outcomes of care. In addition, the report's accompanying document highlights practices in the Region that include efforts to address the health needs of refugees and migrants. The information received from Member States, partners and WHO Country Offices in response to the aforementioned WHO global call for contributions was examined and compiled in the accompanying document – practices in addressing the health of refugees and migrants in the European Region.

Methodology and type of evidence

A rapid scoping review of available technical reports, peer-reviewed and grey literature in English, as well as from Member States and partners' contributions to the global call for contributions, was conducted between August 2017 and 20 January 2018.

The synthesis question

The objective of the review was to address the following questions.

- What are the current migration and displacement trends in the Region?
- What are the relevant global and regional legal frameworks used in the Region in addressing the health of refugees and migrants?
- What are the current health challenges and outcomes of refugees and migrants in the Region?
- What are the current policies, interventions and practices, experiences and lessons learned within the Region? The section on current public health interventions gives examples of interventions and good practices.
- What is the way forward and what recommendations can be identified for addressing refugee and migrant health in the Region?

II. CURRENT SITUATION

Migration trends in the Region

The United Nations Department of Economic and Social Affairs' estimates indicate that more than 90 million migrants live in the WHO European Region, amounting to almost 10% of the total population in the Region, and almost one third of international migrants worldwide *(6)*. Based on the latest UNHCR estimates *(7),* approximately 5.2 million refugees (including people in refugee-like situations) and 1.4 million asylum seekers live in the Region (Fig. 1).[1]

[1] Figures from Andorra and San Marino are not available.

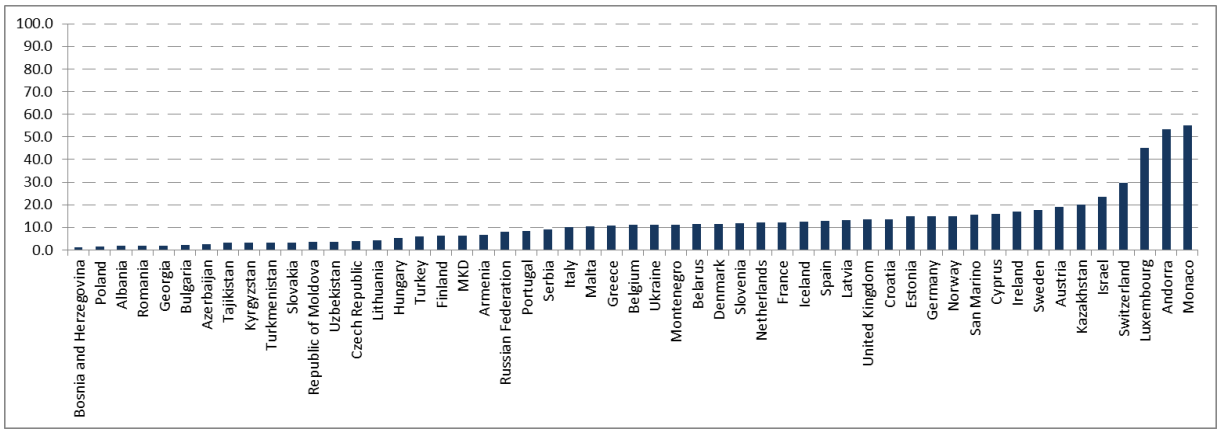

Fig. 1. International migrant numbers as a percentage of total population, 2017

Source: United Nations Department of Economic and Social Affairs *(6).*

During recent years, the WHO European Region has experienced an influx of refugees and asylum seekers trying to reach European shores. According to IOM estimates *(8),* the Mediterranean Sea is one of the commonly used routes by refugees and migrants to reach Europe. The route is also considered to be one of the deadliest, claiming lives of 3139 refugees and migrants in 2017. In 2016, 363 401 individuals arrived in Europe via this route and 5143 lost their lives during the journey.

Based on recent ILO estimates *(9)*, 56.6 million labour migrants reside in the Region.[2] The average labour force participation rate for the migrant population was estimated to be 73%, and around 12% of all workers in the Region were migrants.

While most refugees and migrants are usually young adults, migrant populations currently arriving in Europe include many elderly and disabled people, as well as an increasing number of minors, many of whom are unaccompanied children *(10)*. Globally, the number of applications for asylum from unaccompanied or separated children reached record highs in 2015 (98 400) and 2016 (75 000) *(11,12)*. Sweden and Germany received the highest number of unaccompanied minors in 2015 (35 800) and 2016 (35 900), respectively. Women, including pregnant women, made up more than half of all refugees and migrants (45 million) living in the Region (6*)* and were often disproportionately represented in vulnerable groups, such as victims of gender-based violence, human trafficking and sexual exploitation *(13)*.

Refugees are formally owed protection, including access to health services, by their first country of registration for asylum. In practice, however, according to the European Union (EU) Agency for Fundamental Rights, fundamental rights remain under threat in many Member States *(14)*. Such rights may routinely be denied, particularly at the stage at which asylum is determined.

III. KEY REGIONAL FRAMEWORKS AND LEGAL INSTRUMENTS

Globally, the relevant policy framework is provided by the 2008 World Health Assembly resolution 61.17 on health of migrants *(15)*, the 2017 Executive Board 140.9 Framework of Priorities and Guiding Principles to Promote the Health of Refugees and Migrants *(2)* and the 2017 World Health Assembly resolution 70.15 on promoting the health of refuges and migrant *(3)*. Of paramount importance will be active WHO engagement with the Global Compact on Migration and the Global Compact for Safe, Orderly and Regular Migration.

[2] Figures from Andorra, Monaco and San Marino are not available.

Other relevant frameworks and resolutions include:

- the 1951 Convention relating to the status of refugees (ratified by 50 of 53 Member States) and the 1967 Protocol relating to the status of refugees;
- the 1990 International Convention on the Protection of the Rights of all Migrant Workers and Members of their Families (ratified by five of the 53 Member States);
- the 2000 Protocol to Prevent, Suppress and Punish Trafficking in Persons, especially Women And Children (ratified by 52 of the 53 Member States);
- the 2000 Protocol against the Smuggling of Migrants by Land, Sea and Air (ratified by 48 of the 53 Member States);
- World Health Assembly resolution 62.14 on reducing health inequities through action on the social determinants of health; and
- WHO Regional Committee for Europe resolution EUR/RC52/R7 on poverty and health, and related follow-up, such as efforts to address health inequity linked to migration and ethnicity.

Of regional relevance are the Bratislava Declaration on Health, Human Rights and Migration, signed by the Member States of the Council of Europe in 2007; the recommendations on mobility, migration and access to health care, adopted by the Council of Europe Committee of Ministers in 2011; and the Strategy and Action Plan for Refugee and Migrant Health in the WHO European Region, adopted by the Member States in 2016.

The Council of Europe Convention on Preventing and Combating Violence against Women and Domestic Violence assures rights and protection from gender-based violence; promotes the empowerment of women and equality between men and women; and promotes and provides assistance to international cooperative efforts to eliminate violence against women and domestic violence, including support for the integration of law enforcement approaches *(14)*. The convention contains a number of articles that ensure the protection of women from violence, through commitments to education, prevention, substantive law, and protection and support; these are all explicitly secured without discrimination on any grounds, including migrant or refugee status.
Also important are the Dublin Regulation (Regulation No 604/2013; sometimes known as the Dublin III Regulation; previously the Dublin II Regulation); the new Communication from the European Commission to the European Parliament, the Council, European Economic and Social Committee; and the Committee of the Regions document on the delivery of the European Agenda on Migration.

IV. HEALTH CHALLENGES AND OUTCOMES ASSOCIATED WITH MIGRATION AND DISPLACEMENT IN THE REGION

Access to health services

Access to health care varies across the WHO European Region and within national boundaries. While the universal right to health as a basic human right, regardless of a person's administrative status, has been ratified by the International Covenant on Economic, Social and Cultural Rights and the EU Charter of Fundamental Rights, laws and practices deviate from these obligations in some countries. In practice, access within public health systems mostly depends on the particular status of the individual migrant. For example, legal status is generally the most important factor determining access among refugees, in so far as refugee status is legally recognized and adequate health services exist. For labour migrants, access may not only be impacted by their legal status in terms of whether or not they are irregular but also by their official employment status. Among many labour migrants, working without a contract in an irregular situation is not uncommon, often preventing entitlement to relevant national or local health or social insurance schemes. As a result, labour migrants who are in an irregular situation tend not to present to health care institutions because of fear of

deportation. Some countries, however, have established specific policies that protect irregular migrants from deportation when accessing health care in particular circumstances. Luxembourg, for example, provides access with proof of harm in the absence of care, while France and the Netherlands offer a temporary permit for health care in the case of pregnancy.

Access to health care for refugee and migrant children varies across the Region. France, Italy, Norway, Portugal and Spain explicitly entitle all migrant children, irrespective of legal status, to receive equal health care to that available to nationals. Asylum-seeking children have comparatively limited entitlement to health care; however, in certain Member States unaccompanied asylum-seeking children may have better entitlements to health care than those who are accompanied *(16)*. In general, refugees and asylum seekers have suboptimal access to primary health care services in the WHO European Region, which results in over-reliance on emergency services *(17).*

Legal entitlement, however, does not guarantee access, and even where entitlements are established for certain migrant groups and regulations permit access, further barriers may exist in terms of the organization of health care, unawareness of entitlements by health care providers and beneficiaries, limitations of health staff expertise, linguistic and cultural barriers, and the wider governance of migration. For example, irregular migrants in the Region often do not have cost-free access to public health care services other than emergency care *(18,19)*.

Social determinants of health

Just as for the general population, socioeconomic, cultural, environmental and lifestyle factors are key determinants for the health of refugees and migrants. These determinants are also largely responsible for the inequalities and inequities within and between different countries and population groups in terms of health. Migrants are also not a homogeneous group, and different subgroups all have different social, economic and cultural circumstances that account for their varying vulnerabilities throughout the migration process.

The process of migration is, however, also a social determinant in and of itself. Not only do many migrants originate from countries affected by poverty and conflict, poor health systems and high burdens of disease, the conditions surrounding migration may increase inequalities and expose migrants to greater risks and poorer health outcomes *(20)*. These conditions include those experienced during transit and travel, and those in the destination country. They include the hazards associated with the mode and duration of travel, as well as the legal status of the individual, the policies which grant or deny access to migrant-friendly health and social services, and the working and living conditions to which migrants are subject. Social and cultural barriers to integration, acculturation stress, exclusion and discrimination, changes in lifestyle and loss of family and friendship networks are examples of additional factors impacting the health of migrants.

Disease burden

Communicable diseases

Despite a common perception of an association between migration and the importation of infectious diseases, there is no systematic link. Diseases such as tuberculosis (TB), HIV/AIDS, hepatitis, measles and rubella have not been entirely eliminated and still exist in the European Region independently of migration patterns. For example, transmission of TB from migrants to host populations is limited, and the risk of importation of HIV by migrants to Europe is low *(21)*. Refugees and migrants represented 6.3% of all notified cases of TB in the Region. Some countries in the Region have a much higher proportion of refugees and migrants among the notified TB cases (Sweden, 89.5%; Norway, 88.7%; Iceland, 85.7%; Israel, 83.2%; Cyprus, 82.5%; Switzerland, 75.9%; the Netherlands, 72.1%; and Malta, 75.0%) *(22)*. Refugees and migrants constituted 40% of the new

HIV diagnoses in the EU and European Economic Area in 2016 *(23)*. Refugees and migrants also do not pose an increased threat for influenza viruses and other common respiratory infections where these already widely circulate *(21)*. Moreover, the risk of importation of exotic communicable diseases such Ebola or Middle East respiratory syndrome is extremely low and where importation does occur, it mostly involves regular travellers, tourists or health care workers rather than refugees or migrants *(21)*. Cases of typhoid and paratyphoid are also generally related to travel outside the EU *(21)*. However, while many communicable diseases, including vaccine-preventable diseases, result from domestic acquisition rather than importation, refugees and asylum seekers particularly are more vulnerable and susceptible. This is because many come from communities affected by conflict, disrupted or poor-quality health services, and low coverage of vaccinations. Moreover, the long and dangerous journeys they undertake and the conditions experienced in transit or at reception, such as overcrowding and poor sanitation facilities, may increase risk for communicable as well as food- and waterborne diseases *(21)*.

Though not a disease itself, but rather a complication from treatment for many communicable diseases, antimicrobial resistance is a growing concern in the context of migration. In situations such overcrowded refugee camps with poor hygienic conditions, spread of resistant pathogens can easily occur. Disruptions in treatment and misuse of medication during transit and resettlement also risks development of resistance to disease.

Noncommunicable diseases, including mental health

Noncommunicable diseases are an important contributor to the burden of morbidity and mortality among migrants in Europe *(21)*. This is because of the increasing prevalence of chronic and noncommunicable diseases in migrant-originating countries: as high as 25–35% in certain low- and middle-income countries. Cardiovascular diseases, cancers, diabetes and chronic respiratory diseases are the four main noncommunicable diseases, constituting 60% of deaths globally every year; 80% of these occur in low- and middle-income countries, including those from which many migrants in Europe originate. Noncommunicable diseases result from an accumulation of risk factors that derive not only from genetic predispositions and behavioural risk factors but also from social determinants of health. In the context of migration, these include socioeconomic factors such as legal status and living and working conditions, as well as the impact of social and economic policies on the health and well-being of migrants. However, susceptibility and exposure to such risks does vary among different groups *(24)*.

The process of migration itself can also increase vulnerabilities to chronic and noncommunicable diseases, seriously exacerbate these or cause life-threatening complications in the health of migrants with existing and even previously well-managed conditions. This may be due to the mode of travel and conditions endured during transit, which may cause critical and prolonged interruptions in the management of conditions and loss of medication or equipment. In addition, the legal status of migrants often restricts access and utilization of necessary care, especially for irregular migrants. For example, more than half (58.7%) of the Syrian refugees living in Turkey were found to have high risk of noncommunicable diseases and around 41% were found to have moderate risk *(25).* The acculturation process is an additional factor that may adversely impact noncommunicable disease outcomes, not only through experiences of heightened stress but also through changes in lifestyle and adoption of unhealthy behaviours, such as sedentary lifestyles and poor diet *(24)*. For example, migration-related exposure to increased caloric intake and obesity was responsible for disproportionately higher levels of noncommunicable diseases among Indian migrants who had migrated to the United Kingdom compared with communities residing in India *(26)*. Moreover, south Asian migrant communities that undergo westernization and urbanization, whether in Europe or south Asia, have much higher prevalence rates for noncommunicable diseases compared with the same communities who have not experienced such processes *(27)*. Increased

stress during acculturation is another risk factor for the development of noncommunicable diseases *(24)*. The impact of acculturation is, at least in part, why the "healthy migrant effect" is generally seen to diminish after a period of integration in the host country.

With regard to mental health, refugees and migrants encounter many risk factors for developing mental disorders before, during and after migration. The main risk factors associated with poor mental health outcomes for refugees include exposure to trauma or economic hardship, experience of physical harm and separation, and poor socioeconomic conditions such as social isolation and unemployment in the destination country. In general, however, with the exception of post-traumatic stress disorder, the rates of psychotic, mood and substance use disorders among refugees, asylum seekers and irregular migrants appear similar to those found in host countries *(28)*. A systematic review of post-traumatic stress disorder among 5499 resettled refugees in western countries, including Norway, Italy and the United Kingdom, showed an overall prevalence 9%, higher than estimates for host-country populations, which generally vary between 1 and 3% *(29)*. Prevalence of post-traumatic stress disorder is similarly understood to be higher among minor refugees and it has been estimated that more than 25% of refugee minors may develop post-traumatic stress disorder, although many go undiagnosed *(30)*. Capturing prevalence data on mental health disorders for adult and child migrant and refugee populations alike is a significant challenge given the difficulties in diagnosing in mobile populations, especially in emergency situations where mental health services may not be available.

Maternal and child health

Compared with non-migrants, most migrant women still face poorer pregnancy and birth outcomes, with a higher incidence of induced abortions, caesarean sections, instrumental deliveries and complications. In the EU, migrant women tend to have poorer perinatal outcomes than the host population *(31,32)*. For example in Sweden, African immigrants had 18 times more risk of neonatal deaths compared with Swedish mothers *(33)*. Almost 50% of the pregnancies among migrant women in the Russian Federation resulted in abortion *(34)*. Such poorer maternal outcomes are often related to risk factors that precede and contextualize migrant health, such as family planning, exposure to gender-based violence and health-seeking behaviours. Asylum procedures and legal access to maternal care for migrants in transit and destination countries are, however, also important determinants. Reductions in maternal health risks are associated with strong and inclusive integration policies, which also address the availability, affordability, acceptability, familiarity, comprehensibility and quality of services; deficits in these areas often cause delays in care. The financial cost of accessing care, for example, is a major concern and varies significantly between Member States depending on the migrants' legal status. Language and communication barriers, lack of support networks, childcare responsibilities as well as mobility and transport barriers are additional factors that inhibit migrant women's access and utilization of essential maternal health services.

Migrant children constitute a particularly vulnerable group, and many have an accumulated need for basic and preventive health care *(35)*. Asylum-seeking and refugee children, in particular, have higher rates of infectious diseases and dental problems than children within host populations in the European Region. These groups are also more likely to have higher levels of stress-related mental health problems in the first years after resettlement, with unaccompanied minors having the highest rates of symptoms *(35)*. Unaccompanied children are at particular risk for trauma during migration, and exposure to exploitation, abuse and trafficking. Poor living conditions, uncertainty around the reception process and fragmented assistance within destination countries are further risk factors impacting the well-being of refugee and asylum-seeking children.

Health of labour migrants

Because of poor disaggregation of data by migrant type, there is inconsistency and uncertainty in epidemiological, demographic and health data specifically concerning labour migrants. Moreover, the heterogeneity within this group makes the health status of labour migrants difficult to determine. The health status of labour migrants in the WHO European Region is influenced by poor working conditions, high exposure to occupational risk (dangerous jobs, insufficient safety training), lower salaries, limited legal rights and limited access to health care services. It may also vary considerably depending on migrants' legal status and duration of stay in the host country *(36)*. While many labour migrants are residing legally in their host country and work opportunities can improve their health status, many others may be working without a contract or without having permission or being declared by their employer. In these cases, migrants often are not entitled to any health or social insurance and are at greater risk for adverse health outcomes than non-migrant populations, often continuing to work despite illness or injury. The most common work-related health conditions reported by labour migrants in Europe include musculoskeletal, respiratory and mental health problems. Labour migrants face a higher risk of work-related injuries than non-migrant workers *(37)*. Health insurance is a major factor influencing access to health care by labour migrants. For example, absence of a work visa excludes labour migrants from medical insurance coverage in Israel, and only registered labour migrants have full rights to health care services and social benefits in Norway *(36,38)*.

While historically, labour migrants have predominantly been male, an increasing proportion of female migrants has been documented, referred to as the feminization of migration. Gender is a particularly important aspect in addressing the health of labour migrants, as male and female migrants have different vulnerabilities depending on the countries and industries in which they work. While men are more often employed in construction services, women more often work in household services for which there are different occupational hazards *(39).* Migrant sex work presents additional risks, mainly because sex work is not formally considered as labour, which limits them from obtaining residence and work permits *(39)*. There is also evidence suggesting that female labour migrants are more likely to experience gender-based discrimination and violence, as well as suffer from physical and mental health disorders *(40)*.

V. EXAMPLES OF CURRENT PUBLIC HEALTH INTERVENTIONS AND PRACTICES

Based on the contributions from Member States and partners, in line with the Framework of priorities and guiding principles *(2)* and the European Strategy and Action Plan *(5)*, the following examples of current interventions and best practices to promote the health of refugees and migrants in European Region are grouped under 13 different interventions.

1. Promoting the right to the enjoyment of the highest attainable standard of physical and mental health, equality and non-discrimination of refugees and migrants
2. Addressing the social determinants of health and health inequality for refugees and migrants
3. Providing equitable access to universal health coverage, including access to quality essential health services, medicines and vaccines, and health care financing for refugees and migrants
4. Promoting people-centred, gender-, refugee- and migrant-sensitive health policies and health systems and programme interventions
5. Ensuring provision of short- and long-term public health interventions to reduce mortality and morbidity among refugees and migrants, including bridging short-term emergency and humanitarian health assistance with long-term health programmes and vaccination

6. Promoting continuity and quality of care for refugees and migrants
7. Preventing and controlling communicable and noncommunicable diseases, including mental health, for refugees and migrants
8. Improving the health and well-being of women, children and adolescents living in refugee and migrant settings; promoting gender equality and empowering refugee migrant women and girls
9. Addressing the health of migrant workers, occupational health and safety measures, including improving working conditions; addressing workforce strategies
10. Creating health monitoring and health information systems for refugees and migrants
11. Improving communication and countering xenophobia to dispel fears and misperceptions among refugee, migrant and host populations on the health impacts of migration and displacement
12. Enabling participation and social inclusion of refugees and migrants
13. Creating partnerships and cooperation, intersectoral, intercountry, in-country and interagency coordination and collaboration mechanisms: whole-of-government and whole-of-society approaches in addressing refugee and migrant health.

1. Promoting the right to the enjoyment of the highest attainable standard of physical and mental health, equality and non-discrimination of refugees and migrants

In **France**, the health system aims to be inclusive and accessible to migrant patients. As such, the same principles apply to legal residents as to French citizens. Asylum seekers are also covered by the universal free health insurance system (Couverture Universelle Maladie Protection Complémentaire; CMU-C). Low-income irregular migrants are covered by the state medical aid (Aide Médicale d'Etat) with certain conditions and restrictions. However, there are exceptions for vulnerable and at-risk groups such as people with infectious diseases and pregnant women, all of whom are granted a temporary permit to access health care. Anyone falling outside the system can access emergency services and care. Newcomers to France receive an initial orientation to the health system, and information is provided in 23 languages. Practitioners are also being trained in guaranteeing equal quality services for migrant patients and the need to protect privacy.

In the **Republic of Moldova**, migrants and refugees benefit from medical services through the mandatory health insurance system and also benefit from preventive and disease prevention services (e.g. immunization, communication/information, screening, prophylactic treatment for infectious diseases). In addition, the Ministry of Interior has issued guidelines for referral, reception, medical examination and treatment of asylum seekers, refugees, beneficiaries of humanitarian protection and of foreigners placed in the Centre for the Temporary Placement of Foreigners, as approved by a Minister's Order. The Bureau for Migration and Asylum's biannual workshops on migrants' rights includes modules on the right to health.

In **Switzerland**, under the National Programme Migration and Health 2014–2017 run by the Federal Office of Public Health and in collaboration with cantonal authorities and institutions, many good practices have been set up in recent years that contribute to supporting migrant health, promoting equity health care and encouraging non-discrimination practices. The programme specifically focuses on ensuring equal access to health care, promoting health literacy among migrants, empowering patients and encouraging active patient participation, facilitating integration, training health professionals on managing diversity, conducting research on vulnerable groups within migrant populations, and improving communication between health professionals and patients experiencing language barriers. One of the initiatives under the programme is the Swiss Hospitals for Equity Network, the mission of which is to promote high-quality care for all patients regardless of

nationality, ethnicity, language, culture, social and/or economic status. The initiative also supports health professionals and provides a telephone interpretation service.

Lessons learned. It takes will, at all political levels, to act and promote the right to the enjoyment of the highest attainable standard of physical and mental health, equality and non-discrimination of refugees and migrants. This will is not a given. Collaboration between state levels is a challenge as it takes a willingness to make common effort (a challenge per se) in a field that is often not considered as a priority for action.

The Migration and Health programme

The Migration and Health Programme (MIG), formerly known as Public Health Aspects of Migration in Europe, was established in 2011 to support Member States to strengthen health sector capacities to provide evidence-informed responses to the public health challenges of refugee and migrant health. The programme operates under the umbrella of the European health policy framework Health 2020. The programme provides support to Member States under four pillars: technical assistance, health information, research and training, partnership building, and advocacy and communication. The programme promotes a collaborative intercountry approach to migrant health by facilitating cross-country policy dialogue and encouraging homogeneous health interventions along the migration routes to promote the health of refugees and migrants and protect the public health of host communities.

Using an innovative toolkit developed by MIG, several joint public health and health system assessment missions have been conducted (in Albania, Bulgaria, Cyprus, Greece, Hungary, Italy, Malta, Portugal, Serbia, Spain and the former Yugoslav Republic of Macedonia) to analyse and improve the response of these countries to large-scale migration.

The WHO Regional Office for Europe established a field presence in Gaziantep (Turkey) in October 2013 to increase capacity to respond to the public health needs of Syrian refugees. Here WHO continues to assess the needs of these refugees; provides capacity-building support to Syrian medical professionals, who are then permitted to treat Syrian refugees in Turkey; provides technical and financial assistance for outbreak response and setting up early warning systems and immunization campaigns; supplying medical equipment and drugs; and supports dissemination of information material to refugees.

MIG has worked in collaboration with WHO Regional Office for Europe's Division of Health Systems and Public Health and Division of Communicable Diseases and Health Security, and in coordination with the Hellenic Ministry of Health, to conduct rapid assessment visits to Athens, Chios, Idomeni and Lesvos to collect data and review public health needs. Areas of collaboration included strengthening coordination to respond to the health needs of refugees and migrants, increasing immunization services, optimizing a national health plan and increasing health promotion.

2. Addressing the social determinants of health and health inequality for refugees and migrants

In **Cyprus,** interventions are in place to ensure migrants' health rights, reduce excess mortality and morbidity among migrant populations, minimize the negative impact of the migration process on migrants' health outcomes and avoid disparities in health status and access to health services between migrants and the host population. These interventions include a systematic risk assessment undertaken in order to identify the relatively few epidemic-prone diseases that have the potential to cause the greatest amount of morbidity and mortality in the affected population. Findings of the risk assessment are applied to prioritize the surveillance efforts and identify interventions that will be most effective in mitigating the increased risk. Risk factors that influence disease transmission in

emergency settings are also assessed systematically, grouped and viewed by disease category (waterborne diseases, vector-borne diseases and diseases associated with crowding or malnutrition) to link interventions to specific risks. Specific health services targeting these groups, such as triage and delivery of services for acute disease on the frontline, medical examination of all migrants, screening tests for communicable diseases (HIV, hepatitis B, hepatitis C, syphilis, TB), medications for all patients with chronic diseases and immunization programmes, are available at reception centres, with appropriate follow up.

In **Norway**, the Public Health Act contributes to societal development, promoting public health and reducing social inequalities in health. The Norwegian strategy to reduce social inequalities in health (2007–2017) has four priority areas: reduction of social inequalities that contribute to inequalities in health; reduction of social inequalities in health behaviour and use of health services; targeted initiatives to promote social inclusion; and the development of knowledge and cross-sectoral tools. Particular efforts have been made to integrate migrants, including through urban planning to reduce social inequalities. The 2017 White Paper Sustainable Cities and Strong Districts highlights the importance of urban regeneration in vulnerable areas, including strengthening focus on health care, education, employment and the physical and social qualities in neighbourhoods. As an example, the Grorud Valley Urban Regeneration Project 2006–2016, now prolonged until 2026, is an intervention aimed at improving the environment and living conditions in Groruddalen, which has a population of nearly 140 000 people, with strong cultural diversity including over 140 nationalities. Migrants are, therefore, a particular target group of the project, with a strong focus placed on cultural inclusion for improved health and well-being.

In the **United Kingdom**, the Barka Project aims to improve access to occupational skills training, rehabilitation and housing for migrants suffering from homelessness and substance misuse. The project connects the migrant with both home and host country services depending on needs and helps to overcome cultural and language barriers in accessing health care in the host country. In 2014, 145 people were given occupational skills training, rehabilitation or help in finding homes in London.

Lessons learned. As a social determinant of health itself, targeted interventions need to be developed to reduce the negative impacts of the migration process on the health of refugees and asylum seekers.

3. Providing equitable access to universal health coverage, including access to quality essential health services, medicines and vaccines, and health care financing for refugees and migrants

In **Belgium**, the EtHEALTH (Ethnicity & Health) expert group was created to formulate recommendations for the public health authorities on how to reduce ethnic and migrant health inequalities and for targeting irregular migrants and migrants with a precarious legal status. These recommendations included ensuring a clear framework of reimbursement and applying the existing legislation on urgent medical aid; providing a voucher entitling irregular migrants to request assistance; extending the use of medical cards to all irregular migrants, entitling them to urgent health care; diversifying the health professionals and health services available to treat migrants; and providing a temporary residence permit for irregular migrants affected by infectious diseases in order to ensure a full course of treatment.

In **Italy**, health authorities recognized the importance of providing equitable, affordable and acceptable health care to the large number of asylum seeking arrivals and implemented a creative approach to guarantee access to equitable, affordable and acceptable health care for all. Irregular migrants are able to obtain a code to access urgent and essential health care (Stranieri Temporaneamente Presenti). It identifies the migrant to all health service providers, is anonymous

and free of charge. The code can be applied for at any time and can be renewed. Children are included on their parents' code. Irregular migrants are also entitled to preventive care, including maternity care and care for diseases that could progress and become dangerous. Furthermore, Italy has implemented targeted interventions to promote access to health care, including the use of targeted health promotion campaigns, interpreters and cultural mediators in some regions, and the dissemination of information regarding health care entitlements at national and regional levels to different groups and in different languages. National law also explicitly prohibits health services from reporting irregular migrants to officials, except under very restrictive conditions, which also apply to Italian citizens.

In **Portugal**, the Ministry of Health has provided several training sessions to health care and administrative professionals working in local health units and hospitals across the country on the rights and duties of refugees in accessing the national health system. The training presents practical cases for discussion and provides legal documentation. The training sessions are of two types: one is in cooperation with the High Commission for Migration, and the other is part of the interministerial training package led by the Ministry of Work, Solidarity and Social Affairs and developed in the framework of the cooperation protocol in support of applicants and beneficiaries of international protection.

Lessons learned. Access to health is related both to legal entitlements and to the existence of barriers to utilizing health care. As such, Italy has ensured policies are in place to overcome such barriers. The Italian response to the health needs of irregular migrants is an example of policies enacted to ensure the equitable provision of health care for irregular migrants and the elimination of key barriers.

4. Promoting people-centred, gender-, refugee- and migrant-sensitive health policies and health systems and programme interventions

In **Germany**, the project Together Against Tuberculosis aims at supporting patients with TB to successfully finish the WHO-recommended directly observed therapy strategy. A pair of medical students partner with one patient to provide support throughout the whole therapeutic process, promoting quality and continuity of care at the highest standard. Students also assist the treating physician in explaining the disease and treatment to the patient and the patient's family. Students establish a personal relationship with the patient and provide support in organizing the management of medicines and medical check-ups after leaving the hospital. Consideration is also given to the particular needs of female patients, who may often be afraid to communicate or seek care for their disease, for example through fear of rejection from partners. Patients are completely free to participate and provide written informed consent. The programme emphasizes the importance of people-centred care and incorporates gender- and migrant-sensitive approaches to the provision of TB treatment for migrants. Furthermore, students receive supervision and support by their medical school and receive recognition from their medical curriculum after the patient has successfully finished treatment. The goal of supporting patients to successfully treat TB is in parallel with improving the social and cultural skills and competencies of future physicians. Students learn how the well-developed and equipped health system of Germany is perceived by particularly vulnerable individuals, and how social, practical, structural, cultural and linguistic barriers can be overcome.

In **Portugal**, Bué Fixe is a youth organization that aims at encouraging migrants from the community of Portuguese languages living in deprived neighbourhoods of Amadora in the outskirts of Lisbon to adopt safer attitudes and behaviour regarding HIV and AIDS. Through the programme Youth Media, Our Response to HIV/AIDS, initiated in 2009, Bué Fixe works to attain this goal by scaling up existing and effective HIV prevention initiatives in order to reach other young migrants; expanding adequate

support and opportunities to people living with HIV in the community; empowering youth (especially young women) so that they can mitigate HIV risks through safer attitudes and behaviour; and developing community-based initiatives focusing on reducing stigma and discrimination towards people living with HIV. Bué Fixe trains young community leaders to increase their knowledge and skills on HIV- and AIDS-related matters, distributes condoms, circulates informative material and provides information and services on HIV and AIDS through various media outlets.

In the **United Kingdom**, primary care teams with a high proportion of asylum seekers have adjusted service provision to improve access and quality of care in several areas. Linguistic needs include documentation of the language and literacy level of all patients, provision of interpreters and communication in the preferred language, longer appointment times to allow for interpretation and explanation, and simplified labelling of prescriptions for easier understanding. Mobility of asylum seekers creates needs for enhanced access to medical records for different agencies and provision of copies of written material for patients when referred to secondary care. Specific health service needs include testing for HIV and sexually transmitted infections for high-risk groups, catch-up immunization for patients younger than 1 year of age and screening for issues such as homelessness and a history of torture. Staff expertise is improved through the provision of interpreters, enhanced cultural competency training and intersectoral working. To consolidate and sustain good practice, performance indicators that recognized these services have been developed.

Lessons learned. There are multiple barriers for migrants in accessing treatment, understanding the health system and in ensuring effective follow-up. For TB, there are issues of not only accessing treatment but also completing the full regimen. The project in Germany offers a unique way to assist migrants overcome such barriers. Moreover, the didactic approach is extremely useful and, to a large extent, the medical/therapeutic goals are in synergy. It also enables the production of knowledge and insight on the barriers to TB therapy in Germany, which can help to improve future services.

5. Ensuring provision of short- and long-term public health interventions to reduce mortality and morbidity among refugees and migrants, including bridging short-term emergency and humanitarian health assistance with long-term health programmes and vaccination

In **Greece**, PHILOS is a programme of the Greek Ministry of Health, implemented by the Hellenic Centre for Disease Control and Prevention, to fulfil the sanitary and psychosocial needs of people living in open camps. The programme introduces a comprehensive approach regarding the provision of primary health services to refugee populations. Its main objectives are further reinforcement of the capacity of the public health system as a whole and the enhancement of the epidemiological surveillance structures struggling with the stranded migrant population; the provision of on-site health care and psychological services to the target population through coordinated and well-targeted operational actions; strengthening of the National Health System taskforce, the primary health structures and the National Centre for Emergency Care; and the provision of a system of recording for hospitalization and health services to nationals of other countries.

The Sicily Region in **Italy** has become the pioneer within the WHO European Region in the development of an operational strategy to respond to the public health implications of sudden and large arrivals of immigrants. With the start of the military operation Mare Nostrum, the geographical distribution of migrants in Sicily radically changed, thus challenging the capacity of the regional health authorities throughout the whole Region. To address this challenge, the contingency plan identified all actors involved in the public health response to migration, integrating their roles in a coherent process, and established a homogeneous procedure to improve the organizational aspects of the public health response by increasing the efficiency of both logistical and human resources.

The contingency plan also addressed the various risks and challenges faced by migrants during the different phases in which they arrive, providing a detailed overview of these from rescue at sea to reception in migration centres, and the medical triages conducted throughout the process. For example, the plan includes mandatory monitoring and evaluation of the conditions in migration centres on a periodic basis. The contingency plan has been produced by the regional health authorities in Sicily with the technical assistance of the WHO Regional Office for Europe. It has been produced on the basis of the assessment mission carried out by the Regional Office with officials of local and national authorities specifically with the aim of coordinating the health response to large arrivals of refugee and migrant populations by identifying best practices and potential gaps in the health sector. Using the WHO Toolkit for Assessing Health System Capacity to Manage Large influxes of Refugees, Asylum Seekers and Migrants, the WHO Regional Office for Europe has also conducted assessment missions in other Member States who have received large numbers of refugee and migrant populations, including Bulgaria, Cyprus, Greece, Hungary, Malta and Serbia.

In **Serbia**, with WHO support, three local contingency plans are being developed for the border regions that are on migrant routes. These plans are expected to be completed and adopted by the end of 2018 and will improve capacity of health authorities and local governments in these regions to respond in a timely and adequate manner to heightened new waves of arrivals.

Lessons learned. The mass arrival of refugees and migrants is a complex and intersectoral issue and responding to the challenges requires the involvement and cooperation of a diverse range of stakeholders. There is a need for enhanced engagement among all actors involved within and beyond the health sector. Contingency planning as in Serbia is a primary example of the coordinated and collaborative work being done within Europe to consolidate regional capacity and improve health system planning and development to continue to adapt and manage the increasing number of migrants to Europe. The contingency plan in Sicily also acts in recognition not only of the ethical duty to protect the health of migrants but also that the health of the individual is much influenced by the health of the community. The aim of the plan is, therefore, to also improve the health of the whole resident community.

6. Promoting continuity and quality of care for refugees and migrants

In the **Czech Republic**, the policy for the integration of foreign nationals includes raising awareness of foreign nationals and overcoming language barriers between patients and health care providers. In order to achieve this goal, the Ministry of Health created a patient guide and communication cards for foreigner patients and health professionals in various languages. Centres for the Support of the Integration of Foreigners provide professional social consulting on various problems including health care and health insurance to migrants, free of cost. Centres may also provide interpretation services and even accompany foreign national to the health care provider. Similar services are provided to refugees who participate in the state Integration Programme for Beneficiaries of International Protection.

In **Finland**, The PALOMA (Developing National Mental Health Policies for Refugees) project (2016–2018) works to develop a national model for mental health work with refugees and individuals from comparable backgrounds. The project aims to provide guidelines and build capacity among professionals working with refugees on the prevention, recognition and treatment of mental health problems. The PALOMA model is targeted to different levels of administration and different contexts and will be implemented nationally to ensure mental health services are better and equally organized throughout Finland. The model covers primary and specialized care, as well as preventive initiatives outside of the social and health service sectors to promote quality and continuity of care.

In **Kazakhstan,** with reference to the Wolfheze Consensus Statement on the minimum package for cross-border TB control and care in the WHO European Region, the Government in collaboration

with the IOM has implemented a project to enhance its operational and institutional mechanisms to fully deliver TB-related health services to migrants. The project aims to promote migrant-sensitive health policies, legal and social protections and interventions to provide equitable, affordable and acceptable access to TB services for migrants. It is also focuses on improving health monitoring and health information systems. Key practices have included the development of a legal framework for migrants' access to health care with a focus on TB services; training on TB and migration for immigration officials, including border guards; development of a predeparture orientation package for migrants with a focus on health; and public information campaigns through the distribution of information material on migrants' rights in Russian, Tajik and Uzbek languages. There has also been advocacy for regional cooperation with United Nations agencies and development partners in central Asia, and exchange of experiences on prevention, control, diagnosis and treatment of TB during high-level meetings. As a result of such activities, two bilateral agreements have been established to cover cross-border control, prevention and treatment of TB in the Central Asian Region, and protocols for medical escorting of migrants with TB during their return. There has also been extensive capacity-building for project partners, state officials and medical professionals in the predeparture orientation of migrants.

In **Sweden**, health screening must be offered to all applicants for international protection by the county councils/regions in which they reside. The health screening is voluntary and intended to identify any health problems relating to the individual. Screening aims to deliver a medical assessment of health care service requirements for each individual. It must include questions about the person's immunization status and his or her exposure to infections, as well as any other information that may be needed to identify infectious diseases. The questions must be based on the epidemiological situation of the places where the person in question has stayed before arriving in Sweden. The health screening must also include a health dialogue concerning the person's past and present physical and mental health. A part of this dialogue must concern the person's psychosocial situation or traumatic experiences. A physical examination and tests must be carried out as part of the health screening. They should be based on the findings from the questions asked earlier and the health dialogue. Such screening and dialogue aims to link migrants to the health system and ensure continuity of care.

Lessons learned. Governments in central Asia need to focus their efforts on controlling TB across borders, ensuring access of migrants to TB prevention, treatment, care and support. Involvement of nongovernmental organizations (NGOs) as partners, as well as regional and intercountry coordination and the establishment of referral mechanisms are best practices for ensuring safe migration and the right of migrants to the highest attainable standard of health.

7. Preventing and controlling communicable and noncommunicable diseases, including mental health, for refugees and migrants

In **Belgium**, with the aim of providing free vaccination services and promoting the importance of vaccines among people in vulnerable situations, Flanders launched mobile vaccination teams in 2014. These focused on children falling through the safety net of the School Health Service or the Flanders Agency for Child and Family and provided services free of charge to all people who could not access medical care. Potential target groups include Roma, victims of trafficking, and homeless people. Vaccination data are recorded in a centralized system, where it is then available to all other vaccination services. Moreover, since 2016, all asylum seekers are vaccinated at the time of the asylum application, at the same time as screening is conducted for TB. Those coming from countries with polio also receive an extra polio vaccine in line with WHO recommendations. Additional priority

is given to vaccination against measles, mumps and rubella (WHO elimination goal for measles and rubella) and combined diphtheria, tetanus and pertussis, the latter especially for pregnant women.

In **Greece**, tailored vaccination programmes in the form of mass vaccination campaigns have been developed to address gaps in vaccination coverage among migrant and refugee children. Priority vaccines have been defined and provided through a specific programme: in infancy for measles, mumps and rubella; combined diphtheria, tetanus, pertussis and polio; and TB. More than 30 000 vaccines have been administered under the programme, with estimated vaccination coverage (first vaccine dose) for children appropriate to age of 83% for measles, mumps and rubella; 82% for combined diphtheria, tetanus, pertussis and polio; 76% for pneumococcal vaccine; 75% for *Haemophilus influenzae* type b; and 79% for hepatitis B virus. Vaccination was mainly conducted by NGOs with considerable experience and expertise in mass vaccination campaigns, as well as by some health services of the national health system and the Institute of Public Health. Specific mass campaigns have been organized to implement the priority vaccination programme in all refugee and migrant accommodation, including children living in residential centres and in other urban areas (e.g. hotels, apartments) or atypical structures.

In **Poland**, the Office for Foreigners implements epidemiological protection procedures that provide for a thorough check of the health status of those crossing Polish borders and applying for international protection; this is aimed primarily at diagnosing, isolating and providing immediate treatment for patients suffering from infectious diseases presenting an immediate epidemiological threat. The Early Detection of Infectious Diseases Programme specifically consists of rigorous diagnostic procedures and increased patient observation from the moment of arrival until the risk of infection is ruled out. This programme is intended to ensure proper and effective sanitary and epidemiological protection for all people living in filtered areas; early detection and isolation of persons suspected of infectious diseases or infections; minimization of the risk of spreading of infectious agent among both foreigners and the Polish population; and improving continuity of care.

In **Sweden**, a national and international telepsychiatry service between Sweden and Denmark has been implemented to enhance access to refugee groups to more appropriate mental health care in terms of the bilingual proficiency and cultural competence of the health professionals. The free service was offered to 45 refugees and 12 asylum seekers, with a total of nine languages being spoken over the 34 months of the project. Each patient had an average of 5.2 telepsychiatry sessions with referrals either for diagnostic assessment and subsequent treatment or for treatment via the telepsychiatry service. Clinicians not only spoke the same language as their patient but also had a comprehensive knowledge of the health care system in both the host country and the patient's original country. A questionnaire was administered to patients in the final session. The questions explored their attitudes towards aspects of telepsychiatry, including technology, confidentiality, preference and information. Two open-ended questions investigated participants' views on the benefits and disadvantages of this type of service. Patients reported a high level of satisfaction with the service, stating that they would be happy to use telepsychiatry again and to recommend it to their peers. Patients preferred telepsychiatry sessions with a clinician who spoke their native language than a normal interpreter-assisted consultation as the latter also increased their concerns regarding confidentiality.

The **WHO Regional Office for Europe**, in collaboration with the European Commission Directorate General for Health and Food Safety, has established the Migration and Health Knowledge Management project to fill knowledge gaps in the area of migration and health in the Region. The project focuses on expanding knowledge and understanding of migration and health, fostering knowledge sharing and supporting the development and uptake of evidence-informed approaches to ensure actions meet the health needs of refugees and migrants. The project is developing technical guidance recommendations across six priority issues in migrant health: child health, elderly health, health promotion, mental health, maternal and newborn health and noncommunicable diseases. For each priority issue, knowledge and good practices will be shared in various formats for

immediate use and application by decision-makers, health practitioners and other relevant stakeholders. Interactive webinars on various topics are also being conducted to complement the technical guidance and enable unique thought-provoking perspectives to be brought to refugee and migrant health challenges.

Lessons learned. Providing early access to culturally appropriate health care is important to prevent and reduce the risk of poor health outcomes related to communicable and noncommunicable diseases, including mental health conditions. In the absence of native speaker clinicians, interpretation services may be critical to ensuring provision of high-quality care for refugee and migrant populations.

8. Improving the health and well-being of women, children and adolescents living in refugee and migrant settings; promoting gender equality and empowering refugee migrant women and girls

In **Austria**, sexual violence as well as female genital mutilation and cutting maybe defined as persecution under the Asylum Act. Migrant, refugee and asylum-seeking women are provided support services free of charge. As migrant women often go to hospitals rather than local doctors, hospitals of a certain size are obliged to set up victim support groups and smaller hospitals must cooperate with larger ones if they do not set up one themselves. Victim support groups are responsible for early detection of sexual, physical and psychological violence (particularly in women) and for raising awareness among hospital staff of violence as a cause of injury or ill being. Some hospitals also have specialized units to perform necessary operations to help victims of female genital mutilation and cutting, and training programmes are offered to medical staff. Other services to promote gender equality and promote the health of migrant women and girls include more than 50 violence-specific aid facilities and protection centres for women and children affected by domestic and sexual violence, including a specific shelter for those exposed to forced marriage, many of which offer support in relevant foreign languages to accommodate the high percentages of migrant clients. There is specialized training for staff of the Office for Immigration and Asylum on traumatism and interculturalism, and the Austrian Integration Fund also provides training to Muslim women as peer educators, including on the prevention of violence.

In **Spain**, the Association Salud y Familia (Health and Family) is implementing several programmes to improve access to health services for irregular migrants in the Barcelona region. The association combines policy advocacy with coordination with service providers and the Government to guarantee irregular migrants access to a health card. In collaboration with the public hospitals of Cataluña, they also implement the programme Mothers Between Two Cultures, aimed at designing and piloting intercultural education activities targeting migrant mothers with different cultural background who have children of 3 years or younger. The objective is to improve coverage and reduce unmet needs in the area of maternal and child health prevention and promotion through strengthening knowledge, capacity and social support networks. The Association also offers a programme called Assistance for At-Risk Maternity, which provides partial assistance for pregnant women to receive prenatal care and psychosocial support.

Lessons learned. Networking is important and it is necessary to develop mechanisms to support medical staff in their work with female migrants, including on legal regulations on violence and female genital mutilation and cutting and information about intercultural sexual education; for example this is especially important in the areas of contraception, and prevention of STDs. Austria promotes several counselling organizations that implement projects in an integral way for migrants.

9. Addressing the health of migrant workers, occupational health and safety measures, including improving working conditions; addressing workforce strategies

In **Finland**, the National Institute for Health and Welfare runs a project called Cope that examines the current state of migrant health, social care workers' integration and education and existing bottlenecks in integration. Cope examines the functioning, challenges and management of culturally diverse work teams and how organizations take into account the diversity of work teams and clients. Cope aims to find out how both migrant clients and culturally diverse work teams affect the learning and educational needs of health care personnel. Ways to solve challenges for competence, work teams and leadership resulting from diversity are explored. Cope seeks to find means for lifelong learning to ease and prepare workers in handling migrant clients and the development of professional competence. It also introduces and launches good practices to improve migrant education and the means by which they can utilize their knowledge and skills in the Finnish work life.

In **Spain**, the Spanish Ministry of National Social Security and the Ministry of Labour and Immigration divide workers into six groups or social security regimes according to the type of work they perform; the grouping governs the amount of taxes paid by the employer and employee, injury and illness leaves, subsidies, disability compensations, pensions, working hours, vacation time and hiring and firing practices. The special household service regime covers workers who receive a wage to perform exclusively domestic services in various arrangements. A crucial element of domestic services is the nature of the contracts, which can often be verbal, making it difficult for workers to register complaints and regulate adherence to sick leave and occupational safety measures. A study carried out as part of a bigger project (Project Immigration, Work and Health) found that documentation status was relevant in terms of empowerment and bargaining but did not appear to influence work tasks or exposure to hazards directly. The authors suggested that household service workers should be covered by the general regime as that would at least establish better conditions for documented workers.

In **Tajikistan**, The Ministry of Health and Social Protection together with IOM, has engaged the Ministry of Labour, Migration and Employment to foster policy development and the planning and implementation of activities aimed at improving the health of migrants and guaranteeing their right to health. Special attention has been given to strengthening the capacities of government entities also outside the health sector, including staff in the Ministry of Labour, to address migrants' health needs. Activities include integrating the Ministry's representatives into the development of migrant health-related policy, conducting national and regional trainings on TB and HIV prevention, and providing technical support to the Ministry of Health to implement a project on HIV prevention among migrants and their families. As a result of these activities, there is now a joint work plan on TB prevention among migrants for 2017–2020 signed between the two Ministries. The Ministry of Labour is also leading activities in engaging the Tajik diaspora for TB prevention among migrants in the Russian Federation, and now plays a key role in promoting the implementation of the Minimum Care Package for Cross Border TB Control and Care among Migrants. In 2017, the Ministry of Labour conducted high-level meetings with representatives of the Ministry of Health, the Ministry of Foreign Affairs, NGOs and the Tajik diaspora, with the subsequent development of the 2018 work plans on TB and HIV prevention among migrants through the Tajik Diaspora Network.

Lessons learned. The interagency partnership in Tajikistan on TB and HIV among migrants is an example of an effective multisectoral and interorganizational approach for collaborative action on migrant health. It demonstrates the importance of enhancing capacity across sectors to better integrate health into national policies and programmes. Although the Ministry of Labour has demonstrated a high commitment to a multisectoral approach for addressing the health needs of migrants, recurrent staff turnover in the Ministry indicates a need for permanent training and technical support on the topic of migration and health. The Ministry of Labour has strong links and

cooperation with the Tajik Diaspora in the Russian Federation and the Ministry of Health needs to utilize this for health promotion, particularly in cross border control and care of TB and HIV among migrant workers and their families.

10. Creating health monitoring and health information systems for refugees and migrants

In **Finland**, current guidelines for the voluntary initial health assessment for asylum seekers focus on screening for infectious diseases. There is, however, an increasing awareness of noncommunicable diseases, in particular mental health issues. The National Institute for Health and Welfare launched the TERTTU project (Developing the Health Examination Protocol for Asylum Seekers in Finland: a National Development Project 2017–2019) in collaboration with the Finnish Immigration Service to improve the current national health examination protocol for asylum seekers. The project aims at evidence-based development of the current national health examination system towards a standardized protocol used in migrant reception. It also aims at improving health monitoring for asylum seekers in Finland though systematic data collection on the health and service needs of newly arrived adults and children. This will result in an improved health record system and increased knowledge and understanding of the relevant health concerns and needs of asylum seekers at the local, regional and national levels.

In **Serbia**, The Migrant Health Information System, supported by WHO, was established in 2015. All health care providers in the country, both state institutions and NGOs, provide data on a weekly basis about the number of health conditions registered and services provided. This system set the basis for timely monitoring of the situation and response planning.

In **Turkey**, population-level information about noncommunicable diseases is obtained through the WHO STEPwise approach to surveillance (STEPS) of risk factors. This focuses on obtaining core data on the risk factors established as determinants of the major disease burden. The STEPS questionnaire assesses five major risk factors: daily cigarette smoking, consuming fewer than five portions per day of fruit and/or vegetables, failing to meet physical activity recommendations, overweight or obesity, and high blood pressure. The WHO STEPS survey for Syrian refugees living in Turkey was a cross-sectional study based on the refugee population in 10 provinces and conducted in December 2015. The survey indicated a higher risk of noncommunicable diseases among the Syrian refugees than in the host population. The WHO STEPwise approach contributes to improved health surveillance and monitoring.

Lessons learned. The monitoring and recording of specific, disaggregated data is extremely important for developing and targeting interventions to respond to the health needs of refugees and migrants. More work is needed, and systems require further refinement.

11. Improving communication and countering xenophobia to dispel fears and misperceptions among refugee, migrant and host populations on the health impacts of migration and displacement

In the **Czech Republic,** the goal of the integration policy (outlined in item 6) is also intended to communicate with the general public about the issues of migration and integration in relation to citizens and immigrants. The migration reality of the last few years brings a risk of certain adverse effects such as xenophobia, islamophobia, racism, extremism or other expressions of negative attitudes of individuals or groups towards immigrants. Crimes with racial undertones are still very few and isolated, but in some areas with higher concentrations of immigrants, negative attitudes of the majority population towards foreigners have been registered. The integration policy also aims to

consistently oppose xenophobic tendencies in society and to intervene actively against manifestations of hatred towards immigrants, while adhering to the requirements laid down by legislation. Emphasis is placed on the principles and tools of integration, on intensive promotion of government integration measures and on the activities of the organizations supporting integration and on clarifying the meaning of integration in the process of building a harmonic coexistence with immigrants. A variety of projects from the Centres for the Support of the Integration of Foreigners and NGOs (e.g. multicultural festivals, defence against hate crimes) are subsidized from the state budget and EU funds.

In **Germany**, the online portal zanzu.de provides simple explanations in 13 different languages on sexual and reproductive health and rights, including the human body, pregnancy and birth, contraception, HIV/AIDS and other sexually transmitted infections as well as sexuality and relationships. Importantly, there is detailed information available on the respective rights and laws in Germany, as well as existing support and counselling structures. The website is not just multilingual but also utilizes illustrations and integrated text-to-speech functions and special icons in order to be easily accessed by immigrants who have recently arrived in Germany and may not yet have the adequate language skills to obtain quality information on issues of sexual and reproductive health. Based on a human rights approach, the online portal provides comprehensive information enabling people to live self-determined lives and make informed and responsible decisions. It is also accessible to practitioners and intermediaries who either advise or treat adult immigrants professionally, such as physicians and counsellors.

In **Malta**, to attend specifically to the health needs of migrants and assist health professionals working with them, the Migrant Health Liaison Office has developed training for cultural mediators to facilitate communication between migrants and health care providers and overcome some of the cultural and linguistic barriers experienced on both sides during the health care encounter. The role of cultural mediators is more than that of an interpreter and aims to explain and negotiate the cultural beliefs and behaviours related to health, illness and medical care. Mediators have been recruited from several migrant communities in Malta, including Congolese, Eritrean, Ethiopian, Nigerian and Somali communities. Moreover, half of the cultural mediators with the Migrant Health Liaison Office are women and provide assistance during prenatal and gynaecological appointments at the women's clinics within the health centres. The Office has also conducted community outreach on sexual and mental health and how to navigate the health system, with materials published in many languages.

In the **Republic of Moldova**, national authorities involved in the asylum system and in the integration of foreigners (public authorities as well as civil society representatives) are provided with ongoing training to promote the right to health and equality for refugees and migrants. For example, the Bureau for Migration and Asylum organizes a biannual workshop entitled Migrants' Rights. The workshop aims at strengthening the functional capacities of the authorities in the field of migration, with a particular emphasis on ensuring respect for migrants' rights. It is structured around several basic modules including the right to health, international standards for migrants' rights, fundamental civil rights of migrants, access to the labour market and social and economic rights, access to social security and education and the right to family reunification. Each module is discussed in detail with the involvement of the participants, using case studies to examine the issues of migrants accessing their rights. Discussion also includes avoidance of discrimination and xenophobia, approaching legislation and practice by each concerned institution, presenting successful cases and practices as well as the existing deficiencies and analysis of the case law.

Lessons learned. Comprehensive and effective integration policies not only require migrants to be well informed about the health system and available services but also must address potential hostility of the host population towards these vulnerable groups.

12. Enabling participation and social inclusion of migrants

In **Germany**, to improve support for refugees, asylum seekers and those designated as tolerated individuals (where deportation has been temporarily suspended) in accessing the labour market, the Federal Employment Agency has developed programmes with a focus on the special needs of these groups. For example, programmes such as Prospects for Refugees, Prospects for Young Refugees and Prospects for Female Refugees help these groups to gain occupational orientation combined with practical work experience in companies. The goal of these programmes is to offer help with access to the labour market and vocational training in Germany, the mapping of skills, skills assessments and qualification checks, as well as teaching job-related German. Young refugees can obtain information about access, structure and functionality of the dual vocational training system and the labour market. This helps to empower them to make an independent choice for an occupation, preferentially for dual vocational training. In 2016, about 7500 young refugees started just within the Project for Young Refugees. With the measuring system for skill assessment, early activation and language acquisition (Kompetenzfeststellung, frühzeitige Aktivierung und Spracherwerb), participation in an activation measure is combined with participation in an integration language course. In this way, language skills are immediately and successfully used in practise, which increases learning effectiveness. Furthermore, participants become better acquainted with the requirements of the labour market. German language courses for those with good prospects of remaining in Germany have been further expanded for both people who want to acquire basic German language skills and those in need of vocational language skills. On 1 July 2016, the Ordinance for Vocational Language Training Support became effective, installing a language training support tool exclusively financed by the Federal Government for the first time.

In the **Netherlands**, with regard to promoting the participation and social inclusion of refugees and migrants, good practices are seen in many municipalities. For example, the municipality of Leiden's 24 x 24 programme is a tailored approach aimed at helping migrants to integrate into Dutch society and the labour market. It recognizes the talent and contribution of migrants and is designed to enable them to be socially and economically independent, and fully engaged in the Leiden community. The programme has several components, for example mentoring by volunteers, discussions on cultural differences and Dutch culture, language instruction, civic integration activities, internships and work and training mediation. This long-term programme empowers new residents to have their own place in the society.

In **Poland**, the Office for Foreigners considers that it is important to allow foreigners to know the principles of Polish society and the state even while at the stage of waiting for a decision on the provision of international protection. In addition, the Act on Granting Foreigners Protection in the Territory of the Republic of Poland guarantees them off-centre assistance, consisting of cash benefits to cover their costs of stay in the territory of the Republic of Poland. This ensures that everyone can choose the form of aid for their specific needs. Centres for foreigners organize open days when the local community can see the conditions of stay of foreigners applying for international protection, and the work performed by the centre staff. Residents, journalists and representatives of public institutions may enter the centres freely and talk to residents. All guests of the open day can expect many attractions, including ethnic dishes prepared by residents, dance shows and other games and activities. The centres also organize trips and some cooperate periodically with nearby animal shelters or local charities for fundraising. These activities are important for fostering participation and inclusion of migrant populations in the Polish community.

In **Turkey**, with the aim of both integrating Syrian professionals and ensuring the health care needs of Syrian refugees are met, the Government has now allowed Syrian health professionals to work in the health system in Turkey. As such, the Public Health Directorate General of Turkey associated with the Ministry of Health, together with the WHO Country Office, have developed an adaptation training for Syrian doctors, nurses, midwives and patient guides/bilingual medical translators living

in Turkey. Supported by multiple donors, training provides classroom and practical coursework to certify and authorize Syrian health professionals to practise in refugee health centres and deliver primary services to refugees free of charge. They also work under the mentorship of Turkish health professionals for several weeks to familiarize themselves with the health system. This approach seeks to give professionals the knowledge and experience needed to best apply their skills in the Turkish setting.

In the **United Kingdom**, the Migrant and Refugee Communities Forum is a bilingual mentoring support scheme developed in 2007 in order to take advantage of the skills of unemployed refugee doctors who wanted to support non-English-speaking refugees and migrants experiencing mental illness. Mentees not only reported feeling better but also started attending college, volunteering and some secured paid work. The Forum has now opened the mentoring role to all individuals who want to support refugees and migrants. Training and structured support is provided for mentoring vulnerable refugees and migrants weekly for at least six months to help them to break out of isolation and build confidence for a new start.

Lessons learned. The training initiative in Turkey for health care among Syrian refugees is a way to address some of the key barriers to refugee health care and to ensure the provision of culturally and linguistically appropriate services. It is also a good example of collaboration between national and international partners to strengthen health system capacity. With establishment of this capacity within the primary health system, health service provision for the host community is also improved, with the release of pressures on emergency, secondary and tertiary care.

13. Creating partnerships and cooperation, intersectoral, intercountry, in-country and interagency coordination and collaboration mechanisms: whole-of-government and whole-of-society approaches in addressing refugee and migrant health

The **Strategy and Action Plan for Refugee and Migrant Health in the WHO European Region** has been developed by the WHO Regional Office for Europe. At the High-level Meeting on Refugee and Migrant Health, held in Rome, Italy, on 23–24 November 2015, Member States of the WHO European Region agreed on the need for a common framework for collaborative action on refugee and migrant health, acting in a spirit of solidarity and mutual assistance to promote a common response, thereby avoiding uncoordinated single-country solutions. The WHO Regional Office for Europe developed the Strategy and Action Plan guided by the Rome High-level Meeting and discussions during the 138th session of the WHO Executive Board and the Sixty-ninth World Health Assembly and based on the discussions on migration and health that took place during the sixty-fourth and sixty-fifth sessions of the WHO Regional Committee for Europe in 2014 and 2015, respectively. The Strategy and Action Plan was also developed in the context of the 2030 Agenda for Sustainable Development, Health 2020 and the World Health Assembly resolution 61.17 on health of migrants. It provides a coherent and consolidated national and international response to protecting lives and providing for the health needs of refugee and migrant populations in countries of origin, transit and destination, and to respond to the health needs associated with the migration process. The Strategy and Action Plan emphasizes the need to involve and strengthen collaboration with and among United Nations agencies and bodies, the EU and Eurasian Economic Union, the IOM and other national and international institutions and organizations with roles and mandates for migration and health issues, including NGOs, the private sector, professional networks and academia. Coordination between national, regional and local levels is also important, as is consultation with civil society and migrant communities.

There are nine priority areas included in the Strategy and Action Plan:

- strategic area 1: establishing a framework for collaborative action

- strategic area 2: advocating for the right to health of refugees, asylum seekers and migrants
- strategic area 3: addressing the social determinants of health
- strategic area 4: achieving public health preparedness and ensuring an effective response
- strategic area 5: strengthening health systems and their resilience
- strategic area 6: preventing communicable diseases
- strategic area 7: preventing and reducing the risks posed by noncommunicable diseases
- strategic area 8: ensuring ethical and effective health screening and assessment
- strategic area 9: improving health information and communication.

The Strategy and Action Plan was endorsed by the WHO European Regional Committee in 2016.

The **Knowledge Hub on Health and Migration** is a joint effort between the WHO Regional Office for Europe, the Ministry of Health of Italy, the Regional Health Council of Sicily and the European Commission. The partnership is committed to building expertise and competency on the public health aspects of migration and making knowledge and information in this area widely available. The platform works across five priority areas including strengthening the evidence available on migration and health, webinar seminaries, summer school, policy dialogues and high-level summits. The first Summer School on Refugees and Migrant Health was held in Sicily, Italy, in 2017. The school hosted 76 participants from 25 different countries, including 30 nominated delegates from 16 Member States. The next summer school is currently being planned for 2018 and the intention is that that it will be repeated in subsequent years.

Lessons learned. Although in the context of their specific circumstance and legal frameworks, most Member States have the capability to respond to the public health challenges associated with migration, they still require better preparedness, greater capacity for rapid humanitarian response and increased technical assistance. The migration crisis in 2015 demonstrated that the capacity of individual countries could be pushed to the limit, and the development of resilience to sustained migration is needed. This calls for integrated global, interregional and cross-border public health interventions and programmes, and recognition that action that focuses solely on host countries will be less effective. The WHO Regional Office for Europe is part of collaborative efforts to interlink Member States to build effective capacities to respond to health needs linked to migration.

VI. PROGRESS, RECOMMENDED POLICY OPTIONS AND WAYS FORWARD

Migration is a major social, political and public health challenge for the WHO European Region and policy-makers are challenged to develop specific and coherent policies addressing the health needs of all migrants, including asylum seekers and refugees, in accordance with the Strategy and Action Plan.

Analysis of the country assessments to date suggests a number of practical conclusions and recommendations concerning enhancing capacity of health systems in managing large influxes of refugees and migrants. National contingency planning should be fully integrated into national health policies, strategies and plans, based on comprehensive needs assessment. Here, focal points for refugee and migrant health within ministries of health play a major role. Effective integration of NGOs is of importance, particularly in early responses.

Intersectoral health policy response in the context of the Sustainable Development Goals and Health 2020 is vital in order to respond to the full range of health determinants. Within the health sector, consideration should be given to the efficient use of resources, effective response to health needs and, particularly, to the effective provision of primary health care with well-trained staff capable of dealing with psychosocial issues. The shift from an emergency to a longer-term response, and procedures for screening, case finding and triage, should be considered explicitly.

Also important are the effectiveness of the health care workforce; necessary staffing demands; training, particularly in cultural sensitivity and competencies; the provision of language support in the field; and the development of defined communication procedures and modalities to achieve a one-voice communications capacity.

Full consideration should be given to the needs for implementation of the 2005 International Health Regulations, including national guidelines for communicable disease preparedness, surveillance and control. Relevant guidelines should be shared widely, including with refugees and migrants themselves. Communication should also take place with local agencies and the media, and with the local health workforce, who should be trained in crisis communications and media contact.

At the operational level, practical support to facilitate access to services has been summarized *(16)*. Legal restrictions on access to health care for refugees and asylum seekers should be removed, regardless of immigration status, and coordinated multisectoral action between agencies extended within and beyond the medical system, for example to include integration of housing, employment and education sectors.

The utilization of services, particularly primary care, could be improved through the provision of: technical support for registering and making appointments, provision of language support and patient advocacy services, provision of free transport to and from appointments, longer appointment times to allow for interpretation and explanation, provision of flexible opening hours and appointment times, gender-specific requests being met and respected, the development and delivery of quality training for professionals, and increased awareness among health professionals of mental health issues for refugees and asylum seekers, particularly minors.

Linguistic barriers to quality health care should be addressed through adoption of an intersectoral approach to the provision and distribution of health information in a range of languages; the provision of professional interpreters, free of cost to the patient and health practitioner; the provision of clear labelling for prescriptions with specific consideration for the language of the patient; and documentation of language and literacy levels of patients.

The evidence on health issues for refugees and asylum seekers should be strengthened by developing information and monitoring systems to promote comparative work across subsections of migrant and non-migrant populations; coordination of data across governmental and nongovernmental agencies; examination of the health effects of different phases of the asylum process; assessment of the long-term health impacts of initiatives relating to integration in housing, employment and education; understanding of the correlation between integration policy and good health outcomes in maternity and mental health; development of non-stigmatizing concepts for research and monitoring; and addressing migrants' own priorities and where these may be at odds with those of professionals.

VI. STRENGTHS AND LIMITATIONS OF THE REPORT

Owing to the limitations of the available evidence, the results of this report should be interpreted with the following limitations.

- Studies assessing refugee and migrant health used inconsistent terminology and methodologies for assessing refugee and migrant health. There is a lack of a shared definition of migrants at the international level and it was challenging to stratifying data by migrant legal status (with and without documentation, and refugees).
- Although migration and forced displacement are increasing, there are a limited number of studies in the Region; most of these were carried out in western countries, and none used clinical or social outcome measures for evaluating the impacts of defined practices.

- There is also relatively little information about the health status of, and health policies for, refugees and migrants, in particular irregular migrants. Moreover, the information available also often does not distinguish between documented and irregular migrants.
- Since the implementation of policies takes place at local level with the involvement of different actors and ministries (e.g. health, labour, foreign affairs, NGOs), it was not possible to ensure that all existing information had been collected, or to claim the completeness of the report.
- The findings may also highlight the lack of available research in the Region on the subject. Although there has been some success in addressing refugee and migrant health, more research is needed to support development of good practice in this area.

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Annex 1. International migrants in the WHO European Region

European Region								
Major area, region or country of destination	**Number of international migrants** (thousands)		**International migrants (% total population)**		**Females among international migrants** (%)		**Median age of international migrants** (years)	
	2000	**2017**	**2000**	**2017**	**2000**	**2017**	**2000**	**2017**
Albania	77	52	2.5	1.8	53.1	49.1	25.4	19.7
Andorra	42	41	64.5	53.3	47.6	47.5	42.5	47.6
Armenia	658	191	21.4	6.5	58.9	59.5	37.0	52.7
Austria	997	1660	12.3	19.0	52.0	52.0	40.5	44.9
Azerbaijan	328	259	4.0	2.6	56.9	52.1	42.6	43.2
Belarus	1124	1079	11.3	11.4	54.2	54.2	42.0	52.8
Belgium	896	1268	8.7	11.1	48.0	49.2	36.7	36.6
Bosnia and Herzegovina	83	37	2.2	1.1	52.2	52.3	35.0	37.1
Bulgaria	43	154	0.5	2.2	57.9	55.6	41.2	37.2
Croatia	585	560	13.2	13.4	53.0	53.7	44.6	49.7
Cyprus	80	189	8.5	16.0	56.6	56.2	32.2	34.4
Czech Republic	221	433	2.1	4.1	46	42.6	52.8	38.9
Denmark	371	657	6.9	11.5	51.5	50.6	34.5	37.0
Estonia	250	193	17.8	14.7	59.6	58.2	54.7	59.3
Finland	136	344	2.6	62.0	50.5	49.1	31.6	36.2
France	6279	7903	10.5	12.2	50.7	51.8	46.3	48.2
Georgia	76	78	1.6	2.0	56.2	56.2	51.6	40.6
Germany	8993	12165	11.0	14.8	49.9	50.2	39.8	43.4
Greece	1112	1,220	10.0	10.9	49.6	54.5	32.4	42.4
Hungary	297	504	2.9	5.2	53.5	50.0	49.3	41.2
Iceland	16	42	5.7	12.5	54.7	50.5	33.7	33.1
Ireland	351	807	9.1	16.9	50.7	51.1	32.9	36.1
Israel	1851	1962	30.8	23.6	53.9	54.6	51.9	47.8
Italy	2122	5907	3.7	10.0	54.0	54.4	34.6	39.2
Kazakhstan	2871	3635	19.1	20.0	54	50.4	45.7	38.9
Kyrgyzstan	390	200	7.9	3.3	58.2	59.6	46.0	46.9
Latvia	430	257	18.0	13.2	58.7	60.7	54.6	63.0
Lithuania	214	125	6.1	4.3	53.1	58.4	49.9	58.2
Luxembourg	140	264	32.0	45.3	50.4	49.2	38.2	41.7
Malta	22	46.0	5.4	10.6	52.2	46.6	33.9	38.9
Monaco	22	21.0	67.9	54.9	52.0	50.9	51.1	53.8
Montenegro	0	71	0	11.3	0	60.8	0	43.0
Netherlands	1556	2057	9.8	12.1	50.8	52.2	37.1	42.5
Norway	292	799	6.5	15.1	50.5	47.8	34.9	36.3
Poland	825	641	2.1	1.7	59.0	57.2	64.7	69.2
Portugal	651	880	6.3	8.5	50.8	53.3	31.3	41.7
Republic of	248	140	5.9	3.5	56.0	64.6	50.3	52.3

Moldova								
Romania	127	371	0.6	1.9	52.4	46.9	60.7	25.1
Russian Federation	11900	11652	8.1	8.1	49.7	50.9	40.4	44.5
San Marino	4	5	14.8	15.7	46.2	44.6	33.2	36.4
Serbia	857	802	9.0	9.1	55.2	56	48.4	56.5
Slovakia	116	185	2.2	3.4	56.0	49.5	50.7	50.4
Slovenia	171	245	8.6	11.8	47.1	43.6	38.1	49.0
Spain	1657	5947	4.1	12.8	49.4	51.4	33.4	39.7
Sweden	1004	1748	11.3	17.6	52.2	50.6	42.0	40.1
Switzerland	1571	2506	21.9	29.6	46.4	51	33.1	43.1
Tajikistan	299	273	4.8	3.1	56.1	56.9	50.3	54.0
The former Yugoslav Republic of Macedonia	126	131	6.2	6.3	58.3	58.3	49.9	52.4
Turkey	1281	4882	2	6	51.9	53	33.7	32.6
Turkmenistan	218	195	4.8	3.4	56.9	53.4	49.2	53.0
Ukraine	5527	4964	11.3	11.2	57.1	57.0	46.6	49.1
United Kingdom	4730	8842	8.0	13.4	52.9	52.4	40.1	37.4
Uzbekistan	1405	1159	5.7	3.6	56.9	53.4	49.2	51.6
European Region	**65642**	**90748**	**7.6**	**9.9**	**52.1**	**52.1**	**41.6**	**44.2**

Source: United Nations Department of Economic and Social Affairs *(6).*

Annex 2. Contributions from Member States and partners

Country	Contributor (number of submissions)	Type
Austria	Federal Ministry of Health and Women's Affairs	Member State
Belgium	FPS Health, Food Chain Safety and Environment	Member State
Bosnia and Herzegovina	Ministry of Civil Affairs	Member State
Cyprus	Ministry of Health	Member State
Czech Republic	Ministry of Health, Consortium of Migrant Assisting Organizations in the Czech Republic, Human Rights Council	Member State, partner
Finland	Ministry of Social Affairs and Health	Member State
France	Human Rights Council	partner
Georgia	Ministry of Labour, Health and Social Affairs	Member State
Germany	Federal Ministry of Health, Together Against TB	Member State, partner
Greece	Human Rights Council	Partner
Italy	Ministry of Health, Human Rights Council	Member State, partner
Kazakhstan	Ministry of Healthcare, IOM	Member State, partner
Latvia	Ministry of Health	Member State
Luxembourg	Ministry of Health	Member State
Malta	Ministry of Health, Human Rights Council	Member State, Partner
Monaco	Prince's Government	Member State
Netherlands	The Ministry of Health, Rijnstate Hospital	Member State
Norway	Ministry of Health	Member State
Poland	Office for Foreigners	Member State
Portugal	Directorate General of Health, ILO, Human Rights Council	Member State, Partner
Republic of Moldova	Ministry of Health	Member State
Serbia	UNFPA, Human Rights Council	Partner
Spain	Human Rights Council	Partner
Sweden	ILO, Human Rights Council (2)	Partner
Switzerland	Federal Office of Public Health, Human Rights Council	Member State, partner
Tajikistan	IOM	Partner
Turkey	Directorate General of Public Health, UNHCR	Member State, Partner
United Kingdom	United Nations University, International Institute of Global Health, Human Rights Council	Member State, partner

Annex 3. Existing initiatives, plans, regional organizations, partners and networks

MIG will continue to work with countries to fill potential gaps in health service delivery, provide policy recommendations for advanced preparedness and response and use the WHO Toolkit to assess the capacity of health systems capacity to manage and respond to large-scale influxes of migrants.

Ongoing work in Gaziantep (Turkey) in October 2013 to increase capacity to respond to the public health needs of Syrian refugees will continue as needed, as will collaborative work with the WHO Regional Office for Europe's Division of Health Systems and Public Health and the Division of Communicable Diseases and Health Security, in coordination with the Hellenic Ministry of Health in Greece.

The Knowledge Hub on Health and Migration and the annual Summer School on Refugee and Migrant Health will continue to be developed. New initiatives for further development include the appointment of the University of Pecs as a WHO Collaborating Centre for Migration and Health to serve as a technical and scientific resource for the Public Health and Migration programme of the WHO European Region. More well-established universities and research institutions across the WHO European Region are in the process of becoming collaborating centres to strengthen MIG's work in supporting countries.

The WHO European Strategy and Action Plan will continue to be implemented, and the Regional Office is monitoring its implementation regularly to provide necessary support to Member States. In addition, for WHO at global and regional levels, several immediate steps are suggested.

1. A new effort to be an active contributor to United Nations processes around migration including the Global Compacts on Migration and Safe, Orderly and Regular Migration, and advocacy for opening legal corridors to allow protected journeys and reduce public health risks.
2. WHO headquarters' supportive processes, which might include headquarters–regional office consultations, designed to explore and define the breadth of migration and associated health needs.
3. The encouragement to each region to create the necessary operational capacity to support Member States to identify and respond to health and migration needs.
4. The development of a coordinated series of regional meetings around an aligned agenda for Member States to follow the headquarters–regional discussion.
5. The promotion of further collaboration with and among United Nations agencies (particularly UNHCR, ILO, United Nations Development Programme, United Nations Children's Fund, United Nations Population Fund and the Joint United Nations Programme on HIV and AIDS), the European Commission, IOM, civil society organizations and other national and international organizations to reinforce interventions and development of tools, and to avoid duplication of efforts.

6. The promotion of multisectoral national and international collaboration, and engagement of community and civil society organizations to foster common action in origin, transit and destination countries.
7. Agreement (perhaps at the headquarters–regional office consultations) concerning cross-office/technical unit work packages based around the main strategic priority areas, with a focus on action planning and implementation aiming at whole-of-government, whole-of-society and also whole-of-WHO office concerns.
8. The promotion of communication and exchange of information helping countries share experiences and good practices, as well as interventions that were less successful.
9. Advocacy for the inclusion of refugee and migrant health issues in existing regional and global funding mechanisms.
10. Strengthened surveillance and the production of evidence and research reports, country assessments and networking platforms.
11. The development of modular trainings on health equity and human rights-based approaches for health and non-health workers